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℞ FOR VA'S NURSING SHORTAGE: IS THERE MORE THAN ONE ANTIDOTE?

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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℞ FOR VA'S NURSING SHORTAGE: IS THERE MORE THAN ONE ANTIDOTE?

THURSDAY, OCTOBER 2, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 10:01 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Bilirakis, Everett, Boozman, Filner, Hooley, and Udall.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. I am going to go ahead and start the hearing, even though all members are not here. I will go ahead and read the statement.

The Subcommittee on Oversight and Investigations of the Committee on Veterans' Affairs will come to order.

In today's hearing, we hope to learn how the VA is addressing its current nursing shortages and what steps the Department is taking to address a potential exodus that could occur over the next few years.

According to the VA, 35 percent of its registered nurses are eligible for retirement by year 2005. If the VA does lose one-third of its 36,000 RNs, where does that leave the veterans who will be in dire need of care?

Because the VA has an aging population which will require more complex care from highly skilled professional nurses, we cannot ignore what is in front of us.

On Monday, September 29, 2003, the American Health Line reported that "Historically, high nursing shortages have created a game show-like frenzy among hospitals, which are offering sign-on incentives, such as vacations, vehicles, massages, concierge services, free tuition for nurses and their children, and bonuses of up to $10,000."

It is easy to surmise from this that there are indeed too few nurses available to fill hospital vacancies, nursing homes and other needs at specialty clinics, but also to fill the need at the VA.

Statistics certainly tell us this is the case, according to the National Conference of State Legislatures' health policy tracking service, which was last updated on April 1, 2003, that found the number of full time equivalent nurses was 1.89 million in 2000. This represents a nursing shortage of 110,000, or 6 percent. It is esti-

mated that by year 2015, the demand will increase and the shortage will almost quadruple, to 20 percent.

What we are looking for here today is not just a discussion about the problem, but what are the solutions to these problems facing our health care organizations.

Earlier this year, I visited a VA hospital in Tampa, FL, the James A. Haley Hospital. While at that facility, I learned that it had achieved Magnet status. When I asked "What does that mean?" I was told that receiving such a designation represented the highest level of recognition that the American Nurses Credentialing Center can grant to a health care organization.

Harvey Holzberg, President's staff, Robert Wood Johnson University's Hospital, said "We believe the quality of nursing is the key to our hospital's success. Receiving the Magnet award is the highest formal recognition testimonial to that quality . . .the award was recognized by the entire hospital family as a formidable accomplishment on the part of our nurses."

Please note I did not say there are not enough RNs. What I am saying is that individuals with their RNs are leaving the profession in search of more lucrative and less demanding work. Major reasons include not only burnout, but the work climate, work satisfaction, patient quality of care, and managerial support. The Magnet program addresses many of these concerns.

To sum it up, the purpose of today's hearing is to find out two things in particular: the extent of the problem, and what is a potential solution that the VA should turn to to attract recent nursing graduates.

I would also like to thank the American Association of Nurse Anesthetists and the National Association of Clinical Nurse Specialists for submitting statements, and they shall be entered into the record.

(See pp. 128 and 133.)

Mr. BUYER. I now recognize the ranking member for any comments she may have.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair.

America faces a critical nursing shortage, and the shortage has many causes. There is a shortage in the number of trained and qualified nurses actively engaged in their profession. There is a shortage of recognition for the dedicated work of our nurses. There is a shortage of interest in gaining admission to America's nursing programs.

HHS determined that graduations for our nursing schools have shown a steady rate of decline, 26 percent for the 5 year period ending in 2000. Why? A projected shortage of more than 800,000 registered nurses is forecast by 2020. There is a decline in interest. Is it less cool today to be a nurse? Nursing is demanding work. Nursing is gratifying work. Nurses are sometimes taken for granted. Nurses are sometimes overlooked as stakeholders contributing to the management of both their patients and their organizations.

Nationally, we must make every effort to assure the health of the nurse training pipeline. Are our nurse training facilities modern

and are they staffed with adequate numbers of qualified instructors?

There are today indications that a shortage in qualified nurse instructors is but one hurdle that must be overcome to assure the adequacy of America's nurses corps.

As the committee of jurisdiction for the Department of Veterans Affairs, this domestic shortage of nurses is of great concern. We must not only seek solutions to this crisis on a national level, we must make every reasonable effort to authorize and encourage VA to compete for quality nurses in a tight market.

Once we look at the root cause of this decline nationally, we will be able to better determine the possible solutions, and what action is necessary to generate greater interest in a career in nursing.

Many ideas and programs have been fielded. We should ask how well these are working to rekindle national interest in the nursing profession.

The VA presents unique challenges because dire fiscal constraints limit nurse recruiting actions. Bonus recruitments and cutting edge programs are limited. Word of mouth stories proliferate the perception that VA nurses are overworked and under recognized by the VA medical system. Management decisions just occur, and there is often one key stakeholder group left out of the decision process. Advocates of the Magnet certification program will testify today. They will present data regarding the benefits of their program. Major health care facilities pay to undergo the certification process. It is a valued symbol. Clearly, certification is a status symbol among health care facilities. It is an indicator that the subject facility is nurse friendly from a management perspective. Nurses and nursing issues become part of the strategic planning process. The certification tends to draw the best nurses to the facility, nurses who seek a total employment package that may include competitive salaries, but truly values participation and job satisfaction.

A positive culture is created around this concept. Certification is an indicator of good management from a nurse's perspective. But just as you can have intelligence without a college degree, or bravery without the reward of a medal, you can have good nurse management without Magnet certification.

The Magnet program is getting results today. No question about it. When 40, 50, or 60 percent of facilities nationwide are certified, will Magnet lose its importance? Will it no longer be a symbol of status?

The fundamental long term value of the Magnet program is that it facilitates interest in and use of strategic management processes. All stakeholders belong in that process. This is basic management, but sometimes it has gone astray. The principles and cultural changes that underlie the certification are the true value of the effort.

I yield back my time.

Mr. BUYER. Thank you.

I would like to welcome the first panel here today. We have Cathy J. Rick, RN, CNAA, FACHE, chief nursing officer, Department of Veterans Affairs. Sandra K. Janzen, MS, RN, CNAA, associate chief of staff, Nursing, James A. Haley Veterans' Hospital,

Department of Veterans Affairs for Tampa, FL, and Mary Raymer, RN, MA, CNAA, nursing education program manager, Health Care Staff Development and Retention Office, Department of Veterans Affairs, New Orleans, LA. Ms. Rick.

STATEMENTS OF CATHY J. RICK, CHIEF NURSING OFFICER, DEPARTMENT OF VETERANS AFFAIRS; SANDRA K. JANZEN, ASSOCIATE CHIEF OF STAFF, NURSING, JAMES A. HALEY VETERANS' HOSPITAL, TAMPA, FL; AND MARY C. RAYMER, NURSING EDUCATION PROGRAM MANAGER, HEALTH CARE STAFF DEVELOPMENT AND RETENTION OFFICE, DEPARTMENT OF VETERANS AFFAIRS, NEW ORLEANS, LA

STATEMENT OF CATHY J. RICK

Ms. RICK. Thank you and good morning. Chairman Buyer and Ms. Hooley and members of the subcommittee, I thank you for this opportunity to present testimony regarding the impact of the national nursing shortage on the Veterans' Health Administration, the nation's largest employer of registered nurses.

As you have mentioned, by the year 2020, the United States RN workforce is forecast to be roughly the same size as it is today. Unfortunately, this is estimated to be nearly 20 percent lower than national RN workforce requirements. A modest increase in enrollment in generic nursing programs was experienced in 2002. However, far larger increases are needed if the trends are to be reversed.

I would like to highlight three key points with regard to nursing workforce issues affecting patient care and staff satisfaction in VA. They are, one, VA's commitment to effective nursing recruitment and retention. Two, VA's direction in terms of making data driven management and staffing decisions, and three, the importance of our proposed legislation in terms of serving veterans' nursing care needs now and in the future.

First, the current and projected shortage of nurses is a symptom of the ever changing landscape of the health care industry in this country.

VHA is committed to addressing short and long term issues affecting staff satisfaction and clinical practice. This is imperative in light of the nursing shortage, to assure a desirable work place that attracts the most promising and competent nurses to VA.

Published findings underscore the need to focus on improving the work environment for nurses, as you both mentioned, in order to increase staff satisfaction and to ensure the provision of safe, high quality patient care.

Negative work environments are characterized by undesirable work schedules, inadequate support staff, lack of respect, and lack of nursing involvement in patient care decisions.

The 2001 report, A Call to Action, VA's Response to the National Nursing Shortage, provided the foundation for VA's retention, recruitment, and outreach activities to address work environment issues.

I will share a few examples of our current initiatives that improve the nursing environment.

First, the VA's staffing plan directive. As required by the Department of Veterans Affairs' Health Care Programs Enhancement Act of 2001, Public Law 107–135, this directive outlines national guidance for incorporating staff opinion in defining workload and patient outcome indicators at the point of care as key determinants for developing and evaluating staffing plans.

A second example is the VA nurse qualification standards. These standards demonstrate VA's commitment to maintaining an appropriate mix of qualified registered nurses to respond to health care trends, and VA will continue to hire and value the contributions of nurses prepared at the associate, baccalaureate, and doctoral level.

Technological advances in health care treatment and equipment, evolving health care trends, modifications in delivery systems, and consumer expectations require nurses to constantly adapt to change and new roles.

One of the results of the new qualification standards is that 64 percent of VA nurses are prepared at baccalaureate and higher degrees. I would note that the importance of this keep in light of Dr. Linda Aiken's recently published research shows that mortality and failure to rescue rates were 19 percent lower in hospitals where 60 percent of the nurses had BSNs and higher, as compared to hospitals where only 20 percent were BSNs.

Another example of initiatives for VA's retention and recruitment is our nurse/physician collaborative. In response to nurses identifying a need for better communication and stronger collaboration between nurses and physicians, VA is implementing a nurse/physician collaboration breakthrough series. This is designed to foster greater interdisciplinary understanding between professions. This has the effect of simultaneously improving patient care, as well as nurses and physicians' satisfaction with the work environment.

Ms. Raymer and Ms. Janzen will be highlighting additional VA retention and recruitment initiatives.

For my second point, I would like to highlight VA's commitment to database management and staffing decisions. The VA nursing outcomes database project is a 16 month project, creating a database of nursing sensitive quality indicators. These data will enable understanding of relationships between nurse staffing and patient outcomes, and facilitate benchmarking for identifying best practices.

In addition to the findings from this project, we look forward to the findings and recommendations from the VA Commission on Nursing. The Department of Veterans Affairs' Health Care Programs Enhancement Act of 2001, again, Public Law 107–135, established the Commission to among other things consider legislative and organizational policy changes to enhance the recruitment and retention of nurses and other personnel. We look forward to their recommendations in May of 2004.

Finally, I would like to thank you for your interest and support of VA's proposed legislation, defining initiatives that will have significant positive impact on our ability to retain and recruit a highly qualified workforce.

These initiatives are designed to correct impediments to retention and recruitment identified by VA administrators and nursing

leadership, and supported by data, and they will provide VA with a far greater competitiveness in hiring and retaining nurses.

These legislative proposals specifically address concerns regarding scheduling flexibilities, and nurse executive pay.

Retention initiatives and recruitment strategies will continue to have my full attention, as we work together to address national nursing workforce challenges. We really do appreciate your interest in assessing workforce needs and implementing innovative strategies to address them.

VA's health care workforce is critical to the success of our mission to care for those who shall have borne the battle.

Thank you for your attention.

[The prepared statement of Ms. Rick, with attachments, appears on p. 43.]

Mr. BUYER. Thank you, Ms. Rick.

Ms. Janzen, I recall having met you at the Tampa facility with Mr. Bilirakis. I have come a long way since my initial asking you that question, what is Magnet status. I just want you to know that. (Laughter.)

Ms. JANZEN. It was very clear from your comments.

Mr. BUYER. There are all types of people and all types of politicians, and a lot of them just like to act like they know what they are talking about. Right? If I don't know, I am going to tell you I don't know. That way, I get to learn. That's why you are here. You are going to help us. Please.

STATEMENT OF SANDRA K. JANZEN

Ms. JANZEN. Thank you very much. I can make my comments shorter because you have become very well educated in the Magnet process.

As you know, I am the Associate Chief of Staff for Nursing responsible for nursing practice at the Tampa VA, the nursing homes in Orlando and Tampa, and the large clinics in Orlando, Viera, and Port Richey, and community-based outpatient clinics.

Thank you for holding these hearings on the nursing shortage and its implications for the VA.

My testimony will present Magnet Nursing Services Recognition Program and how this credentialing process may improve recruitment in retention associated with the nursing shortage in VA.

As you know, in March 2001, our VA facility was the first and still is the only VA that has successfully achieved Magnet recognition. Four others, however, are in the stages of application and 11 more are exploring the application process.

The concept of Magnet recognition emerged with the 1980s nursing shortage, with a study of successful hospitals who did not experience a shortage or difficulty in recruiting and retaining nurses.

Characteristics of Magnet organizations included a participative management style, nursing staff involvement at all programmatic levels, collegial nurse/physician relationships, supportive organizations, and highly qualified transformational nursing leaders.

In the 1990s, these same characteristics continued to be manifested in successful organizations and are now the basis for the Magnet Recognition Program.

In 2002, the Joint Commission on the Accreditation of Healthcare Organizations publicly acknowledged the importance of a supportive work culture such as Magnet in its report, Healthcare at the Crossroads.

Today, Magnet recognition is achieved through a stringent and comprehensive process that includes organizational self assessment, based on the Magnet criteria, development of an action plan to enhance administrative and clinical programs, and a written application that is appraised and scored to determine the degree of excellence.

If an organization exceeds the excellence score, a rigorous site visit focuses on the professional staff providing nursing care, and how organizational leaders support nurses in their practice.

I believe our veterans deserve clinical excellence provided by Magnet nurses.

Patient care requires a team of professionals, and Magnet standards ensure interdisciplinary collaboration, and thus recognizes the entire organization.

How is Magnet recognition helped us? Tampa's nursing recruitment and retention situation has improved dramatically in the past 2 years. It is a very competitive environment in Florida. Our RN turnover rate has dropped from 14.5 to 10.2, or nearly nine percent lower than the Florida average. The vacancy rate in the Tampa VA Medical Center fluctuates between seven and eight percent. This is half the community average in West Central Florida, despite adding new positions to activate more critical care beds, managing double digit growth in outpatient care, and treating the highest volume of patients in the VA health care system.

In 2001, our facility used supplemental agency staff in our intensive care units and acute care areas due to staffing shortages. Although agency use never exceeded two percent of all registered nurse hours, today our units are staffed without any additional agency nurses, and we successfully recruited highly qualified staff to activate a 26 percent increase in our critical care beds.

Our staffing levels have stabilized, and nurses are spending more of their working hours with patients. Tampa nurses perceive staffing levels to be adequate, and they report they have sufficient time to meet patient needs.

Our annual nurse satisfaction survey results have improved in all six domains, some areas more than others. We are going in the right direction.

Tampa's clinical outcomes are also very good. Our patient fall rate is below national benchmarks despite aggressive implementation of initiatives to minimize restraint use. Our pressure ulcer rate compares favorably to external benchmarks. Patient satisfaction is high. Nurses routinely receive compliments from veterans and their families.

We have an educated staff who are valued as competent key members of an interdisciplinary team. Sixty-five percent of our nurses have a bachelor's or master's degree compared to national reports of 38 to 48 percent. This again substantiates the findings in Dr. Aiken's study that Cathy Rick described.

Again, thank you, Mr. Chairman, for holding this very important hearing. An energized, satisfied, well-educated professional nursing

workforce is achievable in VA, using the Magnet model for excellence in patient care. Veterans deserve no less.

Thank you.

[The prepared statement of Ms. Janzen appears on p. 72.]

Mr. BUYER. Thank you. Ms. Raymer.

STATEMENT OF MARY C. RAYMER

Ms. RAYMER. I am very glad to be here this morning. I am from the Health Care Staff Development and Retention Office, which is a field based headquarters office actually located in New Orleans, LA, and what I would like to do is give you a summary of the programs that are currently in place that are managed from that office that address nursing recruitment and retention.

First, just a little brief overview about where our office has observed——

Mr. BUYER. Mary, if you could also include statistical outcomes in your remarks.

Ms. RAYMER. Yes, I will.

Mr. BUYER. Thank you.

Ms. RAYMER. In the last 2 years, we have observed from the office a significant expansion in the recruitment and retention of certain health care professionals. Among these are physicians in certain occupations, like radiology, and pharmacists, as the retail pharmacy industry has grown, that has become an increased issue for the VA.

However, the shortage of nursing personnel is present in almost every community, differing only in severity and in the type of nursing staff needed. Obviously, many of our efforts have focused on nursing recruitment and retention.

The programs currently in place promote nurse recruitment and retention and are broadly grouped into education programs, national placement service, advertising and marketing, and development of the nurse recruitable at each medical center.

I will begin with the education program. The employee incentive scholarship program, the national nursing education initiative, and the employee education debt reduction program are all components of the health professional education assistance program.

The scholarships program provides funding support for VA employees to attend nursing programs, to become licensed practical nurses or registered nurses. The nursing education initiative provides funding support for VA's registered nurses to obtain baccalaureate degrees in nursing and advanced degrees. The VA employee may receive up to 3 years of full time education with a funding support at a maximum of $32,043 allowed in 2003.

Since the programs were implemented in 2000, there has been 30 employees enrolled in the LPN program, with three of those graduating by 2002. There are 197 VA employees enrolled in the associate degree program, with 20 graduates by 2002.

The significant point of these programs is that they produce new nurses for the Department, and help replace those individuals that are planning or have already retired from the system.

The national nursing education initiative provides funding for registered nurses to obtain baccalaureate degrees in nursing and advanced degrees. Through fiscal year 2002, there has been 2,639

scholarships awarded to registered nurses, with 427 of those participants graduating by 2002. Approximately 60 percent of those awards were for baccalaureate degrees and 81 percent of them are awarded to nurses in the staff nurse role.

The program also supports advanced nursing practice and generates potential faculty as 939 participants are enrolled at the master's level, 52 at the doctorate level, and 75 in post-graduate study for such specialties as wound care management or palliative care.

The participants' service obligation with the VA is for 1 to 3 years following the completion of their academic program.

The program has been a powerful recruitment and retention incentive for the VA. Through 2002, the VA had obligated $34.7 million to these programs, with an average award of a little over $11,000 per nurse for an average of 2.2 years of study.

The education debt reduction program provides education debt reduction payments to recently appointed nurses. These are people that have been with the Department or in their appointed position for less than 6 months. The first awards were authorized in 2002, with registered nurses receiving 46 percent of the awards, and a total of $12 million. The average award per nurse was $14,184.

The final education program that we administered is called the VA learning opportunities residency or VALOR. This is a program which has been in place since the 1990s and provides a paid, precepted work experience for baccalaureate nursing students who have completed their junior year. The goal of this program is to retain these students after they finish their program, and hopefully then they will become VA nurses.

In fiscal year 2003, our funding was $1.7 million for this program, and it provided experience for 290 students. The funds are always fully utilized with 116 facilities out of the 165 having at least one VALOR student.

The national placement program, through the use of the vacareers.com web site, the application process on line, and the national advertising programs, do our national programs for video, audio and other kinds of media.

This past year, we implemented a nurse recruiter advisory group that will help us keep in touch with the field and provides a valuable conduit for input into all of these programs.

In planning for 2004, we then developed a comprehensive nursing recruitment and retention proposal that included a variety of initiatives. Among them were the continuation of the education program, the increase of the number of VALOR positions. We asked for an additional 110 positions for VALOR. Then most significantly, the addition of an upward mobility program.

This last program then will provide funding for VA employees who are not nurses to go to school and become either LPNs or RNs. This is a significant program as it will add new nurses to the Department.

In summary, those are the major programs that our office manages and the outcomes we have had to date.

I also thank you very much for having these hearings, and helping us in any way you can to continue our work.

Thank you.

[The prepared statement of Ms. Raymer appears on p. 75.]

Mr. BUYER. Thank you. Ms. Rick, are there hospitals that are in particular geographic regions that have shortages where others do not? Can you tell as you look across the country?

Ms. RICK. The variation with regard to the impact of the shortage in our facilities across the country really mirrors what is happening in all other communities across the country. Although our vacancy rate and our turnover rate on average in all areas of the country is lower than national averages, it mirrors that trend. If it is high, such as in California and New York in the community, those shortage issues are impacting the VA as well.

Mr. BUYER. When Congress came in and chose the 60 percent number of nurses with a baccalaureate degree, was that about right?

Ms. RICK. Health and Human Services data?

Mr. BUYER. Was that a right thing to do?

Ms. RICK. Actually, the current research that was just published last week does validate that projection, that 60 percent or higher, but the statistical difference was when there were at least 60 percent of the RN workforce trained at baccalaureate and higher degrees, yes. It does validate that. That is Dr. Aiken's study that Sandy and I mentioned. We can make copies of that study available to you, if you would like.

Mr. BUYER. Maybe I should re-ask the question this way. What are the increased measurable outcomes that you can elaborate on that would reinforce this is the right thing to do or we should even trend it higher? We made a huge investment here. That is what I would like to know.

Ms. RICK. What Dr. Aiken's study demonstrates is that there is a 19 percent reduced mortality rate, a reduced rate in what is referred to as failure to rescue. There is a reduced rate of complications with a higher percentage of RNs prepared at that level; reduces the incidence of patients who will die from complications following procedures.

Her study was based on a surgical patient population, primarily elective patients, so those patients who are not expected to have a high incidence of complications and mortality.

Mr. BUYER. Going back to my geographic question, are there VA hospitals whereby we would be at 60 percent, if you look at a community based facility, that they might be at 40 percent or 30 percent, or some may be higher, how is the VA rating with regard to local community health standards, geographically?

Ms. RICK. We have not evaluated it to that level of detail at this point. We do plan on doing that. I know that our national average is 62 percent.

Mr. BUYER. Could you do that for us?

Ms. RICK. Sure.

Mr. BUYER. Everything is based on the local community standards, especially when it comes to liability. I would like to know that.

Ms. RICK. We can provide that information.

Mr. BUYER. Thanks. Ms. Hooley?

Ms. HOOLEY, Thank you, Mr. Chair. Just a couple of questions, Ms. Rick.

In your comments, you talked about Dr. Aiken's research relating to RNs and patient ratios and that the ratio of one to four in fact saves lives. Is the VA supporting the findings on that one to four ratio?

Ms. RICK. What Dr. Aiken's study demonstrates is that the numbers and types of staff have a direct relationship and our predictors for patient outcomes. In her follow up study, the study that you are referring to with regard to ratios of licensed staff to patients, the follow up study further defined that the level of education of nurses is a better predictor than the number. In her article that was published last week, which she emphasizes in her research, is that both are significant in determining staffing methodology in patient care delivery models.

The number of licensed staff is important, and even more important is the level of education of that staff.

Ms. HOOLEY. How many of your nurses have a BS or BA or baccalaureate degree?

Ms. RICK. Sixty-two percent.

Ms. HOOLEY. What is your ratio?

Ms. RICK. We do not prescribe a ratio and actually do not even endorse standardized ratios. The staffing plan that I mentioned really is meant to give the staff at the point of care the opportunity to define legitimate workload indicators from their expert opinion and patient outcome indicators, so that they can best determine as an interdisciplinary team, what is the best staffing mix and patient care delivery model.

We really do oppose the approach of having a prescriptive nurse to patient ratio approach because it looks at patient care in isolation of the whole team, and does not really incorporate all of the necessary support staff.

Ms. HOOLEY. How does the VA compare to most large hospitals in the United States? The nursing shortage is happening in the VA. It is happening everywhere. How do the VA hospitals compare in registered nurses, people with baccalaureate degrees; how do they compare with other hospitals?

Ms. RICK. Comparable or better. If you are looking for something more concrete, it is hard to say for each facility, not that we cannot do that, but what I presented were some national figures. Our turnover rate is significantly less. Our vacancy rate is significantly less. We have the ability to attract and retain staff, and with our qualifications standards and the emphasis on the value of that education with our education programs, as Mary mentioned, we are able to achieve a high percentage of strong education for our staff mix.

Ms. HOOLEY. One of the things that I hear all over, and certainly in the Portland VA Hospital, is a nursing shortage, but you hear it literally from every hospital. One of the many causes seems to be that we do not have enough instructors. In our case, in my state, there was an article in the paper the other day about one of the community colleges and their nursing program where literally they do not have the money to expand their program, and they have a waiting list. I think what a shame—they have a waiting list of 60 some students that are all qualified, because we do not have the instructors. We do not have the money to add new programs.

Does the VA work with our colleges to address this issue? What do you do with other institutions in addressing that nursing shortage?

Ms. RICK. Most definitely, we do. You describe a scenario that is replicated across the country with waiting lists for associate degree community colleges as well as baccalaureate programs. That is the case. The aging workforce in the faculty ranks is in dire straits.

What we have done is enter into partnerships in the communities more so than with our national initiative at this time, so that VAs supplement faculty by having joint appointments, providing faculty for clinical experiences, and actually we are looking at a proposal to help fund some of those faculty joint appointed positions as well.

At a national level, I work very closely with the American Association of Colleges of Nursing and the American Association of Community Colleges, to look at appropriate partnerships, to design the right workforce for the best patient outcomes, and try to break down the barriers of those things that we look at that may be individual interests, but really to be patient focused.

Ms. HOOLEY. I would be really interested to know, if you could do that either today or later on, how many of the joint faculty positions there are that you worked with. I am really interested in this whole issue. Right now, we are recruiting nurses from all over the world, taking away in fact some desperately needed health care in some other countries, but needed here.

I am very interested to know what you are doing with other institutions and what those numbers look like in helping deal with this whole issue.

Ms. RICK. We would be glad to provide additional information. We did provide a video tape that describes some of our best practices in that area. The video tape does highlight some of the programs with our academic partners, and that might be of interest to you as well.

Ms. HOOLEY. Thank you.

Mr. BUYER. Mr. Boozman, you are recognized for 5 minutes.

Mr. BOOZMAN. Ms. Janzen, tell me about the difference in the Magnet situation versus the regular hospital? A ward in a regular hospital would be thus versus the other. I guess what I am curious about is is it a money thing? Is the Magnet program a lot more expensive to operate, or is it more an organizational thing? Is it little things like doctors treating nurses with more respect in those situations? I don't mean that bad. Again, things like that. Tell me how it works a little bit.

Ms. JANZEN. In many ways, it really is a little bit of all of those things. I think cost is a question that is clearly a fair question. The cost for Magnet recognition does come with costs, and it is based on the number of beds.

If indeed we were to apply today for our nursing home and our acute facility, it would probably cost us in appraiser fees, the application process and everything, maybe about $44,000. That sounds like a lot of money. However, when you take a look at the recruitment costs that are out there and retention costs, it really does average out. That is part of the cost.

One of the things that really underlies the physician/nurse relationship issue is the issue of competence. Nursing competence, to be able to interact with physicians, and be respected for the unique knowledge that nurses know, this is one of the underlying components that comprises the essentials of magnetism in the current research that is out there on Magnet hospitals.

A very well educated staff that can make good contributions in the interdisciplinary team, strengthens teamwork and patient care.

I believe that we have that at Tampa. I do believe that is one of our areas of difference.

Another area of difference from the community is we are addressing the issues of technology and trying to make our work place a safer place to be, and the Chairman mentioned our ceiling mounted lifts. We are looking to design a facility that really addresses a much safer work environment for nurses, and we really need to look at some technological solutions so that we can keep older nurses working longer, and that they don't become hurt and injured and leave the profession early on.

Another issue that I think is different for our organization, but it is also unique to Tampa, is we have worked very closely with the University of South Florida. The College of Nursing at the University of South Florida and all affiliating organizations in the Tampa Bay area, have almost doubled the number of nurses that they are producing through a new innovative model, where our nursing staff, staff nurses, serve as preceptors for a core number of nurses who go through the bachelor's program.

We have just graduated our first couple of classes. I believe this will have those nurses come to work for us or Moffit or Shriners, because that is our work group. We had one student who wanted to live away from us, but within less than a month after having graduated, experienced the private sector and came back home to the Tampa VA, within one month.

I do think that is another effective model. We try many things. It is a very competitive market in Florida. If you notice, our turnover rate is higher than the national average, and we are a Magnet facility.

Mr. BOOZMAN. Once the consulting fees are done, that aspect, your operation, is there more expense at that point, compared to a normal facility? Is it more just in the organization, how you do it, compared to another facility?

Ms. JANZEN. I think the expectation is to live to a higher standard for the rest of your life, which is a wonderful thing, I think, for an organization. I do believe in time, we will be better able to say what the positive outcomes are for patients. We are beginning to collect that information in a more systematic way, but I think our outcomes will be better.

Mr. BOOZMAN. I guess your cost of doing business, once you have done the consultant stuff and we say that is over, going forward, is that the same as any other hospital?

Is your staffing higher or lower? Are you paying more? Do you see what I am saying?

Ms. JANZEN. Yes. I do not think we are paying any more than the community. The VA is not a pay leader.

Mr. BOOZMAN. I am comparing to the other VA hospitals that have not gone through this.

Ms. JANZEN. It has not been measured in the VA. We are looking at how we can possibly do that in more concrete ways to build a business case. I think it is going to be less. After 4 years, there is the cost of redesignation, which is not as high as the initial application.

I think the costs are going to be less. However, we are going to continue to strive to improve care very systematically like a good organization will do. I do not think that the cost is going to be any more. In fact, I certainly hope in time it will be less.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Mr. Udall, you are recognized for 5 minutes.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you, Chairman Buyer.

Ms. Rick, thank you for being here today. We very much support the idea, at least I do, that you are doing better than the private sector in these turnover rates and the vacancy rates, and you are showing some real successes there.

What I wanted to ask you about is to discuss the mortality rate as a function of the BSN degree ratio among the nursing staff of a facility. You mentioned it in your testimony and you also attached the Penn study.

Clearly, this not a stand alone issue. Perhaps the economically disadvantaged public service style hospitals can afford fewer BSNs, and what do you think are the other factors that would explain this mortality rate measurement?

Do you believe these studies are accurate? I know there are some that have contested the studies.

Ms. RICK. I have the utmost confidence in the study, and not just because I am educated at that level. It is not a self interest at all. It is really focused on patient outcomes. I know that is a challenge to those of us who are educated at a higher level than an associate degree.

I want to emphasize my personal and VA's commitment to associate and diploma degree nurses. It is a significantly valuable contribution by all nursing staff. I do think that mix is appropriate to consider long term in the health care industry, and especially in the VA.

The rigors of Dr. Aiken's study, I cannot speak to as well as others can that are perhaps better versed in research, but anything that gets published in JAMA and that goes through the kind of rigorous review from the foundations that supported it, is not something that is treated lightly. It is not something that others may call ill prepared, ill designed, ill interpreted.

I think it is significant and should be taken very seriously, and I think what the challenge will be to folks like yourself in legislation is to look at it from the patient's perspective, and to really look at how to understand the science and the evidence that she offers us in this study, and follow up studies that will need to be done, so that we really focus on what is right for patient care delivery and be careful about those of who may have—I do not know that

I want to include myself in that—everybody has some self interest. I just caution you to be attentive to that.

The evidence is sound. The science is well-developed and well-published. It is well-analyzed.

I think there is need for additional science in the same area. The impact on patient outcomes, there are many compounding factors. Nurses are not the only impact. We know that. It is clear this is a significant finding. I think it is a wake up call to all of us to really look at it from the patient's perspective.

Being a consumer, I would like to consider that it is taken seriously.

Did I answer your question?

Mr. UDALL. Yes. Thank you.

One of the things you mentioned I think in your testimony is one of the factors that is identified as far as nursing shortages is that there is a poor image of nursing as a career choice, and you cite this 2001 Gallup poll of the public perceptions of professions, where nurses ranked number one in terms of honesty and high ethics for the second consecutive year, but at the same time, nursing ranks 137 out of 250 professions in terms of desirability.

What do you think we can do to help change that image? Is there anything that we can do to change the image so that more individuals go into nursing?

Ms. RICK. I am not sure that legislative leaders—there is not something that comes to mind that would have a significant impact. It really is the burden of the practice settings to create the right work environments, and to demonstrate that it is not only an honorable profession, but a satisfying profession, and to really address those issues with regard to having the right support staff and having those who are educated to provide professional care really have the opportunity to do that, and to really look at having the right people do the right things in increasing the respect and voice of nursing, so it is clearly looked at as a full partner in the interdisciplinary team.

I think it is really our burden to continue down that road. Legislatively, we can always use more money. You know that. I think the burden is for us to really work on our work environments and hopefully get the support with regard to our proposed legislation on flexible schedules and pay equities for our leadership ranks.

Mr. UDALL. Thank you. Mr. Chairman, I see my time is exhausted here. Thank you.

Mr. BUYER. Thank you. The University of Pennsylvania in their recent release cited that the educational level of hospital nurses may be as important as how many RNs are at the bedside in determining whether patients survive common surgeries. According to the University of Pennsylvania's School of Nursing Study released today, which was September 24, in the Journal of the American Medical Association, "In a study of 232,342 patients, researchers from the Center of Health Outcomes and Policy Research found that raising the percentage of bedside RNs with bachelor's degrees from 20 to 60 percent would save four lives for every 1,000 patients undergoing just common surgeries. Surprisingly, of 168 hospitals studied in Pennsylvania, the percentage of university-trained RNs varied from 0 to 77 percent. A conservative estimate suggests the

difference between best and worse staffing in education scenarios could translate into 1,700 preventable deaths in Pennsylvania alone."

I would ask for unanimous consent that this study be incorporated by reference only in the record. Hearing no objection, so ordered.

(See p. 50.)

Mr. BUYER. I want to congratulate not only you, Ms. Janzen, but everyone who worked so hard to achieve such status and to be the first in the VA.

Ms. JANZEN. Thank you.

Mr. BUYER. Not to be too hard on the VA, but I wish the leadership of the VA had done that. I wish they were the ones who were driving this force. I am being tough on you now. I wish you had been the driving force, but instead, you know what, sometimes those initiatives come from the field, which in turn you can either say, great job, atta girl, and continue to set the high standards, and inspire others.

As we look at this across the VA facilities, how wonderful it would be if we could have all our VA hospitals achieve the status which Tampa has.

As you go back to Tampa, will you please take with you the warm appreciation and congratulations from us.

Ms. JANZEN. I certainly will.

Mr. BUYER. I apologize for my ignorance when I showed up, and you said hey, we have Magnet status. I said, what is that?

Ms. JANZEN. The staff will be absolutely delighted. Thank you so much.

Mr. BUYER. I feel so awkward now. Ms. Raymer, when you mentioned your statistical outcomes, we talked about recruiting. My question is on retention. These programs have the national nursing education initiative and you also have your VALOR program. What we would like to know is are they working? In other words, after the 3 years, are people then leaving or are you getting the retention benefit that you desired?

Ms. RAYMER. I cannot give you——

Mr. BUYER. If you cannot answer that, you can answer for the record.

Ms. RAYMER. I do not have the statistics to answer it yet, but just in looking at the data, for the people that finish, yes, they do stay.

Mr. BUYER. If you could provide that for the record.

Ms. RAYMER. We will provide that for the record.

Mr. BUYER. Are there any other follow-up questions?

Ms. HOOLEY. Very briefly.

Mr. BUYER. Very.

Ms. HOOLEY. I just have a statement I would like to enter into the record. It is from an Oregon RN, Sarah Atkins, an oncology nurse that works for the Portland VA Medical Center.

[The statement of Sarah Atkins appears on p. 135.]

Ms. HOOLEY. Her statement reveals a lack of management/labor cooperation during the current Magnet certification process.

You can talk to me afterwards about what is the process the VA engages their stakeholders in credentialing, or you can answer me in 30 seconds.

Ms. RICK. It looks like you are directing that question to me.

Ms. HOOLEY. I am.

Ms. RICK. It is expected that we include our labor partners in decisions such as this. It really is a partnership, not only in making decisions with regard to culture and organizational changes, but there are some logistical changes that may evolve over time. The best way to approach considering a Magnet recognition process is to really do it in partnership.

Ms. HOOLEY. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. Ms. Janzen, when you went through the certification process in Tampa, you brought the unions to the table from the beginning; correct?

Ms. JANZEN. In fact, we are very proud of the fact that the recommendation to seek Magnet recognition came from our labor partnership council and then went to the director of the facility.

Mr. BUYER. What happened in Portland was the opposite. That is the impetus of the question. Ms. Rick, as other facilities try to do that, it is very important that everybody sits at the table.

Ms. RICK. I understand.

Mr. BUYER. Thank you. This panel is dismissed. I appreciate your testimony.

I now recognize the second panel. Would you please come and take seats.

I would like to recognize Barbara Blakeney, president of the American Nurses Association.

Dr. Sarah Myers, immediate past president of Nurses Organization of Veterans' Affairs, and Ann Converso, United American Nurses. Ms. Converso, you are on the third panel.

Ms. CONVERSO. I am? Okay.

Mr. BUYER. Unless you have a flight you have to catch, or a lunch appointment.

Please, Ms. Blakeney?

STATEMENTS OF BARBARA A. BLAKENEY, PRESIDENT, AMERICAN NURSES ASSOCIATION; SARAH MYERS, IMMEDIATE PAST PRESIDENT, NURSES ORGANIZATION OF VETERANS' AFFAIRS; AND ANN CONVERSO, VICE PRESIDENT, UNITED AMERICAN NURSES

STATEMENT OF BARBARA A. BLAKENEY

Ms. BLAKENEY. Thank you, Mr. Chairman. Good morning. I am Barbara Blakeney. I am the president of the American Nurses Association. I would like to thank you for the opportunity today to address the issues regarding nursing in the VA.

I would like to highlight a couple of key points today, and that is I think we all recognize that nursing is a primary foundation of health care in this country. It focuses on prevention, long term care, acute care, care across the life span, and quality of care for our veterans will not improve without nurses being active throughout the VA in important policy and decision making processes within the VA.

America is experiencing a crisis in nurse staffing, and the Department of Veterans Affairs is experiencing a similar crisis to national trends, and if the availability of the supply of nursing personnel remains constant, the ability of the Veterans' Administration facilities to meet the health care needs of our veterans will be severely adversely effected.

Congress has recognized this problem by establishing a national commission on VA nursing. That commission will submit its final report to the VA Secretary in May of 2004, with specific legislative and organizational recommendations, to ensure the availability of a qualified nursing workforce, to meet the needs of America's veterans.

The ANA looks forward to the release of this report and to working with the VA to achieve their goals for nursing.

ANA supports an integrated state and federal legislative campaign to address the current impeding nursing shortage. I would just like to say that at a time when we are finally beginning to attract young people into nursing, and a time when there are now nursing candidates available, at this exact same time, the opportunity for those students to take advantage of their education is severely affected by one, what has already been talked about here today, which is a serious shortage of nursing faculty.

Secondly, and I think increasingly more importantly, is the fact that the percentage of nursing education that happens in the public sector is being profoundly impacted by state budgets.

At a time when we finally have nursing students, we are turning them away. In one instance, over 200 nursing students were turned away in a state college system, because of the cut backs in that college system, because of the early retirements offered and accepted by nursing faculty, and by the lack of ability to attract new people into nursing education.

We recognize that is a huge issue today, and we ask the Committee as they look at the veterans' issues to also take into account the huge number of nursing students who go and get their nursing education through the public sector, which is horribly impacted by state budgets at this point.

Many of the solutions that are applicable to the VA are applicable across the health care system. While some issues regarding nurse recruitment and retention were addressed by the Nurse Reinvestment Act, many issues remain that relate to the RN work environment.

I would like to highlight some of the key future strategies that deal directly with the nursing shortage.

On issues of health and safety, ANA has conducted an on-line health and safety survey in August of 2001, where 88 percent of the nurse respondents reported that health and safety concerns influenced their decision to continue working in the field of nursing, as well as the kind of nursing they choose to perform. There are too many nurses out there who love being acute care nurses in acute care hospitals, who can no longer physically do that work. That's a shame, and that's a travesty.

ANA has just launched a proactive multi-faceted campaign aimed at promoting safe patient handling and preventing musculoskeletal disorders among nurses. This campaign, which we call Handle

With Care, will begin with a safe patient handling conference to be held at the Tampa Veterans' Administration Hospital, in their Patient Safety Center of Inquiry and the University of South Florida in March of 2004.

I know you know, Mr. Chairman, that program, that health safety program at the VA Center in Tampa is leading the way in terms of addressing many of the issues that are important for us in terms of keeping nurses in the workforce.

That conference will highlight those issues. That conference will highlight the fact that we need to look at architecture in hospitals. We need to look at engineering in hospitals. We need to create a hospital room of the future that takes advantage of the technology that is being designed in such places as the VA Medical Center in Tampa.

Technology and innovation is a growing issue and a growing area where we need to develop better and future focused areas of inquiry and areas of development.

I would call your attention, Mr. Chairman, to an issue of the Nursing Outlook where a summary of the proceedings of the American Academy of Nursing Conference on using innovative technology to decrease nursing demand and enhance patient care delivery can be found, and I would ask, Mr. Chairman, if this may be submitted for the record.

With regard to overtime, nurses across the country are expressing deep concern about the dramatic increase in the use of mandatory overtime. ANA hears that overtime is a huge issue, and a continuing problem, where nurses can be charged with abandoning of patients if they refuse to accept overtime.

We have had nurses brought before the Boards of Registration and Nursing on issues around overtime.

Staffing is critical. Being able to further develop approaches to staffing and to develop safe staffing patterns is critical.

The VA, like most private health care systems, continues to struggle with the development for valid, reliable and implementable—excuse me. I was in Norway yesterday, Mr. Chairman. I am still struggling with what time of the day it is, sir.

Implementable nursing staffing outlines. The ability to improve the nurse workforce and the nurse environment, which is a critical piece of the Magnet program. It is about being able to create an environment where collaborative practice, where respect for each other's knowledge bases, where respect for each other's perspectives, and what each discipline link can bring to the care of the patient that makes a difference, I believe, in the Magnet program.

ANA is very proud of the Magnet program, proud of our role in helping to create it, and proud of our ANCC program, which is a subsidiary of ANA.

Mr. Chairman, I see my red light is on, so I will stop here, but ask that you consider the fact that the environment in which nurses practice is critical. The environment in which nurses practice will make a difference in the health care of our veterans.

As the daughter of a World War II soldier in Europe, as the niece of a sailor on board the USS Phoenix moored at Pearl Harbor on December 7, and as the cousin of a two tour Vietnam combat engineer, all of whom have received care at the VA system, I recognize

the importance of that system, sir. I do not believe that our veterans deserve any less than the very best.

Thank you, Mr. Chairman. I will be happy to answer any questions.

[The prepared statement of Ms. Blakeney appears on p. 79.]

Mr. BUYER. Thank you. In your testimony, you cited a request for an article from a journal be entered into the record.

Ms. BLAKENEY. Yes, sir. It is Nursing Outlook. It is the May/June issue of 2002, Volume 51, No. 3.

Mr. BUYER. Any objections to entering it into the record?

[No response.]

[Link to *http://www.mosby.com/nursoutlook*]

Mr. BUYER. Hearing no objections, it will be so entered. Will you please leave a copy of that with the Clerk?

Ms. BLAKENEY. Certainly, Mr. Chairman.

Mr. BUYER. Thank you.

Mr. BUYER. Dr. Myers, you are now recognized.

STATEMENT OF SARAH MYERS

Ms. MYERS. Mr. Chairman and members of the Subcommittee on Oversight and Investigations, I am Sarah Myers, a doctorally prepared nurse executive in geriatrics and mental health at the Atlanta Veterans' Affairs Medical Center.

I am presenting testimony in this capacity as well as the immediate past president of the Nurses Organization of Veterans' Affairs, known as NOVA, the professional organization of over 35,000 registered nurses employed by the Department of Veterans Affairs.

NOVA is very concerned about the national nursing shortage, as well as the ability of the DVA to continue to recruit and retain highly qualified nurses to care for our nation's veterans.

National nursing leaders in health care organizations are projecting a shortage of registered nurses that is unprecedented, both current and future projections of the numbers of professional nurses available are such that the nation's demands for these services will be insufficient at best.

At the same time, changes in health care delivery systems will require larger numbers of more educated nurses, who will be performing increasingly complex functions, both in hospitals and other health care settings in the community.

The DVA is already experiencing challenges in maintaining an adequate workforce. If it is to stay adequate, it must remain competitive in both pay and workforce innovations.

It is no surprise in the interim report to the VA Nursing Commission that the staffing theme was pervasive throughout the report.

Earlier this year, NOVA developed a document entitled Critical Need for a Strong Nursing Workforce, which outlines several programs and addresses recruitment efforts to be considered by this Subcommittee, the House Veterans' Affairs, and the DVA for the upcoming decade.

In that report, I have outlined in my testimony a nursing recruitment initiative proposal, which totals $35.45 million per year. The

provision of flexible educational opportunities, academic partnerships to ensure numbers of nursing faculty and outreach programs directed at the high school students are positive recruitment efforts directed at aggressively addressing the nursing workforce issue.

No single strategy will be effective in reversing the nursing workforce crisis. This proposal presents a coordinated approach of a nursing recruitment grant program, a nursing education support program, and a marketing strategy designed to meet the current and future needs of VA nursing professionals.

The program provides a variety of resources for generating RNs and LPNs, ranging from current nursing students to existing VA employees, to future nursing students through outreach in high schools and colleges. As is well documented in health care and the VA literature, the shortage of nursing personnel currently being experienced will reach its most critical state in 2010 and beyond.

You have heard already from Mary Raymer about the VA VALOR program, which I have discussed in my proposal. Another program is the VA nursing education faculty program earmarked for $2 million. This program implements the nursing education faculty-sharing program, which combines VA employment with nursing education, academic program faculty assignments and partnerships.

The VA nursing education faculty program will create partnerships with schools of nursing. The program establishes specific positions for nursing faculty for those schools who have students participating in the VALOR program, as noted above. The schools of nursing establish clinical experiences with their VA partner, which would promote student selection of VA employment following graduation.

Another program is the VA nursing education for employees. As you can see, this program is earmarked for $17.15 million. It funds a tuition assistance or upward mobility program. The initiative provides education and salary replacement funding for VA employees enrolled in licensed practical nursing, associate degree nursing programs and bachelor degree nursing programs.

The proposed program would fund 75 licensed practical nurses per year beginning in the year 2005, and 200 RNs per year beginning in the year 2006.

I think the VA cadet nurse program has been referenced already in a previous testimony. The VA cadet nurse program combines VA volunteer work and the student educational employment program. It offers a progressive work experience program which the student may enter at varying levels.

The VA volunteer role enables students under the age of 16 to gain initial training and experience in working in the nursing environment. After the age of 16, the student can transition to a paid appointment under the student education employment program, as a certified nursing assistant, which could be continued through graduation from a vocational LPN, associate degree program, or bachelor's degree program in nursing.

Thus, the graduating baccalaureate degree nursing student who begins a VA work experience as a volunteer at age 14 would have built 8 years of familiarity and organizational loyalty with the VA.

Also, I have included recommendations for the administrative support for four full time employee equivalent personnel, as well as supplies.

The DVA has implemented several positive initiatives to impact staffing, including the establishment of the Commission on VA Nursing, the establishment of the VA Nursing Workforce Group, as well as the adoption of their recommendations, recent enhancements to the locality pay, and changes to the nurse qualifications standards.

I thank the members of the Oversight and Investigations Committee for this opportunity to share with you some ideas of how to address the recruitment and retention facing the Department of Veterans Affairs.

Consideration of these proposals will go a long way to enhancing a bright future for the dedicated nurses who care for our nation's heroes.

Thank you.

[The prepared statement of Ms. Myers appears on p. 109.]

Mr. BUYER. Thank you. Ms. Converso.

STATEMENT OF ANN CONVERSO

Ms. CONVERSO. Good morning. Thank you, committee members, for this opportunity to draw attention to the very important issue of the nurse staffing shortage in VA medical facilities.

My name is Ann Converso. I have been a registered nurse in acute medical/surgical units and I.V. therapy at the VA Western New York Health Care in New York's VISN 2 for more than 30 years. I have also been an active member of my union, the New York State Nurses Association and its national, the United American Nurses, AFL-CIO, during that time. I now serve as vice president for the 100,000 nurses of the UAN, 6,000 of whom are VA nurses.

In my years as a VA nurse, I have experienced several nursing shortages firsthand. I believe I do speak for other VA nurses when I say that we love our jobs, and the important work we do in caring for our nation's veterans, but because of deteriorating working conditions and a lack of respect, registered nurses are leaving the bedside in favor of many other job options now available to us, from clinic jobs, outpatient jobs, computer jobs, or leaving the profession entirely.

In a 2002 survey by the United American Nurses, three out of every ten nurses said it was unlikely that they would be in a hospital staff nurse position in 5 years. The VA health care system has by no means been immune to the shortages.

As nurses leave the VA system, new nurses are not joining the VA at comparable rates and patient load is increasing. In its own report, A Call to Action, the VA states that it must replace up to 5.3 percent of its RN workforce per year to keep up with RNs retiring. By all accounts, that is not happening. We are caring for more patients who are often sicker with fewer nurses at the bedside.

Clearly, VA nurses have choices. I believe I and other VA nurses can shed some light on why nurses are leaving the bedside and what we can do together to make the VA a more attractive place for nurses to stay and work.

Through my role in my union and my position on the National Commission on VA Nursing, I hear daily from VA nurses about the problems they face at their work places. Staff nurses who play a pivotal role as care givers at their VA facilities say their experience, knowledge and expertise are not being respected. Nurses are functioning at some facilities with staffing levels that are unsafe. Many VA facilities do not meet the threshold medical/surgical ratio of four patients per nurse that is cited in the Linda Aiken's 2002 study on nurse to patient ratios.

Some VA facilities, like their counterparts outside the government, have responded to this staffing crisis by mandating overtime that is unsafe for patients and nurses, forcing nurses to work understaffed or floating RNs to different units without proper training. Additionally, nurses at the bedside are not being involved in decision making processes.

We must also address the inequities that cause the VA medical system to lag behind the civilian facilities as an employer of choice. Compensation under the Nurse Pay Act of 1990 has not kept pace with the private sector's ability to provide multiple salary increases per year, and an innovative structure of non-salary perks and benefits. Too often, qualified experienced nurses in the VA system are being denied promotions solely on the type of nursing education received.

Staff nurses know and are willing to share their solutions. As a long time nurse activist, I know there is a place where staff nurses' knowledge and views are solicited, respected and acted upon—in our unions.

Staff nurses have a seat at the table, a voice in decision making, and the respect we deserve because of our union. Nurses who are organized on average earn a higher salary, have better staffing levels, and have more of a say in their work place.

As a VA union nurse, I have input into bar code medication procedures, representation on my health and safety committees, access to a fair and equitable disciplinary and grievance process, and valuable guidance through the VA promotions process.

In the VA system, we must cultivate an environment where nurses are respected for the invaluable work we do. Actively involving staff nurses in the decision making processes in their VA facilities must be a priority if we are to keep more staff nurses in the VA system.

VA nurses in my union have made a difference in the quality of care in their facilities by advising on the best safety devices to use through their health and safety committees, on inadequate staffing levels through submissions of assignment despite objection forms, through support for legislation like the VA Medical Workforce Enhancement Act. This bill gives the Secretary of the VA the flexibility to empower staff nurses with greater decision making on staffing levels, nurse to patient ratios, and patient caseloads.

Some facilities are exploring ways to involve nurses in decision making processes through the Magnet program, which you have heard about. In the years since its inception, the Magnet designation has become a sought after credential among hospitals.

What is equally if not more important to me is the process a facility must demonstrate it has gone through to achieve Magnet sta-

tus. A Magnet facility's administration must talk to and listen to its nurses. It must show evidence that staff nurses are involved in decision making and care giving processes.

To me and the nurses I represent, the process, the criteria, and the culture that a hospital must develop involving staff nurses in its decision making, in its Magnet application, is even more important than the piece of paper that finally grants the hospital Magnet status.

Both Magnet facilities and VA facilities where RNs have a union, and Tampa has both, are excellent models for involving nurses, the people providing round the clock care for our veterans, in the decision making loop.

If we are to encourage staff nurses not only to come to the VA but to stay in the VA, we must work to give them a voice in the challenges and changes faced in our VA facilities.

VA Secretary Anthony Principi has said that he is making quality patient care a priority. That cannot happen with fewer nurses at the bedside. If we truly seek to attract and retain skilled, experienced registered nurses in the VA system, we must respect front line RNs who deliver bedside care by giving them greater input into their work environments.

I thank you, once again, for the opportunity.

[The prepared statement of Ms. Converso appears on p. 113.]

Mr. BUYER. Thank you. Ms. Hooley, you are recognized for 5 minutes.

Ms. HOOLEY. Thank you, Mr. Chair. Just a couple of things. First of all, for all of the nurses out there, thank you. You do a terrific job.

Ms. Blakeney, you mentioned the need to increase the number of nurse graduates to ameliorate the nursing shortage. We may agree that a cultural change is needed in the way potential nurses view careers in nursing. There may be other methods for increasing the number of nurses, particularly to the benefit of the VA. These are just some things I am throwing out.

Could we, for example, build a VA school of nursing similar to DOD's school on uniform medicines, where students receive free training in return for their promise to serve for a period of time? Would that kind of a program work? Has this been studied?

What can we do in Congress to both increase the nurse pipeline and assure VA recruits its fair share?

Ms. BLAKENEY. Thank you for the question. I believe first, anything that we can do to encourage people to come into nursing, we should be considering doing. Right now, the Congress has before it as part of the appropriations issues, the Nurse Reinvestment Act. I urge you to look at fully supporting that Act, because it will put money in the pipeline to do exactly what you are talking about.

There are possibilities to consider, with students who have federal loans, that the loan forgiveness program be extended into the VA system, so that any new graduate moving into the VA system has a significant loan repayment reduction occurring for as many years as they work in the VA. We already have that in place for medically under served areas, where for every year you work in an under served area, ten percent of your loan repayment is forgiven. The idea of being able to offer that in the VA is certainly some-

thing that I think could be relatively easily done because the infrastructure already exists.

The idea of creating a school of nursing to support the VA in line with the DOD may well be an opportunity worth exploring. It may be possible to even extend the DOD program to include or to create available slots for nurses to go into the VA, as opposed to actually replicating what might already be there. That might be a possibility.

The opportunity to increase student placements in VA medical centers is critical, because what we know is that students, when they are placed for their clinical placements, if they like what they see, it's a good recruitment tool.

Being able to enhance and support the VA medical centers so that they can be more active and being able to serve as clinical placements is certainly a concept worth exploring.

The bottom line is that if we have a nursing shortage, we will have a nursing shortage in the VA system. Keeping the VA financially attractive and keeping the clinical environment in the VA and building the clinical environment in the VA so that it becomes an attractive place to work is part of what the VA can do, and what you and the Congress can do in terms of financially supporting the development of centers of excellence, and in looking at developing centers of excellence within the VA medical centers, not unlike what we have right now in Florida, the opportunity to build that.

The idea that nurses are a critical part of decision making across the board, as my colleague, Ann Converso, has just mentioned, the ability to make sure that nurses are part of that.

I can share with you a personal experience in an institution where I worked, where we built a new ambulatory care center. The nurses were not involved in that. Three days before that center opened, the nurse managers were given a tour of that facility, and within half an hour, we pointed out $500,000 worth of mistakes, because we weren't part of that process.

Nurses need to be a part of the processes. This applies across the board. It is not just the VA system. When nurses are not part of those processes, it speaks to they are not valued. It speaks to the fact that what they know and how they practice is not valued as part of the system.

When we don't build technology into the hospital room, then what we are saying is we do not value the nurse's ability. She is expendable. Her back is expendable. Her legs, her knees are expendable. That is what we do when we do not require and we do not create opportunities for nurses to participate in that decision making from the very beginning.

Creating those opportunities demonstrates a respect for the profession and the individuals who are in that profession, and that is what brings nurses in, and that is what keeps nurses.

It's the environment in which we work, the respect with which we are treated in those environments, and the recognition that we have things that can contribute to the well being of that institution, as well as to our patients; doing those things will address the nursing shortage not only in the VA, but across the country.

Ms. HOOLEY. Thank you.

Mr. BUYER. Thank you. Mr. Boozman?

Mr. BOOZMAN. I'd like if the other panelists would comment also on the nursing shortage, what steps we can take. I appreciate your answer. I think that was very good and very useful. Do you all have anything you would like to add to that?

Ms. MYERS. I do not. I think her remarks were very comprehensive.

Mr. BOOZMAN. I agree. Certainly, this is the primary thing that we are dealing with today. Again, you mentioned the problem with the states and stuff. If you had an action that you wanted us to do, what would you rank at the very top, as far as trying to—the states do not have any money. They are in difficult situations. They are not only cutting this program. They are cutting all of their programs. They are in a very difficult situation. Most of them have balanced budget amendments, unlike the Federal Government.

If you had to say one action, what would you like for us to take away today, as far as your top? I do not know if that is a fair question or not.

Ms. BLAKENEY. The shortage will not get better until we address some of the fundamental flaws that we have in our health care system. For nurses, some of those flaws have to do with having the work that we do better valued within the environment that we are in.

It is having nurses participate and being recognized as valued partners in the decision making that occurs in health care.

If I could do one thing for the already existing nurses, it would be to try to address that. If I could do one thing to attract young people into nursing beyond that, it would be funding nursing education.

A fact that a huge percentage of our nursing programs are in the public sector is very, very good in that it guarantees access. It is very, very bad when we have a state budget crisis as we do today. The ability for the Federal Government to be able to support those programs right now is paramount, and to try to encourage our states to do at least no further cutting in health care and the health care education areas and our schools of nursing.

It is not just nursing. We are here today to talk about nursing, but we have to recognize it is a problem that is going to hit all of our disciplines. We have to think about why that is, and part of why that is the health care system that is struggling. We are not going to solve the nursing shortage or anybody else's shortage, until we fundamentally address the health care issues. That is a huge undertaking, as I think we all recognize.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Mr. Udall?

Mr. UDALL. Thank you, Chairman Buyer.

Dr. Myers, as I look across the portfolio of incentive programs, I see many methods to draw nurses to particular organizations. What programs are targeting semi-retired or alternate career nurses to get them back into the fold?

Ms. MYERS. I didn't identify any of those programs in my testimony, but the one that comes to mind that's not here is the initiative within the VA to support retired nurses on a fee basis system, where they come back and they work X number of days within the VA.

As a personal testimony, at the Atlanta VA, we do have some of those nurses. One currently is working in the methadone clinic, which is one of the areas I am responsible for. There is a program that provides injections to methadone patients, approximately 45 to 50 per day, including a Saturday clinic. It is one of the innovative methods that are being used.

Mr. UDALL. Has that one been successful, the one you are familiar with?

Ms. MYERS. Yes, it has been.

Mr. UDALL. Are there any other programs, information programs, targeting the very young in America to begin changing the culture and to make nursing an attractive profession?

Ms. MYERS. I think I mentioned the VA cadet program. There are also nurse recruiters on every station. They go out to high schools. They are invited to high schools, doing recruitment fairs during the year, where they target high school and middle school students.

Also, nurses within the profession themselves are invited to high schools. Just during this past year, I went to three high schools myself as part of their Career Day. There are many other health professionals within the VA who also are experiencing that same opportunity.

Mr. UDALL. Do you see a change in attitude at the high schools when you are out there personally?

Ms. MYERS. I do. Students who have no idea what they want to do when they grow up, they welcome the idea of people coming. Most of them are surprised that I am not in a nurse's uniform or a scrub. It really is an exciting opportunity for professionals to be involved in, nursing professionals.

I also have students from Georgia State University and Emory University. These are students in the master's program who are pursuing their higher education as nurse practitioners or clinical nurse specialists.

Mr. UDALL. Thank you very much. I yield back, Mr. Chairman.

Mr. BUYER. Thank you. Dr. Myers, in your testimony, in reference to the VALOR program, you stated for fiscal year 2003, $1.701 million for 290 students. However, in 2002, only 17 percent of the VALOR participants were hired by VA facilities.

My question to you is is this a program that we should decrease funding, do away with, or increase funding?

Ms. MYERS. I do not think we should decrease funding. I think we need to go back to the drawing board, meaning the VA, and look at why we have this decrease in the number of VALOR students. It may be we have to use more creative strategies to get students into the program as well as ensure that they graduate from the program.

Mr. BUYER. The nice thing about your testimony is hopefully the chief nursing officer of the VA takes your testimony and holds it tight, goes back to the drawing board on the program. I welcome you to do that. Otherwise, we will take actions, and you may not like what we do. How is that?

Ms. RICK. Hear you loud and clear.

Mr. BUYER. All right. What we try to do here is try to figure out the measurable outcomes. That is not good.

Secondly, Ms. Converso, I am to extend a welcome to you from Mr. Jack Quinn of Buffalo, New York. Congressman Quinn is a member of the full Committee here on Veterans' Affairs. You are smiling. Great. I knew there had to be something I did not know about. Mr. Quinn is a valued member of the committee, and he extends his welcome to you.

Ms. CONVERSO. If you could pass along to him that it is snowing in Buffalo today. Just so he knows. (Laughter.)

Mr. BUYER. You know, ma'am, that is just not newsworthy. (Laughter.)

Ms. CONVERSO. October 2nd, it is. (Laughter.)

Mr. BUYER. It is like saying it is sunny in San Diego. (Laughter.)

Mr. BUYER. I'm sorry.

Ms. CONVERSO. I will remember that.

Mr. BUYER. I am sorry. I will extend that to him.

You had mentioned the lack of consultation and lack of respect are problems for VA staff nurses. Then I have to weigh that against the testimony of Ms. Sandra Janzen with her VA Magnet hospital in Tampa, how the Magnet facilities are known for enhancing communication and valuing of nursing services.

Would you support working toward Magnet status at your facility in Buffalo?

Ms. CONVERSO. Yes, I would, and actually, we have looked into that. I think embodied in my testimony is really the getting there versus the piece of paper.

Mr. BUYER. It is all about getting there.

Ms. CONVERSO. I think it is the culture and it is the respect, and to have people at the decision making table. I think there are facilities out there, whether they are in the VA or outside of the VA, that do not ever achieve Magnet. Maybe they do not have the $40,000 that Ms. Janzen talked about, but their nurses do not leave those facilities because that is the culture of their facility.

I think the other thing that we talked about at the VA Commission last week is sort of reframing the recruitment and retention scenario. I think it is really retention and then recruitment. I think we have them sort of in the wrong order, because we can do a lot of things to recruit, but I think many people in this room will tell you that people come into the profession and after months or a year on the job, are very dissatisfied with the positions they are in.

Mr. BUYER. Sometimes facts create perceptions. Sometimes they are real. Sometimes they are not. I have to ask this question. Out of the 85 Magnet facilities, only a handful of them are under collective bargaining agreements. Why would that be so?

Ms. CONVERSO. I do not know that I have the answer to that.

Mr. BUYER. I do not know, either. I did not know what and why. I will just let it sit. I will let the question sit. I do not know why.

Ms. CONVERSO. I do not know the answer to that question. Sorry.

Mr. BUYER. That is fine. I was just curious. I do not want to create a perception, either, if it is not real. I thought I had to ask the question.

Does anyone have any further questions?

[No response.]

Mr. BUYER. Thank you. I appreciate your testimony. It was of value today. I am sorry.

Ms. Blakeney, were you recruiting in Norway?

(Laughter.)

Ms. BLAKENEY. No, sir. I was actually attending a meeting of the International Council of Nurses, where recruitment was talked about.

Mr. BUYER. Very good. Thank you very much.

We now welcome panel three. Julie Cowan Novak. She is the head of the School of Nursing at Purdue University, West Lafayette, IN. We also have Regina Foley, Vice President and Chief Nurse Executive, Ocean Medical Center in Brick, NJ.

Ms. Foley, Mr. Smith wanted to be here to introduce you. He is caught on the floor.

Please, either of you can begin. Dr. Novak.

STATEMENTS OF JULIE C. NOVAK, HEAD, SCHOOL OF NURSING, PURDUE UNIVERSITY; AND REGINA FOLEY, VICE PRESIDENT OF NURSING AND CHIEF NURSE EXECUTIVE, OCEAN MEDICAL CENTER, BRICK, NJ

STATEMENT OF JULIE C. NOVAK

Ms. NOVAK. Good morning. Mr. Chairman and members of the subcommittee, thank you for inviting me to speak on this very important issue of Magnet status as a tool for recruiting and retaining nurses.

Regardless of the health care organization's size, setting or location, achieving Magnet designation serves to attract and retain quality employees. Magnet designation helps consumers locate health care organizations that have a proven level of excellence in nursing care.

"In an environment rife with controversy about patient safety in hospitals, medical error rates, and nursing shortages, consumers need to know how good the care is at their local hospitals. Magnet is a seal of approval for quality nursing care."

The magnet recognition program was developed by the American Nurses Credentialing Center, the credentialing arm of the American Nurses Association, to recognize health care organizations that provide the very best in nursing case, and uphold the tradition within nursing of professional nursing practice. The program also provides a vehicle for disseminating successful practices and strategies among nursing systems.

The Magnet recognition program is based on quality indicators and standards of nursing practice as defined in the ANA Scope and Standards for Nurse Administrators. The Magnet designation process includes the appraisal of both qualitative, for instance, leadership roles and shared decision making, and quantitative, nurse/patient ratios, factors in nursing.

Recognizing quality patient care and nursing excellence, the Magnet recognition program provides consumers with the ultimate benchmark to measure the quality of care that they can expect to receive. As a natural outcome of this, the program improves the positive work environment and elevates the standards of the nursing profession.

The objectives of the Magnet recognition program includes recognizing nursing services that use the Scope and Standards for Nurse

Administrators, providing a quality in a milieu that supports professional nursing practice, providing a vehicle for the dissemination of successful nursing practice and strategies among health care organizations using the services of registered professional nurses, and promoting positive patient outcomes.

Magnet designation is an important recognition of nurses' worth. I think we have heard several allusions to that issue today. Designation recognizes the quality of a nursing program and demonstrates its importance, and the importance of nurses to the success of the entire organization.

"This is one of the highest achievements a hospital can attain in the nursing world. Magnet status recognizes the caliber of the nursing staff and what that professionalism translates into in terms of patient care and health care services."

Dr. Linda Aiken's independent research shows that Magnet designated facilities consistently out perform their peers in recruiting and retaining nurses. "The label 'Magnet hospital' originally was given to a group of U.S. hospitals that were able to successfully recruit and retain professional nurses during a national nursing shortage in the 1980s. Studies of Magnet hospitals highlight the leadership characteristics and professional practice attributes of nurses within these organizations. Hospitals selected meet the following criteria: 1. Nurses within the hospitals considered them good places to practice nursing. 2. The hospitals had low turnover and vacancy rates. 3. The hospitals were located in areas where there was significant regional competition for nursing services."

Magnet designated health care organizations consistently out perform their peers in recruiting and retaining nurses, resulting in increased stability in patient care systems across the organization.

A national survey conducted in March 1999 dramatically illustrates the competitive edge enjoyed by Magnet designated facilities. This survey found that 93 percent of the public would have more confidence in the overall quality of a hospital if that hospital had passed the nursing standards required to be a Magnet program.

The same survey found that 85 percent of the public would have more confidence in a long term care facility that had passed similar nursing standards.

Thus, in addition to the quality of nursing care, the Magnet designation speaks to a facility's overall quality.

I would note there is a quote also included from Mayo Hospital. We asked a visitor from Mayo how he was able to attract nurses in the middle of Minnesota. He said "We have Magnet status. That is the important thing."

I then had the great pleasure of showing him our award for Magnet status. I would note that at Purdue University, Mayo comes every year to our Career Fair and recruits five to eight of our top nursing graduates from each of our Purdue baccalaureate nursing graduate classes of approximately 100 students.

Their Magnet status is one of the criterion that the graduates use for choosing their place of employment from among five to ten offers per graduate.

Research documents state that high quality nurses is one of the most important attributes in attracting high quality physicians. Therefore, achieving this status creates a positive halo effect be-

yond the nursing services department that permeates the entire health care team.

A basic premise of the Magnet designation is a climate that reinforces collaborative working relationships. As Dr. Aiken and Donna Sullivan Havens reported, "They foster respect and caring for the individual, both patients and staff, and actively bring out the best in people."

The Magnet culture is holistic in creating dynamic and positive milieu for professional nurses. Core values such as empowerment, pride, mentoring, nurturing, respect, integrity, and team work are demonstrated in Magnet facilities. "Thus, these hospitals have been cited as cultures of excellence, the measure of goodness, and the gold standard in nursing."

Magnet hospitals are infused with values of quality care, nurse autonomy, informal non-rigid verbal communication, innovation, bringing out the best in each individual, and striving for excellence.

"The Magnet process facilitated an intense look at the way we organized and delivered nursing care. It encouraged each of us to take responsibility for improving our service."

The Magnet recognition program establishes standards of excellent which health care organizations must attain. According to a study conducted at the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing, "Magnet hospitals consistently provide the highest quality of care."

Of respondents of are cent survey, 93 percent indicated that knowing a hospital had passed rigorous standards would increase their confidence in overall care provided by the hospital.

The Magnet recognition program application and appraisal process has already been highlighted by Sandra Janzen, and is included in detail in my remarks, in terms of the eligibility requirements. Those are presented on the ANCC web site.

Of note, the Veterans' Health Administration's support for the bachelor of science in nursing for positions beyond entry level is consistent with other progressive health care facilities and Magnet designation, that places a high value on learning.

In Aiken's work published in JAMA on September 24, and this has already been mentioned multiple times, it concluded that in hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients, 232,342 cases were analyzed, and those individuals experienced lower mortality and failure to rescue rates.

The criteria for the Magnet application process has been presented in terms of the application fees. It is four phases. First, second, third and fourth phase.

The highlights once Magnet designation is awarded, the health care organization is notified immediately if the Commission on Magnet recognition votes to extend Magnet designation, and a nationwide press release is issued by ANCC.

The public notice of Magnet applicant evaluations by ANCC Magnet recognition program appraisers is, of course, significant input from patients, families, clients, staff and public with who health care organizations interact is sought to assist Magnet program appraisers in the evaluation of nursing services that have ap-

plied for designation, and the contact information, of course, is presented.

In summary, as the head of the Purdue University School of Nursing in West Lafayette, IN and associate dean of the Schools of Pharmacy, Nursing and Health Sciences, I know that our undergraduate and graduate nursing students select from among five to ten employment opportunities each year.

If they are not geographically bound to the greater Lafayette area, they begin their search with an examination of the ANA web site of Magnet designated hospitals. Many of the hospitals with whom we partner in the Central Indiana area and throughout the State of Indiana are applying for Magnet designation, and those are the institutions with which we are expanding our partnerships in learning, engagement and discovery.

Thank you.

[The prepared statement of Ms. Novak appears on p. 116.]

Mr. BUYER. Thank you for your testimony. Ms. Foley.

8STATEMENT OF REGINA FOLEY

Ms. FOLEY. Good morning. My name is Regina Foley. I am a registered nurse and vice president for nursing, chief nurse executive, at Ocean Medical Center. Our hospital is 237 beds, non-profit, non-unionized. It is on the beautiful Jersey shore in New Jersey.

Mr. BUYER. Is it snowing?

Ms. FOLEY. It does snow in New Jersey. Not as much as Buffalo, but it does snow in New Jersey.

Ocean Medical Center is a member hospital of the Meridian Health family, a health system consisting of three hospitals and a number of partner companies, including long term and home care.

As a nurse executive, I have been directly involved with nursing workforce issues and the development of a wide range of short and long term nursing recruitment and retention strategies and programs.

A highlight in our organization is that being in Ocean County, and I cannot give the statistics, but Ocean County has a huge volume or number of older adults. We choose not to call them the gerontology population. They are a little sensitive about that. Sixty-two percent of our volume is the older adult. Obviously, my teams need to develop different strategies to meet the needs of that group. It is a very special population.

The next issue we have are the baby boomers that are coming up right along side of it with huge issues that we will need to deal with.

My responsibilities at Ocean Medical Center include recruiting, maintaining and developing a nursing workforce that is appropriately prepared to deliver quality nursing care to our medically diverse patient population.

I will discuss Ocean Medical Center's commitment to nursing excellence through participation in the Magnet recognition program, as well as other strategic initiatives that have enhanced the work environment for our nursing staff.

I believe that these initiatives, such as incorporating continuing education, research, collegiality, and collaborative practice are extremely important.

When asked why the new RNs chose to come to Ocean Medical Center, many of the staff tell us they wanted to work for a Magnet designated facility for these very reasons.

All of our nurses participated in the preparation of the Magnet application and many interacted with Magnet appraisers during their site visit. Going through the Magnet application process has promoted a greater sense of team work and camaraderie among them. In addition, the Magnet process has fostered in our nurses a sense of ownership, because they understand that this recognition comes with responsibility, as well as accountability, to uphold these standards of excellence.

I believe our turnover rates and vacancy rates, which happen to be only 1.5 percent as of today, quite proud about that, have improved as the nurses have become more involved in decision making and in improving their own practice environment.

We have a new model of care. Our participation in the Magnet recognition program has led to a reassessment of our care delivery model to further enhance the work environment and promote staff retention.

Across the system, we have developed a new model. We have called it the Magnet Model of Care, which increased staffing, a no float policy, which is extremely important, increased technology, such as laptop computers, and a dedicated nurse educator and physician champion.

Nurses on these units are expected to achieve national certification in their area of specialty and to participate in our new CARE program, which is a clinical ladder program. The nurse leader also had to go through a selection process, and part of our criteria was that she was baccalaureate prepared and nationally certified.

These outcomes are being measured monthly to evaluate the impact on the enhancements.

Ocean Medical Center first applied for Magnet recognition in 1998, and was selected as the 12th hospital to achieve this award. Just this past year, I am pleased to report that we are redesignated as a Magnet hospital. All three hospitals in the Meridian Health System have achieved this recognition, and we take pride in being the first health care system in the country to achieve this status.

Our purpose in seeking this recognition originally was to highlight the quality of our nursing department and the importance of our nursing staff to our health care organization. Through the application process, we were able to reflect on our strengths as a nursing department. The in-depth self study process provided us with focus and direction and helped to facilitate our growth in meeting and maintaining the highest standards of excellence.

The site visit reinforced what we had learned and afforded us the opportunity to receive outside validation of the quality of the environment of practice at Ocean Medical Center. During our last site visit, the appraisers cited three areas that were particularly noteworthy, nursing research, initiatives for the care of the older adult, and I said it was very important to ask, and nursing utilization of information technologies.

Other recruitment activities that we have is that we have a boomerang program which reinstates former employees with full benefits and seniority. If they wanted to go to another place, you know, the grass is always greener, and we believe we can allow our staff to explore those options, they can always come back home and be reinstated with their seniority and their benefits.

We have a summer student externship program with the ability to stay on as per diem staff while they are in the program. We offer about $250,000 a year in scholarships. Our OFFER program, they work two 12 hour shifts on the weekend and they receive full time pay and full time benefits through the duration of their academic career. We have a clinical recognition program with salary advancement. Staff also receive monetary reward for national certifications and baccalaureate degrees.

We have a grassroots staff group, and my colleagues have addressed the high school level, thinking about choosing nursing as a career, and we also address the elementary level, if you can imagine, from K–8. The reward that the nurses see from that environment is really terrific.

Some other retention initiatives that we have is that we have a philosophy that we hire for talent and train for skill.

In conclusion, at Ocean Medical Center, we recognize the significance of the current and impending shortage, our aging nursing workforce, and our aging patient populations, and have taken steps to improve our recruitment and retention efforts. Effective recruitment and retention plans, however, must go beyond immediate necessity to fill vacant positions.

The environment where nurses practice must be enhanced so that nursing is seen as an attractive profession that offers professional growth and satisfaction.

Participating in the Magnet recognition program has helped us enhance our efforts in improving the nursing work environment.

Thanks for inviting me to share on behalf of Ocean Medical Center and the ability to work with such great nurses that I have. Thanks.

[The prepared statement of Ms. Foley appears on p. 123.]

Mr. BUYER. Thank you for your testimony.

Ms. Hooley, you are now recognized.

Ms. HOOLEY. Thank you, Mr. Chair.

Dr. Novak, how many hospitals nationwide have applied for the Magnet certification, and what is the rate of certification based on certification requests? How long does it take to get through the process? How many apply? How many fail? Just give me some kind of idea about that.

Ms. NOVAK. I know that there are 85 that are approved, and there are many more in process. I know it can take several years. I am not sure how many have been denied. I might defer to Barbara Blakeney. I am not sure about the denial. I am not on that committee or in that group.

Ms. HOOLEY. Eighty-five are Magnet hospitals.

Ms. NOVAK. Right, and we have several partners in Indiana currently, Clarion, St. Francis is in process, I think, St. Vincent, and our new hospital, the Arnette Hospital is from the beginning in the planning stages.

Ms. HOOLEY. Generally, do you know what the average time is to get through the process? Are we talking about 6 months, 5 years?

Ms. NOVAK. I have heard a range of anywhere from 1 to 2 years. I have not heard anything exceeding that.

Ms. HOOLEY. Once you reach that status, do you have to re-apply? How long does that status last? What is the re-application process?

Ms. NOVAK. I think there is a reinstatement about every 4 years.

Ms. HOOLEY. What do you have to do for that reinstatement?

Ms. NOVAK. I think there are again site visits and there are documents that are prepared for the process. The students who have visited those hospitals have talked with the nurses in those hospitals in their seeking employment. As I mentioned, each of them have many opportunities for employment, and this is one of the driving forces, when they do those visits and visit with the hospitals and with the nurses in those individual settings, they are more likely—we have students going to Methodist Hospital in Houston. We have many going to the Mayo system. We have many going to Cleveland Clinic, a whole variety of settings, many academic health science centers are attempting to achieve this. The University of Colorado has been definitely a very attractive site for many of our students, and it is the Magnet status that is one of the things that very much appeals to them.

In terms of one of your other questions related to solutions and the recruitment piece, one of the things that we are doing locally, and I think many baccalaureate programs are doing, I mentioned that we admit 100 students each year. We are now increasing that over the next 2 years to 150 students that we are admitting, and the partnerships with various hospitals. I think that was also mentioned, with some of their master's prepared nurses actually taking student groups so that they are providing the educators.

Our master's and doctoral program, our developing doctoral program, is going to focus on nurse educator, so that we are attempting to also address that shortage.

Ms. HOOLEY. Good. One of the things I was just going to ask you is, you know, we talked about how to retain nurses, how do you keep them in the profession, because we know a lot of nurses have left the profession, and how do you bring them back. You have done a great job with that.

The other issue was what do you do in a state like mine where they literally, because of state budgets, have cut off nursing programs, where you have a lot more people wanting to get into the programs and there are no slots, and then the whole issue of nurse faculty.

Ms. NOVAK. As I mentioned, we have enlarged our class. We also work closely with the community college program in the area with those individuals that do not meet the requirements. When we went from 100 to what we are focused on, 150, or our target, we were turning away individuals with 1300 SATs, our class was so full, and we had three qualified for every one that we were admitting.

Ms. HOOLEY. That is a real shame that we are turning away people and at the same time, we have all the baby boomers ready to retire, and at a time that we already have a critical shortage.

Ms. NOVAK. Right. We have enlarged our classes, and we can only accept so many because we have to have clinical sites for the education or we compromise the quality. We have gone certainly much further out of the greater Lafayette, IN area in developing partnerships with Clarion and other hospitals in Indianapolis and throughout Central Indiana and the state.

We also have many of our students going for internships and residencies throughout the country. That, again, keeps them hooked into the process and excited about what it is they are doing.

Ms. HOOLEY. Thank you.

Mr. BUYER. I look at it perhaps from another perspective. If Purdue University is having to turn away students with 1300 SATs, she has one great program.

Ms. HOOLEY. Right.

Mr. BUYER. You have one great program. Obviously, you have made a judgment call here on what it takes. You have your own budgets you have to deal with, too, but how you maintain that quality and how you participate in changing the culture to set new standards of excellence. That is why we invited you here to come testify.

Will you please tell me as an administrator here, the testimony that we received here today and articles that have been written about the faculty exodus, how are you retaining—if you are getting these great students, they are there because you have a great program, but how are you retaining the premium faculty?

Ms. NOVAK. I think the same sorts of issues in terms of how we retain nurses in the hospital, listening to them, valuing them, giving them lots of opportunities for growth and development. I think that is always critical at a work site.

Although we have 37,000 students, the facilities were built for probably 30,000, so they have capped many of the undergraduate admissions with the exception of nursing and technology. They are allowing us to grow, and they will allow us to continue to grow as many as we can take in with the faculty, and through these partnerships, we do not have to continually hire an additional faculty member at Purdue, but rather develop adjunct partnerships with the hospital system, so that the hospital— Clarion is designating a Purdue unit of educating—they want our graduates, obviously. They are designating a Purdue unit. They will be providing a clinical nursing specialist who will be the partner educator with Purdue, but primarily hired and paid by Clarion.

We are out developing many of those partnerships, as many as we can, because that is the only way we can expand and still maintain the quality of our program. We have 96 percent pass rates on boards, and we have had that for many, many years. We do not want that to be compromised. As Dr. Aiken's study states, smarts trumps a whole lot of other things. We want to keep these bright young people.

We are also doing a lot with recruitment through our nurse managed clinics. We are identifying middle schoolers, because we believe we need to bring them in younger than high school, and we

have a 22 percent Hispanic population in Delphi, IN, and any of the middle schoolers who are interested can do rotations at our clinic, but we particularly targeted Hispanic middle schoolers that we are bringing into the clinic, getting them interested and excited about health care at a very early age.

We also have a program called Are You Man Enough to be a Nurse. This was initiated at Texas Tech. We have a very strong focus on trying to bring more males into nursing. That slogan was actually developed by a fifth grader who had a father who was a nurse, a male nurse. There was a button contest and that was the theme, and it is really just a great program. That is another way.

We are doing a lot in the recruitment end, spending a lot of time in middle schools and high schools to try to get kids excited about nursing.

Mr. BUYER. What is the average pay of one of your recent graduates?

Ms. NOVAK. In the range of $40,000 to $50,000. Of course, as has been mentioned, there are many sign-on sorts of bonuses and other sorts of things to attract them into the arena. Of course, we want to keep our nursing graduates in Indiana. Seventy-five percent do stay in Indiana at this point. We do not want to compromise that either. We are reaching out and trying to develop those partnerships.

We are also trying to take as many of our programs into rural communities because if an individual comes from a rural community, if you can educate them there and keep them there, particularly our advanced practice nursing students, so they can do their clinical rotations in their home communities, they are more likely to stay in under served areas. We have a very strong focus in our graduate program on that.

Mr. BUYER. Ms. Foley, in your testimony, you were highlighting the positive results of the Magnet program and the nurse vacancy rate that you have presently at 1.5 percent. What was it prior to achieving Magnet status?

Ms. FOLEY. It was about 9, 9.5, at that time. We have been a member of Magnet recognition since 1998.

Mr. BUYER. Congratulations.

Ms. FOLEY. For disclosure purposes, at that time, in New Jersey, we did close a hospital that was a sister hospital to this site, a hospital system called Point Pleasant. In the year 2000, we closed that hospital. The community was a little upset with us. It is quite emotional, closing a health care facility in your neighborhood, and some became disenchanted.

Mr. BUYER. It is just as emotional as trying to open a new one.

Ms. FOLEY. I can only imagine.

Mr. BUYER. Would you concur with that statement?

Ms. Novak. Yes.

Mr. BUYER. Let me move to a strategic vision. As we press the bounds of excellence, achieve these standards of Magnet facilities, trying to then raise the standard, increase cooperation, change a culture, does it raise all boats, or do we have an unintended consequence of only increasing the gap in a tiered health system?

Ms. NOVAK. I think nurses in general have been far under utilized with regard to their expertise. I think a very strong back-

ground in health promotion and disease prevention has been significantly under utilized. I think a health care delivery system that looks at how nursing can change the system, can move us from a public health crisis into a situation that will truly be a significant change from the local to the global community, is very important.

I think we are an untapped resource, basically. I think there is much that nurses can do. We have been restrained at every level, from full practice, from what we have been educated to be able to do. I think that is where the giant disservice is to the American people, including the veterans. I think the veterans' system, with their valuing education and attaining excellence has really been at the forefront, and I think that the private sector has much to learn from that, this adoption of Magnet status would be one more step in terms of leading the way for the private sector who have not made this move, and are still in a very position dominated sort of health care system that does not address that curative care is only going to get us so far, and it is extremely expensive, and we need to put far more emphasis on health promotion and disease prevention, and nurses are the profession to do that.

Ms. FOLEY. The skill and the knowledge of a nurse today is not—I can only speak to the facility that I am in, and I have been there for 15 years—to allow the nurse to be autonomous, independent, choose relationships with wise leaders, the nurse is not utilized today as they should be, to the full scope and breadth that they can contribute.

Believe me, it is not utopia. I do not mean to say best hospital on the earth. It is a darned good hospital in New Jersey and the best nurses in the country.

That environment has to be created for them to really feel that they are making a difference every day, to be passionate about what they are doing, and to know that they are respected and validated, and the validation, I guess, is the Magnet piece, but to be respected on an ongoing basis.

I would not be concerned about the tiered approach. The community will not allow that to happen. Americans will not allow that to be.

I think the Magnet recognition is a foundation that is to be built upon, like 80 some odd hospitals throughout the United States have achieved the status. The ANCC is going to continue to raise the bar. I do not mean to say from a tiered approach, but it is going to be a little tougher in 2005, 2006, 2007. I do not know that you hear a lot about Magnet, Magnet, Magnet, I think it is more about creating that culture in a facility that you want your best care givers to practice in, and the nurses are not tapped into to know what their opinion is.

As I spoke in my testimony about a great environment to work in. That is why we are doing this pilot. We asked 10 to 15 nurses, tell me about your perfect work environment, what do you need. Is it cell phones? Is it technology? Is it national certification? Is it a specific patient population? All the answers are there. I just do not know that we tap into our own resources that we have.

Does that answer your question?

Mr. BUYER. Let me rephrase it.

Ms. FOLEY. I guess I didn't, then.

Mr. BUYER. No, your testimony was great. America has a tiered health system, quasi-governmental, private tiered health system. We do. We mask a lot of the problems and never really want to discuss them. We really do not.

I endorse and love pressing the bounds. I do. Raising standards, pressing bounds.

As we are doing that, are we only making the better better or as you press the bounds, are you raising all health systems? That is what I am trying to figure out. Are we creating gaps in those tiers? I just do not know. If you do not have the answer, say you do not have the answer. I am just asking from a business standpoint, because we have something on movement for the country, and I just would like to know.

I believe that for this Committee to press the VA to do this Magnet status, we look at it because it is about the care to the veterans, and we are going to make that demand on the VA because this Committee gives our veterans special status. We have a bias on this Committee with regard to the veteran.

Now, I am going to look across the country, because what happens in the country impacts the VA. I am trying to find out as you press the bounds, if you are saying your top ten students, Mayo Clinic comes down and takes them, they are not going into an inner city or a rural hospital. See what I am saying?

Ms. NOVAK. They come and take ten great students, but we have I would say about 100 great students that graduate every year, because of our intense scrutiny on the front end of the process. I am just saying that Magnet hospitals are an attraction to them.

If you are looking at recruiting and retaining and interesting new graduates in the VA system, that is something that they look at. It is not that they necessarily want to go to a Mayo Clinic. They want to go to a Magnet hospital where they are going to be valued, and where they are going to be able to function to the full extent of their scope of practice, and that is what they are interested in.

I think more and more hospitals are in the process because of the shortage, of trying to attain Magnet status. It is 85 now. I think that number is going to increase significantly because other hospitals in the private sector are going to do this, to try to attract top graduates and graduates in general.

I think in terms of the tiering, we are working very closely with the community college system, with our loan diploma program locally, and I think it is the only one in the State of Indiana, to try to move them sort of through that ladder concept and matriculation, so that they will have baccalaureate degrees. I think this study by Aiken—she is very highly regarded across many, many disciplines, and is a very meticulous researcher, and I would trust her data.

Because of the acuity in hospitals, the VA system and otherwise, the acuity is so significant that we need better educated individuals making those decisions, determining when other health care providers need to be involved, and I think that is a hallmark study for doing that, and I think people go into nursing, if they have a 1300 SAT, they can go into anything they want to go into, really, and we have very bright young people choosing nursing, and more and more of them, I think with the Johnson and Johnson cam-

paign, $20 million was put into that campaign, and we saw between a 10 and 20 percent increase in applications to nursing programs.

It was really moving away from a negative way that nursing has been portrayed in the media to something very positive, and if you look at the nurses, the real nurses, that they have highlighted, they have highlighted those sorts of things that every single panelist has been talking about.

They have tremendous self-respect. They are self-assured. They are confident. They are bright. They know what they are doing. That is who we need to take care of our veterans and everybody else.

Mr. BUYER. I asked the question not to be a critic of the present movement to increase those standards. I only asked the question to scrutinize whether or not there are unintended consequences of the movement.

Ms. Hooley, do you have a question?

Ms. HOOLEY. Just a question and then a statement.

Do we know how many hospitals we have—I am trying to figure out 85, what percentage is that?

Ms. NOVAK. There are several thousand hospitals, I believe.

Ms. HOOLEY. I know there are thousands. I just do not have a clue as to what percentage that is. One of the things that I appreciate from all of the panelists today is talking about the importance of nursing and how valuable they are to our hospitals and care of patients. Many times, they are under utilized. I have believed that for a long time.

The comment I have to make is not only do we have a shortage of nurses that we have to deal with, and then how to best use our nurses, but I think we also need to keep our eye on the longer picture, and that is we have 43 million Americans without any health insurance, as you talk about a tiered system. I think you constantly have to not only look at all aspects of health care, but you have to look at that larger picture that we have a lot of people that do not have anything.

Thank all of you for your testimony.

Mr. BUYER. I want to thank you for coming to sunny Washington, DC. To Ms. Rick, hopefully, you leave the room with a sense that of all your VA hospitals, and I guess now you have four in application, 11 are considering, if you could provide the Committee with regard to what your vision is on how to move Magnet status to the entire system, whether you agree with it or disagree with that. Please have a conversation in paper with us. All right?

Thank you very much for your testimony. This has been a valuable hearing. Thank you. The hearing is now concluded.

[Whereupon, at 12:19 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF THE HONORABLE STEVE BUYER

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGTIONS

COMMITTEE ON VETERANS' AFFAIRS

HEARING ON ℞ FOR VA'S NURSING SHORTAGE:

IS THERE MORE THAN ONE ANTIDOTE?

OCTOBER 2, 2003

GOOD MORNING. TODAY'S HEARING IS ENTITLED: "PRESCRIPTION FOR VA'S NURSING SHORTAGE: IS THERE MORE THAN ONE ANTIDOTE?" I DON'T THINK ANY OF THE WITNESSES THAT WE WILL HEAR FROM TODAY WILL DISPUTE THE FACT THAT THERE IS A CRITICAL NATIONWIDE NURSING SHORTATGE.

DURING TODAY'S HEARING WE HOPE TO LEARN THE EXTENT OF THE PROBLEM WITHIN THE VA AND, MORE IMPORTANTLY, WHAT IS THE DEPARTMENT PROPOSING TO REMEDY THE MASS EXODUS THAT IS LIKELY TO OCCUR OVER THE NEXT FEW YEARS. THIS LOOMING HEALTH CARE CRISIS CERTAINLY DEMANDS THAT THE VA TACKLE THE PROBLEM AGGRESSIVELY—SOONER RATHER THAN LATER.

ACCORDING TO THE VA, THIRTY-FIVE PERCENT OF ITS REGISTERED NURSES ARE ELIGIBLE FOR RETIREMENT BY THE YEAR 2005. IF THE VA LOSES ONE-THIRD OF ITS THIRTY-SIX THOUSAND RN'S, WHO WILL TEND TO THE VETERANS NEEDING CARE IN THE NEXT FEW DECADES. BECAUSE THE VA HAS AN AGING POPULATION, WHICH WILL REQUIRE MORE COMPLEX CARE FROM HIGHLY SKILLED PROFESSIONAL NURSES, WE CANNOT IGNORE THIS PROBLEM.

ON MONDAY, SEPTEMBER 29, 2003, AMERICAN HEALTH LINE REPORTED THAT:

> HISTORICALLY HIGH NURSING SHORTAGES HAVE CREATED A 'GAME SHOW-LIKE FRENZY AMONG HOSPITALS,' WHICH ARE OFFERING SIGN-ON INCENTIVES SUCH AS VACATIONS, VEHICLES, MASSAGES, CONCIERCE SERVICES, FREE TUITION FOR NURSES AND THEIR CHILDREN AND BONUSES OF UP TO $10,000.

ONE COULD SURMISE FROM THIS THAT THERE ARE INDEED TOO FEW NURSES AVAILABLE TO FILL HOSPITAL VACANCIES, INCLUDING THOSE AT THE VA. STATISTICS CERTAINLY TELL US THIS IS THE CASE. ACCORDING TO THE NATIONAL CONFERENCE OF STATE LEGISLATURES' HEALTH POLICY TRACKING SERVICE, WHICH WAS LAST UPDATED ON APRIL 1, 2003, FOUND THAT THE NUBMER OF FULL TIME EQUIVALENT NURSES WAS 1.89 MILLION IN 2000. THIS REPRESENTS A NURSING SHORTAGE OF 110,000 OR SIX PERCENT. IT IS ESTIMATED THAT BY THE YEAR 2015 THE DEMAND WILL INCREASE AND THE SHORTAGE WILL ALMOST QUADRUPLE TO TWENTY PERCENT.

WHAT WE WANT TO HEAR FROM OUR WITNESSES TODAY ARE SOLUTIONS TO THE PROBLEMS FACING OUR HEALTH CARE ORGANIZATIONS IF THEY CONTINUE TO EXPERIENCE DIFFICULTIES IN RECRUITING AND RETAINING NURSING PERSONNEL.

EARLIER THIS YEAR, I VISITED THE JAMES A. HALEY VETERAN'S HOSPITAL IN TAMPA, FLORIDA. WHILE AT THAT FACILITY, I LEARNED THAT IT HAD ACHIEVED "MAGNET STATUS." WHEN I ASKED, "WHAT DOES THAT MEAN"? I WAS TOLD THAT RECEIVING SUCH A DESIGNATION REPRESENTS THE HIGHEST LEVEL OF RECOGNITION THAT THE AMERICAN NURSES CREDENTIALING CENTER CAN GRANT TO HEALTH CARE ORGANIZATIONS. HARVEY HOLZBERG, PRESIDENT'S STAFF, ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL SAID:

> WE BELIEVE THE QUALITY OF NURSING IS THE KEY TO OUR HOSPITAL'S SUCCESS. RECEIVING THE ANCC MAGNET AWARD IS THE HIGHEST FORMAL RECOGNITION TESTIMONIAL TO THAT QUALITY . . . THE AWARD WAS RECOGNIZED BY THE ENTIRE HOSPITAL FAMILY AS A FORMIDABLE ACCOMPLISHMENT ON THE PART OF OUR NURSES.

WE KNOW THAT IN SOME INSTANCES, RNs ARE LEAVING THE PROFESSION IN SEARCH OF MORE LUCRATIVE AND LESS DEMANDING WORK. MAJOR REASONS THAT HAVE BEEN CITED INCLUDE BURNOUT, WORK CLIMATE, WORK SATISFACTION, PATIENT QUALITY OF CARE AND MANAGERIAL SUPPORT.

THE MAGNET PROGRAM ADDRESSES MANY OF THESE CONCERNS. WE WILL LEARN MORE ABOUT THIS PROGRAM TODAY. WE ALSO WOULD LIKE TO HEAR ABOUT OTHER OPTIONS THAT MIGHT BE AVAILABLE TO ASSIST THE VA WITH ITS NURSING RECRUITMENT EFFORTS.

IN AN EFFORT TO BE AS INCLUSIVE AS POSSIBLE, WE CONTACTED FOURTEEN NATIONAL NURSING ORGANIZATIONS AS WELL AS ANA ORGANIZATIONAL AFFILIATES TO RECEIVE THEIR INPUT ON HOW THE NURSING SHORTAGES HAVE AFFECTED CARE IN THEIR SPECIALITY FIELDS. THESE STATEMENTS WILL BEINCLUDED IN THE OFFICIAL HEARING RECORD.

I WANT TO THANK THE AMERICAN ASSOCATION OF NURSE ANESTHETISTS (AANA) AND THE NATIONAL ASSOCIATION OF CLINICAL NURSE SPECIALISTS FOR SUBMITTING THEIR STATEMENTS TODAY.

Statement
of
Cathy Rick, RN CNAA, FACHE
Chief Nursing Officer
Veterans Health Administration
Department of Veterans Affairs
before the
House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigation

October 2, 2003

Chairman Buyer, Ms Hooley, and members of the Subcommittee: I want to thank you for this opportunity to present testimony regarding the impact of the national nursing shortage on the Veterans Health Administration, the nation's largest employer of registered nurses. Today I will share with you the aggressive actions VA is taking to combat the shortage and ensure ongoing quality care for veterans.

Background

National nursing leaders and health care organizations project a shortage of registered nurses that will be unlike any experienced in the past (AACN, 1998). In addition to registered nurses, the nursing workforce includes practical nurses and nursing assistants. However, the registered nurse is at the center of the nursing workforce; the registered nurse coordinates care for the individual veteran patient as well as for the population of veteran patients in our communities. Given the aging of the current registered nurse workforce, the decreasing number of students who choose nursing as a career, and the ever increasing demand for professional nursing services, the current and future number of professional registered nurses (RN) will be insufficient to meet our national health care needs (Janiszewski (2003) Buerhaus, Staiger, & Auerbach, 2000; Carpenter, 2000). Noted nursing economist Dr. Peter Buerhaus wrote that the total number of nurses per capita will likely peak in 2007 and decline steadily thereafter (1998). This is consistent with a Bureau of Labor Statistics estimate that the need for registered nurses is expected to exceed one million by 2010. The nursing shortage is already challenging hospitals to provide safe care in certain areas. (Stechmiller 2002). At the same time, changes in healthcare delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community. Market demand will also drive an increased need for nurses. (Peterson 2001). By 2020, the United States RN workforce is forecast to be roughly the same size as it is today, declining nearly 20 percent below RN workforce requirements. (Buerhaus, Staiger, & Auerbach, 2000). A modest increase in enrollment in generic nursing programs was experienced in 2002; however, far larger increases are needed if the trends noted above are to be reversed.

The projected shortage will result in part from a number of substantial changes that continue to take place in the profession. Factors identified that will intensify a nursing shortage are (AACN, 2000; Bednash, 2000; Carpenter, 2000; Curren, Horner, & Eldridge, 2000; Havens & Aiken, 2000):

- A decline in enrollment in schools of nursing;
- Aging of the nursing workforce (average age nationally, 45.2 yrs, VA 47.4 yrs);
- Average age of a new graduate in nursing has climbed to 30.5 in 1995 - 2000 versus 24.3 in 1985 or earlier;
- Neither racial nor ethnic minorities nor men enter nursing in numbers that reflect the national population;
- Young women, who in the past made up the preponderance of nursing students, now have a wide range of alternative career options available;
- Poor image of nursing as a career choice. In a 2001 Gallup Poll of public perceptions of the professions, nurses ranked number one in honesty and high ethics for the second, consecutive year. However, in the same poll, nursing ranks 137 out of 250 professions in desirability;
- Pay inequities between nurses and other occupations that require less education and have less responsibility;
- Perceived negative work environments, such as: undesirable work schedules, lack of respect and lack of nursing involvement in patient care decisions;
- Inadequate numbers of qualified faculty to educate the numbers of nurses needed.

Impact of the Shortage on VA

Registered nurses comprise the largest segment of healthcare workers within the Veterans Health Administration (VHA N=36,000). VA nursing workforce data support the conclusion that the average age of VA nurses will continue to rise and the number of nurses who are retirement eligible will continue to rise. Based on current trends, retirements will not be abrupt or sudden, but rather a prolonged, gradual, manageable wave of retirements that should extend well beyond 2005. Retirements will require a consistent influx of nurses and ancillary personnel. Difficulties have arisen and will continue as the shortage results in increased time and efforts required to fill registered nurse vacancies.

- The Average age of an RN nationally is 45.2 (DHHS 2000); Average age of VA RN is 47.4 (2002)
- Average age of a VA RN new hire in FY 2000 was 41.65 years;
- VA nurses will be eligible for retirement in large numbers through 2005 (RNs 35 percent, LPNs 29 percent, Nursing Assistant 34 percent).
- 55 percent of all VA Nurse Executives are eligible to retire in 2005; 69 percent will be eligible in 2008

VA's nurse turnover rate at 8.3 percent is less than the national average, which is estimated at 20 percent.

VA is an employer of choice for men and ethnic minorities, hiring higher percentages than are reflected in the general population of nurses.

Minority Category	*National-RN only (DHHS, 2000)*	*VA-RN only (FY2000)*
Males	5.4	13.8
African American	4.9	14.62
Hispanic	2.0	5.85
Asian	3.5	9.58

Based on VA PAID data files-- FY 2000 and US Dept of Health and Human Services' Findings from the National Sample Survey of Registered Nurses, March 2000. VA Nurse Anesthetist data are excluded from this analysis.

The Veterans Health Administration convened the Future Nursing Workforce Planning Group in August 2000 to critically review the impact of the national nursing shortage on the Department of Veterans Affairs (VA), Veterans Health Administration (VHA). Members represented a variety of clinical and administrative roles within VA as well as organized labor. This group published its findings and recommendations *A Call to Action—VA's Response to the National Nursing Shortage* in November 2001. This critical report provided a foundation for VA's retention, recruitment, and outreach activities.

VA Registered Nurse Workforce Requirements

In VA's evolving healthcare environment, nurses must possess clinical decision-making and critical thinking skills, and must have professional preparation in community health, patient education, and nursing management/leadership. Professional nurses use a breadth and depth of knowledge to care for veteran patients in multiple health care settings—from the rapid patient assessments and complex care provided during critical stages of an acute illness through the compassionate attention to detail that enhances quality of life for veterans who are making the transition into a long-term care environment.

VA's nurses must be utilized appropriately, provided a safe working environment and provided with sufficient resources to capitalize on their skills and expertise. Reflective of this, VA does offers BSN and MSN prepared nurses more complex clinical and organizational responsibilities. Technological advances in health care treatment and equipment, evolving health care trends, modifications in delivery settings, and consumer expectations will require nurses to constantly adapt to change and varied roles. VA is committed to maintaining an appropriate mix of qualified registered nurses to respond to healthcare trends and will continue to hire and value the contribution of nurses prepared at the associate, baccalaureate, master's and doctoral level.

Based on the intense and complex healthcare environment, the National Advisory Council on Nursing Education and Practice (1996) has recommended that by the year 2010 two-thirds of all practicing nurses must possess a baccalaureate degree if optimal care is to be provided. VA's registered nurse qualification standard requires specific educational degrees precisely to meet these clinical contributions to the delivery of care and since its inception, the percentage of nurses prepared at the bachelors level or higher has risen to 64 percent. Through the adoption of VA's Nurse Qualification Standard and with continued commitment to funding academic education for nurses, VA

will be well positioned to attain this recommended educational mix and provide optimal care to veterans.

Fiscal Year	*% VA RN's with AD/Diploma*	*% VA-RN's with Bachelors's or higher*
1998	41	59
2001	39	61
2002	36	64

Based on VA PAID data files-- FY 1998-2002. VA Nurse Anesthetist data are excluded from this analysis.

Strategies to Combat the National Nursing Shortage

Utilization Strategies

- VA uses its current Nurse Qualification Standards to model those facilities found to have the best patient outcomes such as Magnet Hospitals and Academic Health Centers. These facilities have a significantly higher percentage of baccalaureate prepared nurses than other facilities (average = 59% vs. 34% for all hospitals). Research has shown that patients live longer and that nurse retention and job satisfaction are higher in these institutions and others that differentiate nursing practice based on education. This is substantiated in an article by Dr. Linda Aiken published in the September 24, 2003 issue of the Journal of the American Medical Association (attached), which provides data demonstrating that mortality and failure-to-rescue rates were 19% lower in hospitals where 60% of nurses had BSNs or higher than in hospitals where only 20% had BSNs. This research also shows that a 10% increase in the proportion of hospital staff nurses with BSNs or higher degree was associated with a 5% decrease in mortality rates and a 5% decrease in failure-to-rescue rates.

  The Nurse Qualification Standard is focused on both the standard of care provided by nurses as well as the level of education. In keeping with this, VA has a waiver of the educational requirements available for associate degrees nurses who have demonstrated that they meet the performance standards of a higher grade.

- VA's Barcode Medication Administration System, Computerized Patient Record, VistA Imagining System and nationally recognized Patient Safety programs provide state of the art technology to enable nurses to make efficient use of their skills and time while providing exceptional safety for both patients and their caregivers. The Nursing Integrated Information System is an attempt to draw data from disparate computer sources and combine it in such a way as to be useful in managing nursing practice. Since the computer systems are being transferred to a different programming language, it is an opportune time to create a computer environment that contributes to nursing care. This effort is a line item in the budget for FY 04.

- VA is actively encouraging medical centers to attain Magnet Recognition Status. As noted above, these hospitals have excellent patient outcomes and higher rates of nurse retention and job satisfaction. VA Medical Center Tampa has the distinction of being the first Magnet facility in our system. Four VA facilities—

Houston, San Diego, Washington, DC and New York—are in the process of filing their initial applications. Approximately 11 other facilities report that they have begun the staff education and planning process that will lead to the application process in the future.

- VA's Office of Nursing Services has created a Program Director position devoted to Workforce Development. The individual in this role will direct and coordinate programs directly impacting recruitment, retention, succession planning and quality of the work environment.

- VA Nursing Outcomes Database Project (VANOD) is a 16-month project for creating a database of nursing sensitive quality indicators that will enable exploration of relationships between nurse staffing and patient outcomes, evidence-based decision-making, and benchmarking for testing best practices. The nursing sensitive quality indicators include falls, pressure ulcers, skill mix, staffing, staff musculoskeletal injuries, patient satisfaction, and RN satisfaction. Twelve randomly selected VA hospitals are included in this pilot project. Two VA Health Services Research teams are participating in the building of the database: VA Puget Sound in Seattle is creating data submission methods and database structure while the Management Decision and Research Center in Boston is creating reporting formats from the data. Future planning is underway to establish nation-wide VA roll out, development of more indicators, and expansion to other care settings such as long term care and ambulatory care.

Retention/Recruitment Strategies

- VA's educational requirements have resulted in significant education opportunities that have enhanced both retention and recruitment of registered nurses. The National Nursing Educational Initiative (NNEI) and Employee Incentive Scholarship programs have provided nearly 50 million dollars to enable 1103 registered nurses and non-nurse VA employees to complete degrees in nursing. Funding for education through the NNEI is likely one reason that VA has little difficulty recruiting associate degree nurses.

- In response to nurses identifying a need for better communication and stronger collaboration between nurses and physicians, VA is implementing a Nurse-Physician Collaboration Breakthrough Series designed to foster greater awareness/knowledge of retention, succession planning and nurse-physician interactions as related to quality patient care.

- Wide disparity in the utilization of pay and hiring authorities resulted in the publication of *VA Pay and Hiring Authorities* an annotated reference for clinical and human resources professionals designed to eliminate confusion, encourage flexibility and support recruitment and retention endeavors. This document is available in both electronic and print versions.

- VA's newly implemented web-based entrance and exit interviews will allow uniform data collection specific to registered nurses regarding factors that influence nurses to seek or to leave VA employment. The data collected can be aggregated to display facility, network, or national trends and will be of great use

to the planning and implementation of future nurse recruitment and retention strategies.

- VA has forwarded proposed legislation to the House Veterans Affairs Committee containing initiatives that will have significant impact on our ability to recruit and retain a highly qualified workforce. These initiatives, designed to correct impediments to retention and recruitment identified by VA administrators and nurse leadership, will provide VA medical centers a more competitive edge in hiring and retention. The proposals are as follows:

  1. Enable VAMCs to offer flexible tours. Specifically we are proposing the following:
     A) Three 12-hour tours (36 hours) paid as 40 hours;
     B) 9 months of work with 3 months off, with pay apportioned over a 12-month period;
     C) 7 ten-hour days/7 days off, with pay for 80 hours; and

     Inflexibility in work schedules is a major cause of dissatisfaction in nurse employment. A 2000 survey conducted by the American Organization of Nurse Executives (AONE), found that after salary, the top benefit sought by nurses was "flexible scheduling and control over shifts." Providing different options for scheduling would be a way of bringing more nurses into the workplace and retaining their services.

  2. Establish a Nurse Executive Special Pay Program
     We are recommending that the Secretary be authorized to approve special pay of $10,000 up to $25,000 per year to the nurse executive at each VA medical center and nurse executive positions in the VACO Nursing Service,

     The special pay would range from a minimum of $10,000 to a maximum of $25,000, based on factors such as the grade of the nurse executive, the scope and complexity of the nurse executive position, the nurse executive's personal qualifications, the characteristics of the healthcare facility, e.g., tertiary, single site or multi-site, nature and number of specialty care units, demonstrated recruitment and retention difficulties, and such other factors as the Secretary deems appropriate. The special pay would not make VA a pay leader; it would however allow medical centers to compete with private sector pay levels and/or to relieve pay compression at the highest levels.

     Approximately 55 percent of all VA Nurse Executives are eligible for retirement by 2005; 69 percent will be eligible by 2008. In addition, 35 percent of all current VA registered nurses are eligible to retire by 2005. When coupled with the national shortage, this potential loss of nurses could jeopardize VA's ability to accomplish its healthcare mission.

- The Veterans Affairs Learning Opportunity Residency (VALOR) Program recruits nursing students with outstanding scholastic records for structured summer clinical learning experiences; part-time employment during the school year followed by special hiring incentives for permanent employment at graduation. The program is geared to meet the most frequently identified issue of nursing education for both faculty and students—the need for productive clinical learning.

Outreach Strategies

- In collaboration with our academic and community partners, VA encourages innovative actions to increase shared faculty arrangements—moving nursing education toward a model in which nurse clinicians are more actively involved in classroom as well as clinical teaching. Such arrangements offers a "win-win" strategy to VA medical centers as well as our academic partners by addressing the shortage of nursing faculty and providing VAMC's with outstanding opportunities to recruit graduating nurses already inclined to work for VA based on their positive student experiences. One example of a successful shared-faculty collaborative is that between the VA Puget Sound Health Care System and the University of Washington. A video highlighting this initiative has been provided to the Committee.

- VA medical centers across the country are taking active roles in community outreach, encouraging youth, teens and adults seeking a second career to enter the nursing professions. A video highlighting this initiative has been provided to the Committee.

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107-35), which took effect on January 23, 2002, established the National Commission on VA Nursing (NCVAN) to, among other things, "consider legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel" by the VA. That Act requires the NCVAN to report its findings and recommendations to Congress by May 2004. VA looks forward to the Commission's report.

In conclusion, VA's healthcare workforce is critical to the success of our mission "to care for him who shall have borne the battle, and for his widow, and his orphan"; as such, VA will engage in a growing program of assessing nursing workforce needs and implementing innovative strategies to address them.

Thank you, again, Mr. Chairman, for this opportunity to address the impact of the national nursing shortage on the Veterans Health Administration. I will now be happy to answer any questions that members of the Subcommittee might have.

Attachment 1

EMBARGOED: Not for release until September 23 at 4 pm EDT

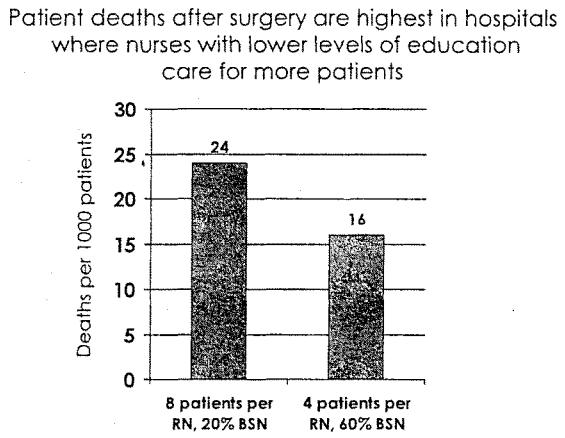
Contact: Joy McIntyre **Telephone: 215.898.5074; 5673**

Fax: 215.573.2062
Email: joyme@nursing.upenn.edu

Penn Research Finds More Patients Die after Everyday Surgeries In Hospitals Where Fewer RNs Hold Bachelor's Degrees (BSN)

(Philadelphia, PA)— The education level of hospital nurses may be as important as how many RNs are at the bedside in determining whether patients survive common surgeries, according to a University of Pennsylvania School of Nursing study released today in *The Journal of the American Medical Association (JAMA).*

In a study of 232,342 patients, researchers from the Center for Health Outcomes and Policy Research found that raising the percentage of bedside RNs with bachelor's degrees from 20 to 60 percent would save four lives for every 1,000 patients undergoing common surgeries. Surprisingly, of 168 hospitals studied in Pennsylvania, the percentage of university-trained RNs varied from 0 to 77 percent.* A conservative estimate suggests the difference between best and worst staffing and education scenarios could translate to 1,700 preventable deaths in Pennsylvania annually.

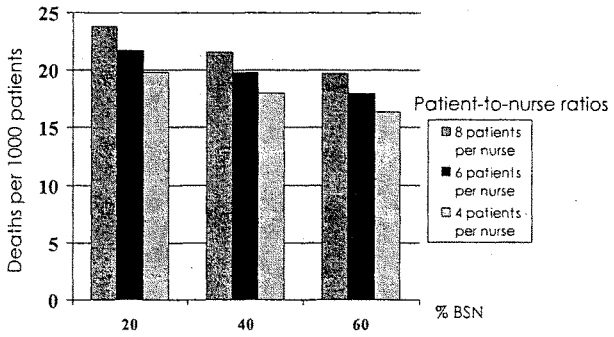


*There are three ways to become a registered nurse: hospital-based "diploma schools," associate degree programs, and Bachelor of Science in Nursing (BSN) or baccalaureate programs at universities.

JAMA/BSN
Take 2 of 3

The study builds on earlier work from the research center on patient deaths from common orthopedic, general, and vascular surgeries—most considered elective—which found adding one patient to nurses' workloads increased patients' risk of dying by seven percent. The latest findings show patients have the highest risk in hospitals where nurses with less education care for more patients: 24 deaths per 1,000 patients when 20% of nursing staffs have BSNs care for an average of 8 patients, to 16 deaths when hospital staffs with 60% BSNs care for four patients.

Patient deaths after surgery are highest in hospitals where nurses with lower levels of education care for more patients

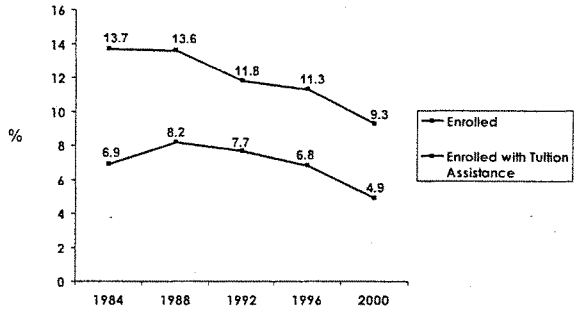


"Despite calls for quick fixes to ease the current shortage of nurses, the public would be better served by increasing nurses' education as well as their numbers," said University of Pennsylvania nursing and sociology professor Linda H. Aiken, PhD, RN, who directed the study. Nationally, 43 percent of hospital nurses have at least a bachelor's degree.

Specifically, the researchers found that:

- A 10% increase in the proportion of hospital staff nurses holding a bachelor's degree is associated with a 5% decrease in post-operative mortality.
- Twenty-three percent of patients developed a complication following admission and 8.4% of them died. Fourteen out of every 1,000 of these patients could be expected to die in hospitals where 20 percent of the nurses had BSNs compared to 60%.
- The findings are independent of the qualifications of patients' surgeons, the availability of technology, hospital teaching status, and nurse experience.
- Almost one in four baccalaureate-prepared hospital nurses received a degree through continuing education following initial schooling, often facilitated by employer educational benefits, yet the trend is decreasing.

Declining Proportions of Hospital Nurses in Higher Education and Getting Tuition Assistance



Source: US Department of Health and Human Services

"Nursing education policy reports published in the past decade concluded that the United States has an imbalance in the educational preparation of its nurse workforce with too few RNs with BSN and higher degrees. Our findings provide sobering evidence that this imbalance may be harming patients," the study's authors wrote.

The study was funded by the National Institutes of Health, the Agency for Healthcare Research and Quality, and The Robert Wood Johnson Foundation. The researchers surveyed 10,184 nurses in 168 Pennsylvania hospitals caring for 232,342 patients from April 1, 1998 to November 30, 1999.

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Attachment 2

Educational Levels of Hospital Nurses and Surgical Patient Mortality

Linda H. Aiken, PhD, RN; Sean P. Clarke, PhD, RN; Robyn B. Cheung, PhD, RN; Douglas M. Sloane, PhD; Jeffrey H. Silber, MD, PhD

JAMA. 2003;290:1617-1623.

ABSTRACT

Context Growing evidence suggests that nurse staffing affects the quality of care in hospitals, but little is known about whether the educational composition of registered nurses (RNs) in hospitals is related to patient outcomes.

Objective To examine whether the proportion of hospital RNs educated at the baccalaureate level or higher is associated with risk-adjusted mortality and failure to rescue (deaths in surgical patients with serious complications).

Design, Setting, and Population Cross-sectional analyses of outcomes data for 232 342 general, orthopedic, and vascular surgery patients discharged from 168 nonfederal adult general Pennsylvania hospitals between April 1, 1998, and November 30, 1999, linked to administrative and survey data providing information on educational composition, staffing, and other characteristics.

Main Outcome Measures Risk-adjusted patient mortality and failure to rescue within 30 days of admission associated with nurse educational level.

Results The proportion of hospital RNs holding a bachelor's degree or higher ranged from 0% to 77% across the hospitals. After adjusting for patient characteristics and hospital structural characteristics (size, teaching status, level of technology), as well as for nurse staffing, nurse experience, and whether the patient's surgeon was board certified, a 10% increase in the proportion of nurses holding a bachelor's degree was associated with a 5% decrease in both the likelihood of patients dying within 30 days of admission and the odds of failure to rescue (odds ratio, 0.95; 95% confidence interval, 0.91-0.99 in both cases).

Conclusion In hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and failure-to-rescue rates.

INTRODUCTION

Nurse understaffing is ranked by the public and physicians as one of the greatest threats to patient safety in US hospitals.[1] Last year we reported the results of a study of 168 Pennsylvania hospitals showing that each additional patient added to the average workload of staff registered nurses (RNs) increased the risk of death following common surgical procedures by 7%, and that the risk of death was more than 30% higher in hospitals where nurses' mean workloads were 8 patients or more each shift than in hospitals where nurses cared for 4 or fewer patients.[2] These findings are daunting given the widespread shortage of nurses, increasing concern about recruiting an adequate supply of new nurses to replace those expected to retire over the next 15 years,[3] and constrained hospital budgets. These findings also raise questions about whether characteristics of the hospital RN workforce other than ratios of nurses to patients are important in achieving excellent patient outcomes.

Nurses constitute the surveillance system for early detection of complications and problems in care, and they are in the best position to initiate actions that minimize negative outcomes for patients.[4] That the exercise of clinical judgment by nurses, as well as staffing adequacy, is key to effective surveillance may explain the link between higher nursing skill mix (ie, a higher proportion of RNs among the nursing personnel of a hospital) and better patient outcomes.[5-10]

Registered nurses in the United States generally receive their basic education in 1 of 3 types of programs: 3-year diploma programs in hospitals, associate degree nursing programs in community colleges, and baccalaureate nursing programs in colleges and universities. In 1950, 92% of new RNs graduated from hospital diploma programs,[11] whereas by 2001, only 3% graduated from hospital diploma programs, 61% came from associate degree programs, and 36% were baccalaureate program graduates.[12] Surprisingly little is known about the benefits, if any, of the substantial growth in the numbers of nurses with bachelor's degrees. Indeed the conventional wisdom is that nurses' experience is more important than their educational levels.

Despite the diversity of educational programs preparing RNs, and a logical (but unconfirmed) connection between education and clinical judgment, little if anything is known about the impact of nurses' education on patient outcomes.[13] Results of some studies have suggested that baccalaureate-prepared nurses are more likely to demonstrate professional behaviors important to patient safety such as problem solving, performance of complex functions, and effective communication.[14-16] However, few studies have examined the effect of nurse education on patient outcomes, and their findings have been inconclusive.[17]

The 168 Pennsylvania hospitals included in our previous study[2] of patient-to-nurse staffing and patient mortality varied substantially in the proportion of staff nurses holding baccalaureate or higher degrees. This variability provides an opportunity to conduct a similar study examining the association between the educational composition of a hospital's RN staff and patient outcomes. Specifically, we tested whether hospitals with higher proportions of direct-care RNs educated at the baccalaureate level or above have lower risk-adjusted mortality rates and lower rates of failure to rescue (deaths in patients with serious complications). We also examined whether the educational backgrounds of hospital RNs are a predictor of patient

mortality beyond factors such as nurse staffing and experience. These findings offer insights into the potential benefits of a more highly educated nurse workforce.

METHODS

Data Sources, and Variables

We analyzed outcomes data derived from hospital discharge abstracts that were merged with information on the characteristics of the treating hospitals, including unique data obtained from surveys of hospital nurses.[2] The institutional review board of the University of Pennsylvania approved the study protocol.

Hospitals. The sample consisted of 168 (80%) of the 210 adult acute-care general hospitals operating in Pennsylvania in 1999 that (1) reported surgical discharges to the Pennsylvania Health Care Cost Containment Council in the specific categories studied here, (2) had data on structural characteristics available from 2 external administrative databases (American Hospital Association [AHA] annual survey[18] and Pennsylvania Department of Health Hospital Questionnaire[19]), and (3) had at least 10 nurses responding to our questionnaire, which previous empirical work demonstrated was sufficient to provide reliable estimates of survey-based organizational characteristics of the hospitals. Six of the excluded hospitals were Veterans Affairs hospitals, which do not report discharge data to the state. Twenty-six hospitals were excluded because of missing data, most often because their reporting to external administrative sources was done as aggregate multihospital entities. Ten small hospitals, most of which had 50 or fewer beds, had an insufficient number of nurses responding to the questionnaire to be included.

A 50% random sample of RNs residing in Pennsylvania and on the rolls of the Pennsylvania Board of Nursing received questionnaires at their homes in the spring of 1999. Surveys were completed by 10 184 nurses, an average of more than 60 nurses per hospital, and the 52% response rate compares favorably with other voluntary, anonymous surveys of health professionals.[20] We compared our data with information from the AHA annual survey and found that the number of nurses from each hospital responding to our survey was directly proportional to the number of RN positions in each hospital. This suggests similar response rates across hospitals and no response bias at the hospital level. Moreover, demographic characteristics of the respondents paralleled those of Pennsylvania hospital nurses in the National Sample Survey of Registered Nurses.[21] For example, the mean ages of Pennsylvania hospital nurses in our sample and in the National Sample Survey of Registered Nurses were 40 and 41 years, respectively; the percentages of Pennsylvania hospital nurses working full-time were 66% and 69%, respectively; and those having earned bachelor of science in nursing (BSN) degrees were 30% and 31%, respectively.

Hospital staff nurses were asked to indicate whether their highest credential in nursing was a hospital school diploma, an associate degree, a bachelor's degree, a master's degree, or another degree. The proportion of nurses in each hospital who held each type of credential was computed. Because the educational preparation of the 4.3% of nurses who checked "other" was unknown, their answers were not included in our hospital-level measures of educational qualifications. It was later verified that this decision did not bias the results. Because there was no evidence

that the relative proportions of nurses holding diplomas and associate degrees affected the patient outcomes studied, those 2 categories of nurses were collapsed into a single category and the educational composition of the hospital staff was characterized in terms of the percentage of nurses holding bachelor's or master's degrees.

Two further variables were derived from the nurse survey. Nursing workload was computed as the mean number of patients assigned to all staff nurses who reported caring for at least 1 but fewer than 20 patients on the last shift they worked. Because nurse experience was an important potential confounding variable related to both clinical judgment and education, the mean number of years of experience working as an RN for nurses from each hospital was also calculated and used in the analyses.

Three hospital characteristics were used as control variables: size, teaching status, and technology. Hospital-level data were obtained from the 1999 AHA annual survey and the 1999 Pennsylvania Department of Health Hospital Survey. Three size categories (<100 beds, 101-250 beds, ≥251 beds) were used. Hospitals without any postgraduate medical residents or fellows (nonteaching) were distinguished from those with 1:4 or smaller trainee-to-bed ratios (minor teaching) and those with ratios higher than 1:4 (major teaching). High-technology hospitals were those that had facilities for either open-heart surgery, major organ transplantations, or both.

Patients and Patient Outcomes. Discharge abstracts for the universe of 232 342 patients aged 20 to 85 years who underwent general surgical, orthopedic, or vascular procedures from April 1, 1998, to November 30, 1999, in the 168 nonfederal hospitals were obtained from the Pennsylvania Health Care Cost Containment Council, which checks the data for completeness and quality. A list of the diagnosis related groups studied was provided previously.[2]

We examined the association between the educational attainments of nurses across hospitals and both deaths within 30 days of hospital admission (derived by linking discharge abstract data and Pennsylvania vital statistics data) and deaths within 30 days of admission among patients who experienced complications (failure to rescue). Patient complications were determined with *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes in the secondary diagnosis and procedure fields of discharge abstracts indicative of 39 clinical events using protocols drawing on expert consensus as well as empirical evidence to distinguish complications from preexisting comorbidities.[22-24]

The 2 patient outcomes studied were risk-adjusted by including 133 variables in our models, including age, sex, whether the admission was a transfer from another hospital, whether it was an emergency admission, a series of 48 variables indicating surgery type, dummy variables indicating the presence of 28 chronic preexisting conditions as classified by *ICD-9-CM* codes, and interaction terms chosen on the basis of their ability to predict mortality and failure to rescue in the present data set. Construction of the patient risk adjustment models used an approach similar to that reported by Silber and colleagues.[22-26] The *c* statistic for the mortality risk adjustment model was 0.89 and for the failure to rescue model, 0.81.

We also estimated and controlled for the effect of having a board-certified surgeon on risk for mortality and failure to rescue. For each patient, the license number of the

operating physician of record was matched to a physician's name using a public use file from the Pennsylvania Bureau of Professional and Occupational Affairs, and subsequently to records from the American Board of Medical Specialties directory of board-certified medical specialists.[27] A dummy variable was constructed to indicate whether or not the operating physician was board-certified in general surgery or another surgical specialty. A second dummy variable was used to identify patients (8% of all patients) with operating physicians whose license numbers could not be linked to names to determine board-certification status. Use of these 2 variables in tandem produced a reasonable way of controlling for surgeon qualifications in our models.

Data Analysis

Descriptive statistics (means, SDs, and percentages) and significance tests (χ^2 and F tests) were computed to compare groups of hospitals that varied in terms of their educational composition on hospital characteristics, including nurse experience and nurse staffing, and patient characteristics. Logistic regression models were used to estimate the effects of a 10% increase in the proportion of nurses who had a bachelor's or master's degree on patient mortality and failure to rescue, and to estimate the effects of nurse staffing, nurse experience, and surgeon board certification. The associations of educational composition, staffing, experience of nurses, and surgeon board certification with patient outcomes were computed before and after controlling for patient characteristics (demographic characteristics, nature of the hospital admission, comorbidities, and relevant interaction terms) and hospital characteristics (bed size, teaching status, and technology).

To account for the clustering of patients within hospitals in our sample, all model estimates were computed using Huber-White (robust) procedures to adjust the SEs of the estimated parameters. Direct standardization estimates derived from the final model are presented to indicate the size of the effects of educational composition of nursing staff independently of and jointly with nurse staffing levels. With all patients and using the final fully adjusted models for predicting death and failure to rescue, the probabilities of poor outcomes were calculated for patients in hospitals assuming that 20%, 40%, and 60% of the hospital RNs held bachelor's or master's degrees and under various patient-to-nurse ratios (4, 6, and 8 patients per nurse), with all other patient and hospital characteristics unchanged.[28] All analyses were conducted using STATA version 7.0 (STATA Corp, College Station, Tex), using $P<.05$ as the level of statistical significance.

RESULTS

Characteristics of Hospitals and Patients

Table 1 provides information on characteristics of the 168 hospitals in our sample. About 19% of the hospitals had more than 250 beds, 36% were teaching hospitals, and 28% had high-technology facilities. Across all hospitals, nurses had a mean (SD) of 14.2 (2.7) years of experience and a mean (SD) workload on their last shift of 5.7 (1.1) patients. The proportion of staff nurses with bachelor's degrees or higher degrees ranged from 0% to 70% across the hospitals. In 20% of the hospitals (34/168) less than 20% of staff nurses had BSN or higher degrees, while in 11% of

the hospitals (19/168) 50% or more of the nurses had BSN or higher degrees. Hospitals with higher percentages of nurses with BSN or master's degrees tended to be larger and have postgraduate medical training programs, as well as high-technology facilities. Hospitals with higher proportions of baccalaureate- and master's-prepared nurses also had slightly less experienced nurses on average and significantly lower mean workloads. The strong association between the educational composition of hospitals and other hospital characteristics, including nurse workloads, makes clear the need to control for these latter characteristics in estimating the effects of nurse education on patient mortality.

Table 1. Characteristics of the Study Hospitals, Overall and by Educational Composition of the Nurse Workforce

Characteristic	All Hospitals (N = 168)	Percentage of the Hospital Nurse Workforce With BSN or Higher Degrees					P Value for Trend*
		<20% (n = 34)	20%-29% (n = 53)	30%-39% (n = 36)	40%-49% (n = 26)	≥50% (n = 19)	
Large (≥251 beds), No. (%)	32 (19.1)	1 (2.9)	3 (5.7)	9 (25.0)	8 (30.8)	11 (57.9)	<.001
Teaching hospitals, No. (%)	61 (36.3)	5 (14.7)	14 (26.4)	15 (41.7)	12 (46.2)	15 (78.9)	<.001
High technology, No. (%)†	47 (28.0)	2 (5.9)	10 (18.9)	12 (33.3)	10 (38.5)	13 (68.4)	<.001
Nurse experience, mean (SD), y	14.2 (2.7)	14.9 (3.6)	14.4 (2.1)	14.0 (2.3)	14.3 (2.6)	12.5 (3.1)	.19
Nurse staffing, mean (SD) ratio of patients per nurse	5.7 (1.1)	6.5 (1.1)	5.7 (1.0)	5.5 (1.1)	5.5 (1.0)	5.2 (1.1)	<.001

*P values were derived from χ^2 and F tests.
†High technology was defined as hospitals that had facilities for open-heart surgery, major organ transplantations, or both.

Table 1. Characteristics of the Study Hospitals, Overall and by Educational Composition of the Nurse Workforce

Table 2 describes characteristics of the patients in our sample and how they varied across hospitals with different nurse educational compositions. Of the patients studied, 43.7% were men and the mean (SD) age was 59.3 (16.9) years. Of the 232 342 patients, 53 813 (23.2%) experienced a major complication not present on admission, 4535 (2.0%) died within 30 days of admission, and the death rate among patients with complications (failure to rescue) was 8.4%. The 2 largest categories of surgical procedures patients underwent were orthopedic (51.2%) and digestive tract/hepatobiliary (36.4%) procedures.

Table 2. Characteristics of Surgical Patients in the Study Hospitals, Overall and by Educational Composition of Staff Registered Nurses*

	All Hospitals (N = 168)	Percentage of the Hospital Nurse Workforce With BSN or Higher Degrees				
		<20% (n = 34)	20%-29% (n = 53)	30%-39% (n = 36)	40%-49% (n = 26)	≥50% (n = 19)
Total patients, No. (%)	232 342	24 766 (10.7)	54 366 (23.4)	58 329 (25.1)	47 955 (20.6)	46 926 (20.2)
Age, mean (SD), y	59.3 (16.9)	61.3 (16.9)	60.8 (16.7)	58.9 (17.1)	59.0 (16.9)	57.3 (16.8)
Men, No. (%)	101 624 (43.7)	10 350 (41.8)	23 298 (42.9)	25 369 (43.5)	20 891 (43.6)	21 716 (46.3)
Emergency admissions, No. (%)	63 355 (27.3)	4691 (16.9)	15 495 (28.5)	16 535 (28.3)	13 583 (28.3)	13 051 (27.8)
Deaths within 30 days of admission, No. (%)	4535 (2.0)	582 (2.3)	1170 (2.2)	1057 (1.8)	911 (1.9)	815 (1.7)
Patients with complications, No. (%)	53 813 (23.2)	5731 (22.9)	12 439 (22.9)	13 278 (22.8)	10 551 (22.0)	11 814 (25.2)
Deaths among patients with complications (failure to rescue), No. (%)	4535 (8.4)	582 (10.2)	1170 (9.4)	1057 (8.0)	911 (8.6)	815 (6.9)
Major diagnostic categories (MDCs), No. (%)						
Vascular surgery (MDC 5)	11 194 (4.8)	1006 (4.1)	2275 (4.2)	2610 (4.5)	2307 (4.8)	2996 (6.4)
Digestive system (MDC 6)	54 919 (23.6)	6728 (12.3)	13 159 (24.0)	13 377 (24.4)	10 898 (22.7)	10 757 (22.9)
Hepatobiliary system (MDC 7)	29 660 (12.8)	4050 (13.7)	6909 (12.7)	8138 (14.0)	5651 (11.8)	4912 (10.5)
Musculoskeletal system (MDC 8)	118 945 (51.2)	11 124 (44.9)	28 515 (52.5)	30 256 (51.9)	25 019 (52.2)	24 031 (51.2)
Skin, subcutaneous tissue, breast (MDC 9)	12 771 (5.5)	1390 (5.6)	2634 (4.8)	3156 (5.4)	3015 (6.3)	2576 (5.5)
Endocrine, nutritional, and metabolic diseases and disorders (MDC 10)	4853 (2.1)	468 (1.9)	874 (1.6)	792 (1.4)	1065 (2.2)	1654 (3.5)
Comorbidities, No. (%)						
Hypertension	79 827 (34.4)	8524 (34.4)	19 243 (35.4)	18 604 (31.9)	16 726 (34.9)	16 730 (35.7)
Diabetes mellitus	31 385 (13.5)	3705 (11.8)	8001 (14.7)	7207 (12.4)	6294 (13.1)	6178 (13.2)
Insulin-dependent diabetes	3607 (1.6)	420 (1.7)	785 (1.4)	949 (1.6)	700 (1.5)	753 (1.6)
Cancer	28 558 (12.3)	3050 (12.3)	6438 (11.8)	6425 (11.0)	6121 (12.8)	6524 (13.9)
Chronic pulmonary disease	19 819 (8.5)	2566 (10.4)	5251 (9.7)	4670 (8.0)	4063 (8.5)	3269 (7.0)
Congestive heart failure	11 795 (5.1)	1445 (5.8)	2899 (5.3)	2688 (4.6)	2313 (4.8)	2450 (5.2)
Arrhythmia	3965 (1.7)	444 (1.8)	973 (1.8)	886 (1.5)	856 (1.8)	805 (1.7)
Aortic stenosis	2248 (1.0)	235 (.9)	498 (.9)	574 (1.0)	479 (1.0)	462 (1.0)
Board-certified surgeon	170 063 (73.2)	16 324 (65.9)	37 580 (69.1)	45 178 (77.5)	37 053 (77.3)	33 928 (72.3)

*All characteristics differed significantly across the groups of hospitals at the $P<.001$ level, according to an F test (in the case of age) and χ^2 tests (in all others).

Table 2. Characteristics of Surgical Patients in the Study Hospitals, Overall and by Educational Composition of Staff Registered Nurses*

The most common patient comorbidities were hypertension (34.4%) and diabetes (13.5%). While the largest proportion of patients (58 329 or 25%) were cared for in hospitals in which 30% to 39% of the nurses were at least BSN-educated, the numbers ranged across the sample (Table 2). Moreover, characteristics of patients, including whether the operating physician was a board-certified surgeon, differed across the groups of hospitals defined by the percentage of nurses with BSN or higher degrees, although few of these characteristics varied across groups in a consistent pattern.

Effects of Hospital RN Education on Mortality and Failure to Rescue

Table 3 presents odds ratios (ORs) representing the raw or unadjusted effects of nurse education, staffing, and experience, and the effect of a board-certified surgeon as operating physician. Also in Table 3 the adjusted ORs show the effects of those factors in a model controlling for all of these factors and for other hospital and patient characteristics. There was a statistically significant relationship between the proportion of nurses in a hospital with bachelor's and master's degrees and the risks of both mortality and failure to rescue, both before and after controlling for other hospital and patient characteristics.

Table 3. Odds Ratios Estimating the Effects of Nurse and Physician Variables on Patient Mortality and Failure to Rescue*

Outcome and Effect	Estimated Separately and Unadjusted, OR (95% CI)	*P* Value	Estimated Jointly and Adjusted, OR (95% CI)†	*P* Value
Mortality				
Nurse education	0.94 (0.89-0.99)	.02	0.95 (0.91-0.99)	.008
Nurse staffing	1.14 (1.08-1.19)	<.001	1.06 (1.01-1.10)	.02
Nurse experience	1.03 (1.01-1.06)	.009	1.00 (0.98-1.02)	.86
Board-certified surgeon	0.51 (0.41-0.63)	<.001	0.85 (0.73-0.99)	.03
Failure to rescue				
Nurse education	0.92 (0.89-0.96)	<.001	0.95 (0.91-0.99)	.02
Nurse staffing	1.11 (1.06-1.16)	<.001	1.05 (1.01-1.10)	.03
Nurse experience	1.03 (1.01-1.06)	.009	1.01 (0.98-1.03)	.52
Board-certified surgeon	0.61 (0.50-0.74)	<.001	0.80 (0.68-0.94)	.007

Abbreviations: CI, confidence interval; OR, odds ratio.

*Odds ratios indicate the change in the risk of mortality or failure to rescue (deaths in patients with serious complications) associated with a 10% increase in the proportion of nurses with bachelor's or master's degrees (nurse education), an increase in workload of 1 patient per nurse (nurse staffing), a 1-year increase in average staff nurse experience, and having an operating physician holding board certification in surgery or a surgical specialty. Significance of all effects assessed using *z* statistics.

†Odds ratios and CIs were derived from robust logistic regression models that accounted for clustering of observations within hospitals. Adjusted for patient's age, sex, diagnosis related group, comorbidities, and significant interactions between them. Also adjusted for hospital characteristics including high technology, teaching status, and number of beds.

Table 3. Odds Ratios Estimating the Effects of Nurse and Physician Variables on Patient Mortality and Failure to Rescue*

Each 10% increase in the proportion of nurses with higher degrees decreased the risk of mortality and of failure to rescue by a factor of 0.95, or by 5%, after controlling for patient and hospital characteristics. This adjusted OR of 0.95 (95% confidence interval, 0.91-0.99) is a multiplicative parameter. To estimate how much of a difference would be expected between hospitals in which 20% vs 60% of the nurses had at least BSNs, it should be taken to the fourth power (since the difference between 20% and 60% is equivalent to four 10% intervals). The resultant ratio ($0.95^4 = 0.81$) indicates that all else being equal, the odds of 30-day mortality and failure to rescue would be 19% lower in hospitals where 60% of the nurses had BSNs or higher degrees than in hospitals where only 20% of nurses did.

All 3 of the other clinician characteristics studied (nurse staffing, experience, and board-certified surgeon as operating physician) had significant associations with mortality before controlling for each other, the educational composition of RNs, and all other patient and hospital characteristics. The final model indicates only very slight changes in the parameters estimating the nurse staffing effect that we previously reported[2] when nurse education is added (from a 7% increase in risk of both negative outcomes with a 1 patient-per-nurse increase in mean workload

originally reported to a 6% increase in mortality risk and a 5% increase in risk of failure to rescue).

Nurses' years of experience were not found to be a significant predictor of mortality or failure to rescue in the full models. The strong and significant decrease in mortality associated with having a board-certified surgeon as operating physician is largely explained by the tendency of patients with board-certified surgeons to be treated at hospitals with other characteristics associated with better outcomes. None of the interaction terms created by combining these 4 variables achieved statistical significance, suggesting that nurse education, nurse staffing, and surgeon board certification operate independently of each other in predicting mortality and failure to rescue.

These effects imply that altering the educational background of hospital nurses by increasing the percentage of those earning a BSN would produce substantial decreases in mortality rates for surgical patients generally and for patients who develop complications. Direct standardization techniques were used to predict the excess deaths in all patients and patients with complications that would be expected with varying levels of nurse educational levels and workloads. As Table 4 shows, if the proportion of BSN nurses in all hospitals was 60% rather than 20%, 3.6 fewer deaths per 1000 patients (21.1 - 17.5) and 14.2 fewer deaths per 1000 patients with complications (failure to rescue) would be expected. Moreover, Table 4 indicates that the effect on mortality of a 20% increase in the percentage of BSNs in the workforce would be roughly equivalent to the effect of a reduction in mean nurse workload of 2 patients, and that both the mortality and failure-to-rescue rates would be decidedly lower if both the workloads were lighter and the workforce were composed of higher percentages of BSN-prepared nurses.

Table 4. Estimated Rates of Mortality and Failure to Rescue per 1000 Patients, by Levels of Nurse Education and Staffing

	Staffing (Patients per Nurse)			
Education, % With BSN	8	6	4	Overall
	Mortality			
20	23.8	21.6	19.7	21.1
40	21.7	19.8	18.0	19.2
60	19.8	18.0	16.4	17.5
Overall	22.0	20.0	18.2	19.5
	Failure to Rescue			
20	100.2	92.6	85.4	90.4
40	92.2	85.0	78.4	83.1
60	84.7	78.0	71.8	76.2
Overall	93.4	86.2	79.5	84.3

Abbreviation: BSN, bachelor of science in nursing degree.

Table 4. Estimated Rates of Mortality and Failure to Rescue per 1000 Patients, by Levels of Nurse Education and Staffing

COMMENT

To our knowledge, this study provides the first empirical evidence that hospitals' employment of nurses with BSN and higher degrees is associated with improved patient outcomes. Our findings indicate that surgical patients cared for in hospitals in which higher proportions of direct-care RNs held bachelor's degrees experienced a substantial survival advantage over those treated in hospitals in which fewer staff nurses had BSN or higher degrees. Similarly, surgical patients experiencing serious complications during hospitalization were significantly more likely to survive in hospitals with a higher proportion of nurses with baccalaureate education.

When the proportions of RNs with hospital diplomas and associate degrees as their highest educational credentials were examined separately, the particular type of educational credential for nurses with less than a bachelor's degree was not a factor in patient outcomes. Furthermore, mean years of experience did not independently predict mortality or failure to rescue, nor did it alter the association between educational background or of staffing and either patient outcome. These findings suggest that the conventional wisdom that nurses' experience is more important than their educational preparation may be incorrect. The improved outcomes associated with higher levels of BSNs in a hospital was found to be independent of and additive to the associations of superior outcomes in hospitals with better nurse staffing we reported previously.[2] Thus, both lower patient-to-nurse ratios and having a majority of RNs educated at the baccalaureate level appear to be jointly associated with substantially lower mortality and failure-to-rescue rates for patients undergoing common surgical procedures.

In our sample of 168 Pennsylvania hospitals in which the proportion of nurses with bachelor's degrees and mean patient-to-nurse ratios varied widely, 2% (4535/232 342) of the surgical patients undergoing the procedures we studied died within 30 days of hospital admission. Our results imply that had the proportion of nurses with BSN or higher degrees been 60% and had the patient-to-nurse ratio been 4:1, possibly 3810 of these patients (725 fewer) might have died, and had the proportion of baccalaureate nurses been 20% and had staffing uniformly been at 8:1 patient-to-nurse ratios, 5530 (995 more) might have died. While this difference of more than 1700 deaths across 2 educational and staffing scenarios is approximate, it represents a conservative estimate of preventable deaths potentially attributable to nurses' education and RN staffing levels because our patient sample represents only about half of all surgical cases in the study hospitals.

One limitation of our analysis is the potential for response bias in the education and staffing measures derived from the nurse survey, given a 52% response rate. However, examining the Pennsylvania respondents in the probability-based National Sample Survey of Registered Nurses conducted in 2000,[21] we found no evidence of overall differences between our sample and Pennsylvania hospital staff nurses at large in terms of job satisfaction or demographic characteristics, including education.

A second limitation relates to study design. Longitudinal data sets, preferably including hospitals from more than 1 state, will be essential for establishing the

generalizability of these findings as well as establishing whether and how levels of baccalaureate-prepared nurses and nurse staffing in a hospital are causally related to patient outcomes. Also, as in any research drawing on administrative patient outcomes data, there is a potential for differences in completeness and consistency of diagnostic coding across hospitals to influence risk adjustment.[29]

A number of checks on the validity of these findings were completed. Allowing nurse education to have a nonlinear effect and testing whether the effect of education varied across levels of educational composition using quadratic and dummy variables did not significantly improve model fit, suggesting that incremental increases in more educated nurses in a hospital were associated with progressively better outcomes. Including the small proportion of nurses who checked "other" as their highest degree with nurses in the baccalaureate or higher category or in the associate degree or diploma category rather than omitting them from calculations yielded no change in the estimated associations between education and patient outcomes. In an attempt to determine whether unobserved variables that distinguished patients treated in hospitals with different levels of nurse education, we computed propensity scores[30] representing the likelihood that patients with various characteristics were treated in hospitals with high and low levels of baccalaureate nurses. These scores were not a significant predictor of mortality or of failure to rescue, nor did they significantly alter our estimates of the association between education and outcomes.

Research suggests that nurse executives in university teaching hospitals prefer a nurse workforce with approximately 70% prepared at the baccalaureate level and estimate that current levels average 51%. Also, community hospital nurse executives prefer to have 55% of their RNs educated at the baccalaureate level.[31] Data are not currently available to estimate the proportion of hospitals nationally that have 50% or more of their RN workforces prepared at the BSN level or higher, but since only 11% of Pennsylvania hospitals met this standard in our sample there appears to be a wide gap between the preferences of hospital executives and current staffing patterns.

Only 43% of all hospital staff nurses nationally in 2000 were prepared at the BSN level or higher. Enrollments in baccalaureate nursing programs declined by almost 10% from 1995 to 2000, although the past few years have seen an upturn.[21, 32] The return of diploma- and associate degree-prepared RNs to colleges and universities after their initial preparation has been an important source of baccalaureate-prepared nurses. About 22% of currently employed hospital RNs with BSN or higher degrees received them after their basic educations.[21] However, the proportion of hospital nurses pursuing further studies declined from 14% in 1984 to 9% in 2000, as did the proportion of hospital nurses who received tuition assistance from their employers (from 66% in 1992 to 53% in 2000).[21, 33] Meeting the demand for baccalaureate-prepared hospital nurses requires renewed support and incentives by employers to encourage nurses to pursue education to the level of baccalaureate and beyond.

In the current nurse shortage, as in previous ones, public policy discussion has centered on how to increase the supply of RNs. However, little attention has been paid to considering where investments in public funds in the 2 major educational pathways into nursing practice—associate or bachelor's degree programs—will best serve the public good and the interests of employers. Nursing education policy reports published in the past decade concluded that the United States has an imbalance in the educational preparation of its nurse workforce with too few RNs with

BSN and higher degrees.[34-36] Our findings provide sobering evidence that this imbalance may be harming patients.

Our documentation of significantly better patient outcomes in hospitals with more highly educated RNs at the bedside underscores the importance of placing greater emphasis in national nurse workforce planning on policies to alter the educational composition of the future nurse workforce toward a greater proportion with baccalaureate or higher education as well as ensuring the adequacy of the overall supply. Public financing of nursing education should aim at shaping a workforce best prepared to meet the needs of the population. Finally, our results suggest that employers' efforts to recruit and retain baccalaureate-prepared nurses in bedside care and their investments in further education for nurses may lead to substantial improvements in quality of care.

AUTHOR INFORMATION

Corresponding Author and Reprints: Linda H. Aiken, PhD, RN, Center for Health Outcomes and Policy Research, University of Pennsylvania, 420 Guardian Dr, Philadelphia, PA 19104-6096 (e-mail: laiken@nursing.upenn.edu).

Author Contributions: *Study concept and design:* Aiken, Clarke, Cheung, Sloane, Silber.

Acquisition of data: Aiken, Clarke, Sloane, Silber.

Analysis and interpretation of data: Aiken, Clarke, Cheung, Sloane, Silber.

Drafting of the manuscript: Aiken, Clarke, Cheung, Sloane.

Critical revision of the manuscript for important intellectual content: Aiken, Clarke, Cheung, Sloane, Silber.

Statistical expertise: Clarke, Cheung, Sloane, Silber.

Obtained funding: Aiken, Sloane, Silber.

Administrative, technical, or material support: Aiken, Clarke, Cheung.

Study supervision: Aiken, Clarke.

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Author Affiliations: Center for Health Outcomes and Policy Research, School of Nursing (Drs Aiken, Clarke, Cheung, and Sloane), Leonard Davis Institute of Health Economics (Drs Aiken, Clarke, and Silber), Department of Sociology (Dr Aiken),

Population Studies Center (Drs Aiken, Clarke, and Sloane), and Departments of Pediatrics and Anesthesia, School of Medicine (Dr Silber), University of Pennsylvania, Philadelphia; and Center for Outcomes Research, Children's Hospital of Philadelphia (Dr Silber).

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Attachment B

Attachment 2

VA NURSING DATA

FY2000-June 2003[1]

VHA Nursing Personnel Statistics

Total VHA Employees (9-30-02)	
RN	36,648
LPN	9,943
NA	8,833
Total	55,424

Average Age of VHA GS Employees (9-30-02)	
Licensed Practical Nurses	45
Nursing Assistants	46

Advanced Practice Nurses (9-30-02)	
Nurse Practitioner	2,474
Clinical Specialists	685
Total	3,159

VHA RN Age Statistics	VHA (9-30-02)	US Overall (March 2000)
Average Age	47.4	45.2
Percent of Nurses under 40 yrs	17%	31.7%
Percent of Nurses under 35 yrs	8.1%	18%
Percent of Nurses under 30 yrs[2]	3.0%	9.1%

RN Vacancy Rate Note: VA rates include all settings—hospital, nursing home, clinics	VHA	US Hosp[6]
2002	7.5%	--
2001	8.2%	--
2000	7.7%	10.2%
1999	6.2%	--
1998	4.9%	--

RN Turnover Rates Note: VA rates include all settings—hospital, nursing home, clinics	VHA	US Hosp[6]
6-30-03 (partial yr)	9.6%	--
2002	8.3%	--
2001	8.6%	--
2000	9.1%	21.3%
1999	8.5%	--

RETIREMENT

- VHA RN retirement eligibility through 2005 is projected as 35%[3]. "Based on best-judgment predictions now, it's not a large, violent, sudden wave, but rather a prolonged, gradual, manageable wave of retirements that should extend well beyond 2005." Other VHA retirement eligibility through 2005 is 29% LPN and 34% NA.
- RNs enrolled in CSRS equal 10,543 versus 24,348 in FERS. Retirement predictions regarding FERS-enrolled RNs is limited due to lack of historical trend data (as a result of its newness) and lack of data re the influence of the portability of FERS on overall recruitment and retention.
- *Vacancy and Turnover rates for VA reflect all categories or nursing and all delivery sites (e.g., hospital, nursing home, outpatient clinic).*

EDUCATION

- Average age at graduation from basic nursing education is increasing, i.e., 30.5 years in 1995-2000 versus 24.3 years in 1985 or earlier.
- 35%[4] of VA new RN hires would not advance beyond entry level with the new Qualification Standards. It is unclear if hiring these less than BSN-prepared nurses is a result of facility preference or indifference, and/or an inability to attract RNs with a BSN.
- As compared to the U.S. RN education distribution, VA has a greater proportion of higher educated RNs, 19% with more than a BS versus 10.2% in the general population and 40%[5] with less than a BS versus the nation's 56.6% [2000 data].
- As of 2002, VA's trend of higher educated RNs continues to grow, with 39% holding more than a BS degree and only 36% with less than a BS degree.

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[1] Based on VA PAID data files-- FY 1998, 2000, 2002, 2003, and US Dept of Health and Human Services' Findings from the National Sample Survey of Registered Nurses, March 2000. VA Nurse Anesthetist data are excluded from this analysis.

[2] In 1980, US RNs under 30 = estimate 25.1%

[3] To place this in perspective though, for RNs, [other than the current year retirement percent rate, which because it includes retirement eligible RNs who have not as yet retired, is always larger than average, i.e., 12%] the retirement rate is incremental at a seemingly manageable 3.7 to 5.3 % per year. The new RN hires in 2000 comprises 9 % of total VA RNs. therefore, to date, new hires are replacing retirees.

[4] 41% in 1998

[5] 47% in 1998

[6] American Organization of Nurse Executives, *Acute Care Hospital Survey of RN Vacancy & Turnover Rates (Jan 2002)*

FUTURE TREND

Dr. Peter Buerhaus predicts that the total number of nurses per capita is likely to peak by 2007 and decline steadily thereafter. By 2020, US RN workforce is forecast to be roughly the same size as it is today, declining nearly 20% below RN workforce requirements. This shortage – possibly large – is unprecedented because it will be driven by rapidly aging RN workforce that will not be replaced by younger cohorts.

From the data available, the average age of VA nurses will continue to rise. VA needs to focus more effort on increasing its desirability to younger nurses and maintaining a safe work environment with consideration to the needs of an older workforce.

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Statement
of
Sandra K. Janzen, MS, RN, CNAA
Associate Chief of Staff/Nursing
James A. Haley Veterans' Hospital
before the
House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigation

October 2, 2003

Mr. Chairman, I am Sandra Janzen, the Associate Chief of Staff for Nursing responsible for nursing practice at the James A. Haley VA Hospital in Tampa, Nursing Home Care Units in Tampa and Orlando, and large clinics in Orlando, Viera and Port Richey, Florida. I thank you for holding these hearings on the nursing shortage and its implications for the Department of Veterans Affairs (VA).

I am presenting testimony before this Subcommittee to discuss the Magnet Nursing Services Recognition Program and how Magnet credentialing may improve recruitment and retention associated with the nursing shortage in VA facilities. In March 2001, our VA facility was the first, and is still the only VA health care facility that has successfully achieved Magnet recognition. The concept of Magnet recognition emerged during nursing research of the nursing shortage in the 1980s that studied successful hospitals that were not experiencing a nursing shortage, compared to most hospitals in the country. These hospitals demonstrated superior ability to recruit and retain professional nurses.

Characteristics of Magnet organizations included participative management style, nursing staff involvement at all programmatic levels, collegial nurse-physician relationships, supportive organizations, and highly qualified transformational nursing leaders. In the 1990s, these same characteristics continued to be manifested in successful organizations and were formally adopted by the American Nurses Credentialing Center as standards for Magnet recognition. In 2002, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) publicly acknowledged the importance of a supportive work culture such as Magnet in its report *Healthcare at the Crossroads*.

Today, Magnet recognition is achieved through a stringent and comprehensive process that includes organizational self-assessment based on Magnet criteria, development of an action plan to enhance administrative and clinical programs, and a written application that details how the organization meets the criteria. The application is appraised and scored to determine the degree of excellence achieved by the organization. When an organization exceeds the excellence score, a rigorous site visit is scheduled to verify, clarify,

and substantiate the application. This site visit is primarily focused on the professional nurse to determine models used by staff to provide excellent nursing care and how organizational leaders supported nurses in their practice of nursing.

Magnet recognition is a journey toward nursing excellence for patient care provided in an environment in which leaders listen to the voice of nursing as the patient's strongest advocate. Patient care requires a team of professionals and Magnet standards ensure interdisciplinary collaboration.

This award for excellence might be viewed as an organizational excellence award for nursing similar to the Baldrige Award. It focuses on nursing excellence in practice as demonstrated by clinical outcomes and quality management indicators related to effective staffing. Magnet recognition is not just recognition for nursing services, but recognition for the entire organization that actively supports and highly values the nursing contribution to patient outcomes.

How can a Magnet journey ease the effects of the nursing shortage? The application requires a serious evaluation of work processes that support patient care and the environment where nurses provide care. How do we know that Magnet recognition has helped us? Tampa VA Medical Center's nursing recruitment and retention situation has improved significantly in the past two years. Our RN turnover rate has dropped from 14.5% (2002) to 10.2% (2003), nearly 9% lower than the Florida average. The vacancy rate at the Tampa VA Medical Center fluctuates between 7% and 8%. This rate compares very favorably with the community average in West Central Florida, despite adding new positions to activate more critical care beds, managing double-digit growth in outpatient care, and treating the highest volume of patients in the VA health care system. In 2001, our facility used supplemental agency staff in our intensive care units and acute care areas due to staff shortages. Although agency use never exceeded 2% of all RN hours, today our units are staffed without any additional agency nurses, and we have been able to successfully recruit highly qualified staff to activate a 26% increase in critical care beds.

Despite a highly competitive nursing market in the Tampa Bay area, we have successfully recruited sufficient registered nurses to expand inpatient capacity. Our staffing levels have stabilized, and nurses are spending more of their working hours with patients. Our VA Tampa Nurses perceive staffing levels to be adequate, and, just as importantly, they report that they have sufficient time to meet patient needs. These same nurses report high levels of satisfaction with their ability to care for patients. Our staff is more satisfied with the improved and consistent staffing levels. We conduct an annual nurse satisfaction survey, and our results have improved in two major areas, organizational policy involvement

and pay. Our nurses are involved in determining how patient care is to be carried out, and they feel appropriately paid for their work.

Consistent with research of Magnet facilities, VAMC Tampa's clinical outcomes are very good compared to external benchmarks. For example, our patient fall rate is below national benchmarks despite aggressive implementation of initiatives to minimize restraint use. Our pressure ulcer rate compares favorably to external benchmarks. Patient satisfaction with care is high, and nurses routinely receive compliments. These outcomes are achieved by a highly motivated, engaged staff, who place the highest value on providing patient care. We have a highly educated staff, who are valued as key members of an interdisciplinary team. We promote a culture where education is held in high regard. Sixty-five percent of our nurses have a bachelors or master's degree, compared to national reports of 38% to 48%. The importance of higher levels of educational preparation was illustrated in a recent study by Linda Aiken, PhD., RN, who found that a 10% increase in baccalaureate-prepared nurses resulted in a 5% decrease in unexpected surgical mortality. (JAMA, September 24, 2003 - Vol 290, No. 12, pp. 1617-1623).

Being a Magnet organization requires achievement of, and adherence to, higher standards of practice. Magnet standards provide a framework for performance improvement, require measurement against the best in the industry, and monitor satisfaction of nurses who pride themselves as being among the best who work for a great healthcare organization. As you can see, our investment in these requirements has resulted in significant benefit to our veteran patients and to our staff.

I again thank you Mr. Chairman for holding this very important hearing. An energized, satisfied, and well-educated professional nursing workforce is achievable in VA. The challenges of workforce shortages can be overcome by nurses who are able to practice in a professional environment and serve one of our most important patient populations, the veterans who serve this country.

Mr. Chairman, this concludes my statement. I will now be happy to answer any questions that members of the Subcommittee might have.

Statement
of

Mary C. Raymer, RN MA CNAA
Nursing Education Program Manager
Department of Veterans Affairs
Health Care Staff Development and Retention Office

Before the

Oversight and Investigations Subcommittee
of the
House Committee on Veterans' Affairs

October 2, 2003

Chairman Buyer, Ranking Member Hooley and Members of the Subcommittee:

I am pleased to be here today to discuss the impact of the nursing workforce shortage on the Department of Veterans Affairs. My remarks will focus on the current and planned programs administered by the Health Care Staff Development and Retention Office to address nursing issues.

The Health Care Staff Development Retention Office (HCSDRO/10A2D), located in New Orleans, Louisiana, is a field-based headquarters office, whose primary mission is to assist Veterans Health Administration (VHA) field facilities in recruitment and retention of highly qualified health care professionals. Through a variety of outreach activities, educational programs and other initiatives, HCSDRO assists those facilities in accomplishing their patient care mission by helping to assure filling of critical positions. HCSDRO responsibilities include recruitment and retention activities focused on Title 38 and hybrid Title 38 positions. In the very recent past (i.e., the past two years), VHA has experienced a significant expansion in critical occupations becoming hard-to-fill. A number of facilities are having difficulty filling physician specialties, e.g., anesthesiology, radiology, orthopedic surgery, etc., in part due to salary, but also due to limitations in other benefits like loan repayment, etc. The rapidly expanding retail pharmacy industry, with incredible high beginning salaries for new graduates, is depleting the market of available pharmacists. Of critical importance are our efforts to recruit a highly qualified nursing workforce.

Education Programs Promoting Nurse Recruitment and Retention

The Health Professionals Educational Assistance Program (HPEAP) and the VA Learning Opportunities Residency are the major education related programs currently in use to promote nurse recruitment and retention. The Health Professionals Educational Assistance Program (HPEAP) is comprised of the Employee Incentive Scholarship Program (EISP) and the Education Debt

Reduction Program (EDRP). VA has established the National Nursing Education Initiative (NNEI) as a subcomponent of the EISP. The EISP, NNEI, and EDRP are centralized programs administered by the Health Care Staff Development and Retention Office (HCSDRO), Management Support Office, Veterans Health Administration. The combined centralized budget for the EISP and EDRP is $10 million and the centralized NNEI budget is $10 million per annum.

The EISP authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this initiative include education and training programs in fields leading to appointments or retention in Title 38 or Hybrid Title 38 positions. The specific health care professions include: physician, dentist, podiatrist, pharmacist, licensed practical/vocational nurse, expanded-function dental auxiliary, registered nurse, certified registered nurse anesthetist, physician assistant, optometrist, physical therapist, occupational therapist, certified respiratory therapy technician, and registered respiratory therapist. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum in FY 2003 is $32,043 for the equivalent of 3 years of full-time coursework. Through this program the VHA can obtain new nursing personnel as individuals complete entry level nursing education as licensed vocational/practical nurses (LVN/LPN) and registered nurses (RN). Thus far (through FY2002) 30 employees are enrolled in LVN/LPN programs with 3 graduates and 197 are enrolled in associate degree in nursing programs with 20 graduates in 2002.

The NNEI subcomponent of EISP specifically supports educational opportunities for VA's registered nurses to expand their formal education by funding baccalaureate in nursing and advanced degrees. As of September 30, 2002, the NNEI accounted for 86.4 percent of all the EISP participants. NNEI funding was initially apportioned from the EISP funds in the amount of 10 million dollars per year for five years commencing in 2000. As of September 30, 2002, NNEI scholarships had been awarded to 2,639 of VA's registered nurses with 427 of the participants graduating in 2002. Consistent with the primary goal of increasing the number of baccalaureate prepared nurses, approximately 60 percent of the NNEI awards are for registered nurses enrolled in Bachelor of Science in Nursing programs. Additionally, staff nurses received about 81 percent of the awards. The program also supports advanced nursing practice and generates potential nursing faculty with 939 master's level, 52 doctorate level, and 75 post-graduate level participants. Another benefit of the program is its retention value. Participants must remain with VA for at least 3 years after

completing their academic coursework. The fact the NNEI participants typically work full-time while pursuing their academic studies enhances the retention value of the program. Through FY 2002, approximately $34.7 million was obligated for NNEI scholarships for coursework that averaged 2.2 years per participant. The average total award per participant was $11,383.

The Education Debt Reduction Program (EDRP) authorizes VA to provide education debt reduction payments to employees with qualifying loans who are recently appointed to positions providing direct-patient care services or services incident to direct-patient care services for which recruitment and retention of qualified personnel is difficult. An employee is considered to be recently appointed to a position if the individual has held that position for less than 6 months. Registered nurses represented 46 percent (852) of the 1852 EDRP awards that were authorized in FY 2002. Additionally, registered nurses accounted for nearly $12.1, or 35.6 percent of the $33.9 million that was authorized for the FY 2002 awardees through FY 2007. The average total award for registered nurses amounted to $14,184. The EDRP has been a powerful recruitment incentive for registered nurses.

The final program, the VA Learning Opportunities Residency (VALOR) is a program for student nurses who have completed their junior year in baccalaureate degree programs. This program has been operational since 1990 and provides paid, precepted work experience for nursing students with the goal of retaining those students as VA employees following their graduation. The FY 03 funding provided $1.701 million for 290 students. The majority of Medical Centers (116 of 165) have at least one VALOR student.

National Advertising, Placement Service and Other Programs Promoting Nurse Recruitment and Retention

The HCSDRO also manages the national advertising program for the Department of Veterans Affairs including all forms of print and audio/visual media. Additionally, the Office administers the national placement service via the www.vacareers.com web site. In 2003 a Nurse Recruiter Field Advisory Group with monthly conference calls for all nurse recruiters was established to provide increased linkage with the medical centers and the Health Care Staff Development and Retention Office. The nurse recruiters and the education program coordinators (for NNEI, EISP, and EDRP) provide a critical conduit for information and assessment of needed revisions in current programs as well as development of new initiatives.

Summary

Mr. Chairman, we are planning enhancements to these programs for FY 2004, including development of media tools, revision of the web site, addition of a tool kit for nurse recruiters and provision of additional services for medical center recruitment. We are also implementing upward mobility positions for LPN and RN education and are increasing funding for VALOR.

Thank you for the opportunity to share the Health Care Staff Development and Retention Office current and planned programs for nurse recruitment and retention. Through collaboration in the VHA as well as throughout the health care community we will meet this challenge of ensuring a nursing workforce is available to "Keep the Promise" of caring for our nations' veterans.

WRITTEN STATEMENT

OF

BARBARA A. BLAKENEY, MS, APRN,BC, ANP

PRESIDENT

AMERICAN NURSES ASSOCIATION

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

ON

IMPACT OF THE NURSING SHORTAGE ON VA HOSPITALS

OCTOBER 2, 2003

334 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C.

AMERICAN NURSES ASSOCIATION
600 Maryland Avenue, SW, Suite 100 West, Washington, D.C. 20024-2571, (202) 651-7000

Mister Chairman, Members of the subcommittee, thank you for giving me the opportunity to address you here today regarding the impact of the nursing shortage on the Department of Veterans Affairs.

The American Nurses Association (ANA) is the only full-service association representing the nation's 2.7 million registered nurses through its 54 constituent member associations. The ANA recognizes that the first VA nurses have served the needs of the veterans of the Spanish-American War and have continued that tradition of outstanding service to our nation's veterans. Today, the Veterans Health Administration is the largest employer of registered nurses in the world and serves as a model in the delivery of health care within today's tight fiscal environment.

Nurses are the foundation of the health care system-providing preventive, acute and long-term care across the lifespan. Nurses are at the bedside, 24/7. Quality of care for our veterans will not improve without nurses' active involvement in policy development and implementation strategies.

America is experiencing a crisis in nurse staffing. Health care providers across the nation are having difficulty finding experienced RNs that are willing to work in their facilities. Areas hardest hit include emergency room, critical care and long term care. Projections show that the situation will only get worse.

Today's staffing shortage is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce and the looming health care needs of the baby boom generation. As we gather here today, the U.S. is experiencing a nurse staffing crisis and a growing shortage of registered nurses. A report, last year, by the U.S. Department of Health and Human Services says that we already are facing an RN shortage of more than 136,000 nurses in this country. This is a 7 percent RN shortage. By the year 2020, the HHS report estimates this country will be short of more than 808,000 RNs. Translated, this is a staggering 29 percent nurse shortage.

However, as farsighted as the VA can be in terms of improving nurses' working conditions, changes to the health care delivery system and its program have diminished the VA's ability to attract and retain the best and the brightest.

The Department of Veterans Affairs is experiencing a shortage of nursing personnel similar to national trends and if the available supply of nursing personnel remains constant, the ability of Veterans Health facilities to meet the health care needs of veterans will be adversely affected. The Veterans Health Administration (VHA) provides inpatient, outpatient and home care across various settings. Over the last decade, VA implemented a substantial restructuring of its health care delivery system. Veterans

Health Administration (VHA) moved to a community-based system delivering primary care. According to VA records for the calendar year ending December 31, 2002, there were 162 VA hospitals, 137 nursing homes, 681 community clinics, 11 mobile clinics and 43 domiciliaries. VHA reported over 550,000 admissions. During the same period, more than 49 million outpatient visits were reported (Department of Veterans Affairs, 2002). VHA patient workload continues to rise in the midst of a growing nurse shortage.

In response to this anticipated shortage, the VA has established a task force to focus specifically on nursing workforce planning. The National Commission on VA Nursing was established through P.L. 107-135 and was charged to:

1) Consider legislative and organizational policy changes to enhance the retention of nurses and other nursing personnel by the Department of Veterans Affairs.
2) Asses the future of the nursing profession within the Department.
3) Recommend legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel in the Department.

The Commission held four field hearings across the country last year and received hundreds of witnesses who spoke on ways to improve nursing in the VA. Dozens of VA nurses advocated for changes in the way the VA does business in order to remain an "employer of choice" by nurses.

The Commission will submit its final report to the Secretary of the Department of Veterans Affairs in May of 2004 with specific legislative and organizational recommendations to assure the availability of a qualified nursing workforce to meet the needs of America's veterans. The ANA looks forward to the release of this report and working with the Veterans Affairs Department to achieve their goals for nursing.

While the VHA is a leader in providing quality care, supporting nursing research and advocating on behalf or its nurses, lack of nursing staff at the VA has had a devastating impact on the delivery of quality of care to our veterans. From September 1995 to September 2000, the VA cut RN positions nationwide by 10 percent. These cuts are in contradiction to research findings last fall in the Journal of the American Medical Association that found RN staffing levels had a significant impact on preventable hospital deaths among surgical patients. Lack of staff to provide support services (Ward Secretaries, Escort Services, Lab, Janitorial Services) has further reduced effective patient care by shifting work to an already depleted clinical staff. The training of medical and nursing students also suffers because current staff has little time or energy to provide students with review and feedback crucial to their education as health care professionals.

ANA supports an integrated state and federal legislative campaign to address the current and impending nursing shortage. Many of these solutions are directly applicable to the VHA. While some issues regarding nurse recruitment and retention were addressed with the Nurse Reinvestment Act, many issues remain that relate to the RN work environment.

I would like to highlight some key future strategies that deal directly with the nurse shortage:

HEATH & SAFETY

The American Nurses Association conducted an on-line health and safety survey in August, 2001. A total of 4, 826 nurses participated in the survey. The respondents represented a broad cross section of nurses with extensive frontline nursing experience- 70% had worked more than 10 years as a nurse and 61% spend more than half their time engaged in direct patient care activities. I would like to highlight just a few key findings regarding workplace health and safety concerns.

Eighty-eight percent (88%) of the nurses' respondents reported that health and safety concerns influence their decisions to continue working in the field of nursing as well as the kind of nursing they choose to perform. Eighty-three percent (83%) of nurse respondents continue working despite experiencing back pain. Over three-quarters of the nurses surveyed (76%) indicated that unsafe working conditions do, in fact, interfere with their ability to deliver quality care.

The Department of Veterans Affairs has been historically viewed as a stable, secure and desirable workplace for potential employees. Just a few weeks ago, the American Nurses Association launched a proactive, multi-faceted campaign aimed at promoting safe patient handling and preventing musculoskeletal disorders (MSD) among nurses. The campaign aims to stem the nation's growing nursing shortage by reducing the number of nurses who are leaving the field because of unsafe lifting practices and resulting back pain. This campaign will be launched with a Safe Patient Handling Conference, to be held at the Tampa Veterans' Health Administration Patient Safety Center of Inquiry and the University of South Florida in March of 2004. The ANA has partnered with Audrey Nelson, PhD, RN, FAAN, director of the Tampa Veterans' Health Administration Patient Safety Center of Inquiry, in implementing the goals of the campaign.

OVERTIME

Nurses across the nation are expressing deep concern about the dramatic increase in the use of mandatory overtime. ANA hears that overtime is the most common method facilities are using to cover staffing gaps. Employers may mandate that a nurse work an extra shift (or more) or face dismissal, as well as being reported to the state board of nursing for patient abandonment. Concerns about the use of mandatory overtime are directly related to patient care of our veterans.

We know that sleep loss influences several aspects of performance, leading to a slowed reaction time, delayed responses, failure to respond when appropriate, false responses, slowed thinking and diminished memory. In fact, 1997 research by Dawson and Reid at the University of Australia showed that work performance is more likely to be impaired by moderate fatigue than by alcohol consumption. Their research shows that significant safety risks are posed by workers staying awake for long periods. It only stands to add

that an exhausted nurse is more likely to commit an error that a nurse who is not being required to work a 16 hour shift.

Nurses are placed in a unique situation when confronted by the demands of overtime. Ethical nursing practice prohibits nurses from engaging in behavior that they know could harm their patients. At the same time, RNs face the loss of their license-their careers and livelihoods-when charged with patient abandonment. Absent legislation, nurses will continue to confront this dilemma. For this reason the American Nurses Association supports legislative initiatives to limit the use of mandatory overtime. Federal laws and regulations set maximum hours in the interest of public safety for airline pilots, train engineers and truck drivers. Shouldn't we afford the same precaution for our patients in our VA hospitals?

The VHA has continued the antiquated practice of rotating staff instead of hiring permanent tours of duty. This practice does not allow staff to be creative in their scheduling to accommodate work and family and personal obligations.

In order to minimize the use of mandatory overtime, floating nurses from one unit to another has become a standard practice. If other units have sick calls or increased acuity, then nurses will be floated to that unit. Nursing has become specialized and although nurses are all taught the same basic curriculum in school, once they begin working to hone certain skills their knowledge base in some other areas may not render current with changes in practice. Therefore, a registered nurse should not be assigned to work in a particular unit without first having established the ability to provide professional care in that unit.

STAFFING

Mandatory overtime is a symptom of a larger problem, inappropriately low nurse staffing. The American Nurses Association has long held that the safety and quality of care provided in the nation's health care facilities are directly related to the number and mix of direct nursing staff. More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of patients. Studies show that where they are more nurses, there are lower mortality rates, shorter lengths of stay, better care plans, lower costs, and fewer complications. Four HHS agencies recently sponsored a study on this very topic. The resulting report (Nurse Staffing and Patient Outcomes in Hospitals, released in April 20, 2001) found strong and consistent evidence that increased RN staffing is directly related to the decreased incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding and shorter hospital length of stay.

In addition to the important relationship between nursing staff and patient outcomes, several studies have shown that one of the primary factors for the increasing nurse turnover rate is dissatisfaction with workload/staffing. The American Nurses Association's 2001 survey states that 75 percent of nurses surveyed feel that the quality of nursing care at the facility in which they work has declined over the past two years. Out of the nearly 7,300 respondents, over 5,000 nurses cited inadequate staffing as a

major contributing factor to the decline of quality of care. More than half of the respondents believed that the time they had available for patient care has decreased. This survey reflects similar findings from a national survey taken by the Henry J. Kaiser Family Foundation (1999) that found that 69 percent of the nurses reported that inadequate nurse staffing levels were a great concern. The public at large should be alarmed that more than 40 percent of the respondents to the ANA survey stated that they would not feel comfortable having a family member cared for in the facility in which they work.

Adequate staffing levels allow nurses the time they need to make patient assessments, complete nursing tasks, and respond to health care emergencies. It also increases nurse satisfaction and reduces turnover. The VHA, much like private health systems, continues to struggle with the development of valid, reliable and implementable nurse staffing guidelines.

The development of nurse staffing guidelines has always been a sensitive topic to bring up. Nurses provide the front line of patient surveillance, monitoring patients' conditions, detecting problems and initiating life-saving interventions.

The American Nurses Association Magnet hospital program has had a proven success in raising the standards of nursing practice and improving patient outcomes.

In 2002, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released a report on the nursing shortage that recommended that facilities adopt the characteristics of Magnet hospitals to foster a workplace that empowers and is respectful of nursing staff.

A growing body of research indicates that the Magnet program is making a positive difference for nurses, its patients and employers. For example, studies indicate that patients experience lower mortality rates, shorter lengths of stay and increased satisfaction in Magnet facilities, while nurses also have increased satisfaction, as well as increased perceptions of productivity and the quality of care given. Employers benefit too, as studies indicate that Magnet facilities have lower incidence of needlestick injuries, lower nurse burnout rates and higher retention rates, increased ability to attract new nurses, and higher JCAHO scores. Average nurse retention at Magnet hospitals is twice as long as that of non-Magnet facilities.

The first Magnet hospital, the University of Washington was designated in 1994. Today, there are 85 organizations that are designated Magnet hospitals in the United States and England, including the James A. Haley Veterans' Hospital in Tampa, FL.

Characteristics of a Magnet facility include:

- Strong administrative and organizational support for nursing practice
- Adequate nurse staffing
- Strong nurse-physician communication and relationships

- Nurse autonomy and accountability
- Control over nursing practice and practice environment
- Paramount focus on the patient and patient's family

Magnet hospitals are living evidence that creating professional nursing practice environments is the solution to the flight of nurses from hospital practice.

EDUCATION

The VA has been a leader in providing nurses the incentive and opportunity to advance their education and improve patient care. Through the Nurse Qualification Standards and the National Nursing Education Initiative (NNEI) the VA has created a "career ladder" program for its nursing workforce. The VA has committed significant resources to nurses seeking to advance to their next level of their nursing career. The National Nursing Education Initiative (NNEI) program awards tuition support to nurses to obtain their baccalaureate or post-graduate degrees and training. The average awardees receive $11,000 in tuition assistance. The latest NNEI program statistics indicate that there are 2,702 total participants with 61% enrolled in a baccalaureate program. Nursing is a knowledge-based profession. The ANA has always maintained that nurses have a responsibility for lifelong learning and works to make higher education accessible to both new students and practicing nurses.

The Department of Veterans Affairs approved new Nurse Qualification Standards on November 10, 1999. These standards define the performance and education requirements for a RN to be appointed and promoted within the VHA. The development and implementation of the new standards involved numerous parties including the American Nurses Association. The Nurse Qualification Standards create a framework for advancement and appointment based on the education and practice requirements of the veterans health care system. These standards ensure that RNs are educated to provide the highest quality health care to our veterans, but are flexible enough to recognize and reward performance. This new standards makes a BSN (bachelors of science in nursing) a criteria for promotion. The ANA supports efforts designed to make the BSN the standard for entry into nursing practice.

The VA has changed in its delivery of health care, and I am proud to say that the VA nurses have adopted new roles for meeting these changing needs. However, the role of a registered nurse as the direct care giver for patients needs to remain regardless of changes in the VA healthcare system and with all due respect to the advances in medical technology it is the nurse, at the bedside, whose expertise will determine the patient's outcome. For the VA to remain an "employer of choice" it must continue to recognize the professionalism of nurses.

DISCLOSURE STATEMENT

In compliance with House Rule XI,2(g)(4), the American Nurses Association submits this disclosure of Federal grants and contracts.

In FY 2000 the American Nurses Association (ANA) received a total of $625,083 in grants and award projects from the Environmental Protection Agency, and the Department of Health and Human Services.

In FY 2001 ANA received a total of $564,670 in grants and award projects from the Department of Health and Human Services, and the Environmental Protection Agency.

In FY 2002 ANA received a total of $1,109,430 in grants and award projects from the Department of Health and Human Services, and the Environmental Protection Agency.

September 17, 2003

Dear Constituent Member Association:

ANA is excited to announce "Handle with Care," a new initiative aimed at preventing potentially career-ending back, neck and musculoskeletal injuries in nurses. This new campaign, which launches this week, is designed to support the individual nurse in his or her workplace. The campaign seeks to mount a profession-wide effort to prevent back and other musculoskeletal injuries through greater education and training, and increased use of assistive equipment and patient-handling devices. The campaign also seeks to reshape nursing education, and federal and state ergonomics policy by highlighting the ways technology-oriented safe-patient handling benefits patients and the nursing workforce.

The Handle with Care campaign kit contains the following items:

- a news release titled "ANA Launches 'Handle with Care' Ergonomics Campaign";
- ANA's position statement on the issue titled, "The Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders";
- a backgrounder describing the problem and efforts to address it;
- a fact sheet detailing how ergonomics hazards affect health care workers;
- a sample testimonial from a nurse who has experienced a musculoskeletal injury; and
- a tip sheet on how health care facilities can institute a safe patient handling and movement program and avoid musculoskeletal injuries to nurses;
- a fax-back response form for your organization to fill out and return.

ANA believes the Handle with Care campaign can dramatically improve the health and safety of nurses, increase the safety of patient care and substantially reduce health care costs.

After reviewing these materials, please FAX back the enclosed form, indicating if and how your organization might be interested in partnering with ANA on this campaign. ANA envisions this campaign to be similar to the "Safe Needles Save Lives" campaign, which ANA conducted during the late 1990s. This campaign was highly successful in getting state and federal legislation passed and cultural changes instituted to prevent needlestick injuries in the health care industry.

In the meantime, if you have any questions regarding the program, or if you have names of additional nurses who might be willing to provide testimonials to add to the campaign Web site, please contact ANA Senior Public Relations Specialist Cindy Price at 202-651-7038.

Thank you, and we at ANA look forward to working with you and your organization on this important issue.

Sincerely,

Barbara A. Blakeney, MS, APRN,BC, ANP
President

Linda J. Stierle, MSN, RN, CNAA,BC
Chief Executive Officer

American Nurses Association
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024-2571
Tel (202) 651-7000
Fax (202) 651-7001
www.NursingWorld.org

NEWS RELEASE

Registered Nurses: Experts on the Front Lines
Keeping the "Care" in Health Care

FOR IMMEDIATE RELEASE
September 17, 2003

CONTACT: Cindy Price, 202-651-7038
cprice@ana.org
Carol Cooke, 202-651-7027
ccooke@ana.org
www.NursingWorld.org

ANA LAUNCHES 'HANDLE WITH CARE' ERGONOMICS CAMPAIGN
Multi-pronged effort aimed at preventing work-related musculoskeletal disorders through greater use of assistive equipment and patient-handling devices

WASHINGTON, DC – Recognizing that more than a third of all nursing personnel are affected by back-related injuries, the American Nurses Association (ANA) today unveiled a proactive, multi-faceted campaign aimed at promoting safe patient handling and preventing musculoskeletal disorders (MSDs) among nurses.

Titled "Handle with Care," the campaign will involve collaboration with ANA-related groups, other nursing and specialty organizations, the research and academic community and health care systems in a united effort to prevent back and other musculoskeletal injuries through greater education and training, and increased use of assistive equipment and patient-handling devices. The campaign also seeks to reshape nursing education, and federal and state ergonomics policy by highlighting the ways in which technology-oriented, safe-patient-handling techniques benefit patients and the nursing workforce.

"Studies of back-related workers compensation claims reveal that nursing personnel have the highest claim rates of any occupation or industry," noted ANA President Barbara A. Blakeney, MS, APRN,BC, ANP. "In addition, other estimates report that 12 percent of nurses leave the profession annually as a result of back injuries, and more than 52 percent complain of chronic back pain. These alarming statistics tell us two things – that poor ergonomics hurts nurses, who are choosing to leave the profession rather than suffer unnecessarily, and that poor ergonomics

MORE...

Handle With Care/2...

In addition to launching the campaign, ANA has also been actively lobbying Congress and working through the regulatory process to establish stronger ergonomics protections for nurses. The ANA testified repeatedly before the Occupational Safety and Health Administration (OSHA) throughout the 1990s on the need for an ergonomics standard. This standard was promulgated in 2000 but repealed the following year by Congress, which ordered OSHA to cease all work related to the standard. ANA continued pressing policy and lawmakers to address ergonomics hazards, and earlier this year, OSHA released nursing home guidelines for preventing MSDs.

"While it is encouraging that the federal guidelines explicitly recommend elimination of manual lifting, they are not mandated and are not enforceable," Blakeney said. "We have to do better than that. What we need is another strong federal ergonomics mandate, and the Handle with Care campaign will help in achieving this goal."

Using the ANA position statement, "Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders," as a foundation, the Handle with Care campaign seeks to educate nurses regarding advances in science and technology that support ANA's goal of securing a nationwide "no-lifting" policy. Among the campaign's chief goals are developing safe workplaces in acute- and long-term-care settings through safe patient-handling techniques and patient lift devices; providing nurses with the information they need to recognize and prevent the risk of back injuries and MSDs; and decreasing health care industry costs by reducing nurse injuries and compensation claims.

According to the Bureau of Labor Statistics, nursing personnel are among the highest at risk for MSDs, with nursing aides, orderlies and attendants ranking first (ahead of truck drivers and laborers) and RNs sixth in a list of at-risk occupations for strains and sprains.

"These statistics provide clear, convincing evidence of the urgent need to implement lifting, transfer and other safe-handling devices as well as educational strategies aimed at preventing MSDs," said Blakeney. "The goal of this campaign is to establish a nationwide 'no-lifting' policy, similar to policies that are already in place in the United Kingdom, Australia and other industrialized nations," she added.

MORE...

Handle With Care/3...

"In addition, the campaign aims to stem the nation's growing nursing shortage by reducing the number of nurses who are leaving the field because of unsafe lifting practices and resulting back pain and other sometimes disabling injuries," said Blakeney.

The Handle with Care campaign includes the following components:

- Holding a Safe Patient Handling Conference, to be co-sponsored by ANA with the Tampa Veterans' Health Administration Patient Safety Center of Inquiry and the University of South Florida, March 2-5, 2004.
- Launching an education campaign involving professional nurses, schools of nursing, health care facilities and the health care industry. This campaign will be aimed in part at exposing the fallacy of "proper" body mechanics, which have been widely taught in nursing schools yet do not translate well to nursing practice.
- Developing support mechanisms and networks for injured nurses.
- Forming international partnerships with the International Council of Nurses and the United Kingdom's Royal College of Nursing.

In addition, ANA has partnered with Audrey Nelson, PhD, RN, FAAN, director of the Tampa Veterans' Health Administration Patient Safety Center of Inquiry, in implementing the goals of the campaign. Nelson is a leading nurse researcher in developing and incorporating evidence-based interventions that reduce the risk of occupational injury secondary to patient handling through the use of technology and equipment.

"ANA is excited about the launch of the Handle with Care Campaign, and we look forward to working with the nursing community, educators, legislators and the public in instituting these much-needed ergonomics changes and preventing unnecessary injuries among the nation's hard-working nurses," said Blakeney.

For more information regarding musculoskeletal injuries and the Handle with Care campaign, go to www.nursingworld.org/handlewithcare/.

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The American Nurses Association is the only full-service professional organization representing the interests of the nation's 2.7 million registered nurses (RNs) through its 54 constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

Position Statement
Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders

Summary: In order to establish a safe environment of care for nurses and patients, the American Nurses Association (ANA) supports actions and policies that result in the elimination of manual patient handling. Patient handling, such as lifting, repositioning, and transferring, has conventionally been performed manually by nurses. The performance of these tasks exposes nurses to increased risk for work-related musculoskeletal disorders. With the development of assistive equipment, such as lift and transfer devices, the risk of musculoskeletal injury can be significantly reduced. Effective use of assistive equipment and devices for patient handling creates a safe healthcare environment by separating the physical burden from the nurse and ensuring the safety, comfort, and dignity of the patient.

Background

The term musculoskeletal disorder describes a collection of conditions affecting, but not limited to, muscles, nerves, tendons, ligaments, joints, cartilage, or spinal discs.[1] Common manifestations of musculoskeletal disorders include low back pain, sciatica, rotator cuff injury, and carpal tunnel syndrome.[2] Job tasks, such as patient handling, can lead to the development of these conditions or exacerbate existing ones.

Nurses suffer a disproportionate amount of musculoskeletal disorders consequent to the cumulative effect of repeated manual patient handling events,[3] often involving unsafe loads. Among nurses, back, neck, and shoulder injuries are commonly noted as the most prevalent and debilitating.[4] Though nurses have historically been trained to use "proper" body mechanics to prevent injury from lifting and transferring patients, questions arise as to their true value and applicability to the practice of nursing.[5]

While mostly associated with dependent patient care, the risk for musculoskeletal injury secondary to manual patient handling crosses all specialty areas of nursing. As such, no nurse is effectively clear from the risk of injury. The impact on the nursing workforce

may lead to adverse consequences at the organizational level, as well, through increased absenteeism, lost work time, burnout, decreasing retention, high turnover, and threatened recruitment. Moreover, the occurrence of musculoskeletal injuries may have a profoundly discouraging effect within the contexts of nursing shortage, aging nursing workforce, and waning numbers of professional entrants.[6]

Manual Patient Handling

The distinction of manual patient handling specifically refers to tasks such as lifting, transferring, and repositioning of patients without the use of assistive devices. Performing manual patient handling places nurses at increased risk for musculoskeletal disorders. This risk can be attributed to several factors, including weight of load, patient characteristics, awkward posture and positioning, and environmental factors. While attempts to scientifically quantify allowable levels of weight for lifting have been made, designations based on static loads or developed using non-representative study populations cannot be generalized to the nursing workforce.[7] Patients' bodies have an asymmetric distribution of weight and do not possess available, stable areas to grip thereby making difficult the attempt to hold a patient's weight close to the nurse's own body. Also, there may be occasions when patients are agitated, combative, non-responsive, or can offer limited levels of assistance potentiating the risk for injury.[8] In addition, the structural physical environment of care may necessitate awkward positions and postures further increasing the susceptibility of developing a musculoskeletal disorder. Altogether, these factors merge to create an unsafe load for nurses to manage capably. Even with assistance from additional staff members, it is critical to note that the exposure to the hazard persists.

Engineering Controls

Engineering controls are the best line of defense for worker protection and can be effectively applied to patient handling. Technology has been successfully applied to significantly reduce the risk of exposure to occupational hazards in the healthcare setting, such as for needlestick injuries and communicable airborne diseases. The healthcare industry must embrace the evolution of technological development in terms of its value to the delivery of quality patient care by a safe and healthy workforce.

Specialized equipment exists to assist in patient handling tasks and the selection of products continues to grow. Examples of patient handling equipment include full-body sling lifts, stand-assist lifts, lateral transfer devices, and friction reducing devices. Assistive equipment removes the manual dimension of patient handling and assumes a large proportion of the patient's weight. The use of assistive equipment relieves the caregiver of the total effort and risk associated with patient handling duties.[7,9] The availability and utility of assistive equipment eliminates the need to engage in total manual patient handling. Though some form of manual patient handling must be undertaken by nurses, it should be limited to assisting patients while using assistive equipment (e.g., repositioning a patient in a chair after using a lifting device).

The degree of effectiveness of using patient handling equipment and devices to prevent musculoskeletal disorders is significantly dependent on factors related to availability, maintenance, and sufficient space.[5, 9] Equipment and devices must be readily available to staff in order to encourage their use.[10] Availability incorporates quantity, location, and access of equipment commensurate with staff and patient needs. Further, equipment and devices must be maintained in good operational condition to ensure optimum utility. Disrepair and dilapidation unnecessarily subjects both caregiver and patient to preventable risk for injury. Also, adequate space within patient care settings that accommodates use of patient handling equipment and devices is essential. Barriers and obstacles within the physical patient care environment, such as but not limited to furniture, walls, or other treatment equipment, may be prohibitive aspects to patient handling situations. The extent to which any of these factors are limited can strongly influence the risk for musculoskeletal injury.

Exceptional Situations

There may be occasions when manual patient handling cannot be avoided. Nurses may be presented with exceptional or life-threatening situations prohibiting the use of assistive patient handling equipment. In addition, manual patient handling may be performed if the action does not involve lifting most or all of a patient's weight. Other exceptions include the care of pediatric (infant or small child) or other small patients and the use of therapeutic touch. In any and all cases, effort towards patient handling should be minimized wherever possible without compromising patient care or exceeding the abilities and skills of the nurse.

Quality Patient Care

The use of assistive equipment for patient handling tasks also benefits patients.[11] Patient adverse events related to patient handling and movement include pain (i.e., when lifting patients under their arms) and injury (e.g., falls, contusions, and skin tears). The use of assistive equipment directly contributes to preventing such adverse events and improving patient safety, comfort, and dignity – reflecting ANA's commitment to Patient Safety/Advocacy. Through the elimination of manual patient handling, patients are afforded more secure and stable means to progress through their care. Also, assistive equipment can be designed to incorporate patient comfort and dignity considerations as a way to respect patients' rights and to improve the overall quality of care.

Employer/Management Commitment

Employers and managers should adopt a policy that commits the institution to the safest approach to handling and moving patients. The safest approach prioritizes the use of assistive equipment and discourages the performance of manual patient handling. Organizational actions must support the use of assistive equipment for patient handling tasks by investing in an adequate supply of appropriate assistive equipment, ensuring that equipment is readily available to staff, assuring that staff are well-trained in the use of equipment, and designating resource specialists skilled in the assessment and evaluation

of patient handling.[12] Additionally, any policy related to the elimination of manual patient handling must be non-punitive. Nursing staff should be encouraged to participate in effectively implementing requirements for safe patient handling and not made fearful of reporting incidents of work-related injury. These elements are necessary to ensure that a policy restricting manual patient handling successfully serves to reduce the risk of musculoskeletal disorders.

Employee Participation

Employee participation is vital for the success of workplace health and safety interventions. Front-line staff nurse employees should be motivated and supported to be involved in the development and implementation of efforts to restrict manual patient handling. Staff can provide essential information about organization-specific hazards associated with patient handling and can help guide actions to ensure effectiveness.[13] Staff must also hold decision-making authority in the evaluation and selection of patient handling devices and equipment.[5] Further, initial and on-going training in the assessment of case-specific patient handling as well as the use of devices and equipment is necessary.

Regulation and Enforcement

ANA has campaigned and continues the call for a federal Occupational Safety and Health Administration (OSHA) standard to control ergonomic hazards in the workplace for the prevention of work-related musculoskeletal disorders.[14] A regulation that includes stipulations requiring healthcare settings to use engineering controls (i.e., assistive lift and transfer equipment) for patient handling tasks would lead to the elimination of total manual patient handling. In the absence of a national standard, ANA also supports efforts undertaken at the state level to enact ergonomic legislation. Regulation and enforcement are necessary components of the overall effort to prevent work-related musculoskeletal disorders.

Research

ANA seeks the commitment and consultation of the scientific community in the on-going development of interventions dedicated to the prevention of musculoskeletal disorders related to patient handling. The knowledge base and research evidence describing methods of safe patient handling, particularly the use of assistive equipment, continues to expand. The prompt communication of emerging study findings is fundamental for their timely incorporation into professional practice and education of student nurses.

Conclusion

ANA believes that manual patient handling is unsafe and is directly responsible for musculoskeletal disorders suffered by nurses. Patient handling can be performed safely with the use of assistive equipment and devices that serve as engineering controls for ergonomic hazards. The benefit of assistive patient handling equipment is characterized

by the simultaneous reduction of the risk of injury for nursing staff and improvement in the quality of care for patient populations.

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Effective Date:

Status:	New Position Statement
Originated By:	Nurse Advocacy Programs Center for Occupational Health and Safety
Adopted By:	ANA Board of Directors
Related Past Actions:	1. Policy/Position No. 3.26, The Profession's Responsibility for the Occupational Health, Safety, and Wellness of Nurses, 1992 ANA House of Delegates 2. Policy/Position No. 3.28, Health and Safety in the Workplace, 1993 ANA House of Delegates

American Nurses Association

"Handle with Care" Campaign

Backgrounder

Nursing and Musculoskeletal Disorders

Over the past decade, much attention has been given to the issue of ergonomic hazards as a health and safety concern among health care workers. Professional nursing groups, labor organizations, industry, regulatory agencies, and the scientific community have converged in attempts to arrive at effective solutions to protect health care workers from ergonomic hazards associated with patient handling. Despite the recognition that manual patient handling is a high-hazard task, the incidence of musculoskeletal disorders persists at high rates for nurses and other nursing personnel – signaling the need for continued action. Emerging efforts to prevent musculoskeletal injuries have concentrated on reducing exposures through the use of assistive equipment and devices for patient handling.

Patient handling tasks are recognized as the primary cause for musculoskeletal disorders among the nursing workforce. A variety of patient handling tasks exist within the context of nursing care, such as lifting, transferring, and repositioning patients, and, are typically performed manually. Continuous, repeated performance of these activities throughout one's working lifetime results in the development of musculoskeletal disorders. Of primary concern are back injuries and shoulder strains, which can both be severely debilitating for nurses.

Compared to other occupations, nursing personnel are among the highest at risk for musculoskeletal disorders. According to the Bureau of Labor Statistics, nursing aides, orderlies, and attendants ranked first and RNs sixth in a list of at-risk occupations for strains and sprains that included truck drivers (second), laborers (third), stock handlers and baggers (seventh), and construction workers (eighth). Studies of back-related worker's compensation claims reveal that nursing personnel have the highest claim rates of any occupation or industry.

Exacerbating the Growing Nursing Shortage

The extent of musculoskeletal disorders among the U.S. nursing workforce is particularly distressing when considered in the context of the current nursing shortage. Estimates report that 12% of nurses leave the profession annually due to back injuries and greater than 52% complain of chronic back pain. Specifically, injuries secondary to patient handling tasks compound factors driving the shortage such as aging of the nursing workforce, declining retention and recruitment rates, and lowering social value of nursing.

Federal Legislation/Regulation

In response to persistent outcry from labor organizations and advocates and recognition of mounting scientific evidence, the U.S. Department of Labor – Occupational Safety and Health Administration (OSHA) promulgated a standard intended to protect workers from ergonomic hazards, such as patient handling. In March 2001, Congress repealed the OSHA standard and ordered that the agency cease all work related to the standard.

The U.S. Department of Labor convened a work group called the National Advisory Committee on Ergonomics (NACE) in January 2003. The committee is charged with advising the Secretary of Labor and the Assistant Secretary for OSHA on ergonomic guidelines, research, outreach, and assistance over the next

two years. In March 2003, Federal OSHA released its "Guidelines for Nursing Homes – Ergonomics for the Prevention of Musculoskeletal Disorders." In these "Guidelines," OSHA explicitly recommends that "manual lifting of patients be minimized in all cases and eliminated when feasible." While only a guideline (and not a regulation), this statement still reflects the recognition that manual patient handling is an extremely high-risk job task.

State Legislation

The Washington State Department of Labor and Industries adopted a rule to reduce work-related musculoskeletal disorders on May 26, 2000. Effective July 1, 2002, with implementation being incrementally phased in through 2006, the rule explicitly points out "heavy, frequent or awkward lifting" as a criterion for compliance. Nursing and Personal Care facilities were identified as high risk workplaces for which this rule was intended. Since then, however, business groups have been successful in collecting enough signatures to introduce a Fall 2003 ballot measure aimed at repealing the state ergonomics rule (see flier, "Leggo Our Ergo!" at http://www.wslc.org/reports/04-25-03.htm#Monday).

California enacted an ergonomics regulation referring to repetitive motion injuries (RMIs) on November 14, 1996. This rule specifically requires the consideration of engineering controls to minimize exposures that cause RMIs. In February 2003, the Cal/OSHA Standards Board voted to create an Advisory Committee to study a proposal for a revised ergonomics standard that would require employers to identify ergonomic hazards as part of their Injury and Illness Prevention Program. More details can be found on the California Labor Federation, AFL-CIO website at:
http://www.calaborfed.org/legislation/Scorecards/scorecard%2002%2026%2002.pdf

ANA's Advocacy on Ergonomics

On, June 22, 2003, the ANA Board of Directors approved a position statement presented by the ANA Congress on Nursing Practice and Economics titled, "The Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders." This position statement was crafted with the intent to deliver a message to the larger nursing and health care communities, be the cornerstone upon which to structure a multi-faceted ANA health and safety campaign focused on the prevention of musculoskeletal disorders, and position ANA as a leading voice to advance current ergonomic prevention efforts.

ANA has also partnered with Audrey Nelson, PhD, RN, FAAN, Director of the Tampa Veterans' Health Administration Patient Safety Center of Inquiry (http://www.patientsafetycenter.com/).
Nelson is a nurse researcher leading the way to developing and incorporating evidence-based interventions that reduce the risk for occupational injury secondary to patient handling through the use of technology and equipment. ANA is co-sponsoring with the Patient Safety Center of Inquiry and the University of South Florida the Safe Patient Handling Conference, March 2-5, 2004, in Clearwater, Florida. Future objectives for this partnership include development of safe patient handling curricula for training purposes and conducting educational sessions at ANA's 2004 convention.

For more information about ANA's efforts related to ergonomics, work-related musculoskeletal disorders, and safe patient handling, visit the Handle with Care Web site at www.NursingWorld.org/handlewithcare/ or contact Butch de Castro, PhD, MSN/MPH, RN, Senior Staff Specialist, at (202) 651-7138 or Bdecastro@ANA.org.
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One Nurse's Story

Maggie Flanagan
Registered Nurse, Washington State

My name is Maggie Flanagan and I'm a 46-year-old registered nurse, wife, and mother of two small boys. I live and work in Washington State and am a member of the American Nurses Association and its affiliate, the Washington State Nurses Association. I have a total of 21 years of experience working as a nurse in hospitals and consider caring for high-risk infants an honor and a privilege.

Five years ago in Alaska, I experienced serious back, neck and shoulder injuries that prohibited me from working for eight months. I still work in the same capacity in a hospital facility near my new home, having recently relocated from Alaska to Washington State.

I am providing this testimonial to let other nurses and the general public know just how devastating a back or musculoskeletal injury can be, and to provide evidence as to why action is so desperately needed on this issue. Until I am able to explain my story, people often look puzzled when I say that I sustained a disabling injury from caring for newborn infants. But, take it from me, even though our patients are small, the ergonomic hazards in this particular health care setting are very real and very serious. Providing nursing care to sick and premature infants in a newborn intensive care unit (NICU) is complex, fast-paced and stressful. Newborns in distress require split-second interventions.

Caring for sick newborns also requires long periods of standing and bending, frequently in awkward postures. Increasingly, newborn intensive care units are cramped and loaded with high-tech equipment. In most hospitals, the expanding amount of equipment now used in everyday patient care was not planned for in original designs. The "human" factor seems to have been an afterthought. With equipment arranged like this, our everyday work involves long horizontal and vertical reaches. Alarm soundings from machines can number in the hundreds during a 12-hour shift and must be silenced by reaching high and far. Before my injury, I would reach past the point of discomfort to silence these alarms....alarms that could potentially damage the underdeveloped hearing of my fragile patients. What my injuries have taught me is that continuously reaching far and fast and above one's shoulders is extremely hazardous.

As someone who has experienced an ergonomics injury or a musculoskeletal disorder (MSD), what this really means to a nurse trying to work in a challenging environment and raise two young boys is the following: For years leading up to my eight-month disability, I found that it took longer and longer to recover from a 12-hour shift. Back, neck and shoulder pains plagued me even on my days off. I didn't realize that these cumulative aches and pains could develop into a chronic injury. I didn't know that each shift was becoming "a down payment" for the injury that would become mine "for keeps." In addition to these cumulative problems, I was acutely injured while lifting patient monitoring equipment, which my charge nurse deemed necessary to move. (The charge nurse had originally called throughout the hospital to get help, but there was not

enough staff.) From my experience, I know that moving critically ill infants can have extremely dire consequences, so I agreed to assist.

The lifting activity involved moving a 75-pound monitor down from a shelf above shoulder height, on to a rolling table and back up to a shelf above shoulder height. We had seen men in our unit move the monitors by themselves and thought that the two of us together could also move the equipment, but we were wrong. Had the charge nurse and I been educated about the seriousness of these hazards, she never would have required either of us to perform this lift. Instead, we went ahead and my severe back spasms started soon after completing the equipment move. Looking back, I now know that performing this heavy move was the exact motion that I had used in silencing all the hundreds of alarms that occurred in my daily work. The repetitive strain of answering those alarms with long and high reaches, being protective of my patients' hearing, had taken its toll. My musculoskeletal injury from the heavy lift had occurred in the same areas that were slowly being damaged in my day-to-day work.

My back disorder also involved my shoulders and my neck. I attended physical therapy several times a week. I had a hard time sleeping. I experienced spasms and a lot of pain, and I had to take long-term painkillers. For months after I was hurt, I also could not bathe or dress my children. I couldn't perform simple chores like laundry or using the dishwasher. During my physical rehabilitation, I experienced several setbacks. It took me eight months to return to work.

My family life also suffered because we had to put our children in daycare while I attended rehabilitation services. Prior to my injury, my husband and I had always worked opposite days so we could keep our young children home. I was told by the hospital's insurance adjuster that now that I was an injured worker, my children were not "my priority." I want you to know that no one can give me back the time I lost with my children, or quell the resentment about employer and insurer-imposed decisions about my personal family life.

In the unit where I was hurt, several ergonomic evaluations had been conducted because other nurses had been injured before me. Despite clear recommendations from ergonomics experts to implement control measures and eliminate hazards, my hospital took no action because it wasn't required by law. After my injury the neonatal intensive care unit was remodeled, but the ergonomic recommendations by the hospital's own expert were still not followed.

The release of OSHA's Ergonomics Standard three years ago at least spurred the hospital to form an ergonomics committee. But because the standard has since been repealed, there is now no mandate guaranteeing that the hospital will make the interventions so desperately needed.

In closing, I'd like to offer some reflections about my experience: Repetitive strains symptoms are usually subtle in their onset, and often come and go. The most at-risk group for these injuries are nurses who work long, strenuous hours, who are not able to take breaks and who also become dehydrated. And the worst part is that these injuries most often affect our hardest workers – precisely the workers whom we can least afford to lose.

I know I am not the first person hurt at my job. But what I can't live with is that I won't be the last...unless we start protecting nurses and other health care workers immediately from ergonomic hazards in the workplace. Nurses deserve a place of employment free from recognized hazards because when a worker develops a musculoskeletal disorder, it is not just a lost work day, it can be a life lost forever to pain and disability. Let the protection begin! Thank you.

For more information or to arrange an interview with Ms. Flanagan, contact Cindy Price at 202-651-7038 or Carol Cooke at 202-651-7027.

American Nurses Association

"Handle With Care" Campaign

Fact Sheet

ANA's Handle with Care campaign is intended to develop and implement a proactive, multi-faceted plan to promote the issue of safe patient handling and the prevention of musculoskeletal disorders among nurses in the U.S. Through partnerships and mobilization of ANA-related groups, nursing organizations, research experts, academic centers, and health care systems, the campaign seeks to educate, advocate, and facilitate change from traditional practices of manual patient handling to emerging, technology-oriented methods. The Handle with Care campaign seeks to reshape the professional and disciplinary dimensions of nursing, influence the mindset of the health care industry, and inform federal/state policy by highlighting how safe patient handling produces benefits to patients and the nursing workforce.

Nursing Practice and Musculoskeletal Disorders (MSDs)

- Patient handling tasks are recognized as the primary cause for musculoskeletal disorders among the nursing workforce. Of primary concern are back injuries and shoulder strains which can both be severely debilitating.

- A variety of patient handling tasks exist within the context of nursing care, such as lifting, transferring, and repositioning patients, and, are typically performed manually.

- Patient handling tasks most frequently associated with low back pain: lifting and forceful movements.

- Continuous, repeated performance of these activities throughout one's working lifetime results in the development of musculoskeletal disorders.

- The physical environment of the health care setting also contributes to work-related musculoskeletal disorders. Configurations of and area within patient rooms and the placement of furniture and treatment equipment (e.g., critical care unit monitors, ventilator machines) can limit the space needed for patient handling situations.

- Proper body mechanics is a "myth." Traditionally taught to student nurses to counteract the physical stress of patient handling, such as lifting, so-called "proper" body mechanics do not translate well to nursing practice. Early findings of body mechanics studies were based on static loads (i.e., boxes with handles) and primarily focused on men. Further, body mechanic methods primarily concentrate on the lower back for lifting and do not account for other vulnerable body parts involved in other types of patient handling tasks, such as lateral transfers from gurney to bed along a horizontal plane

A Profession at Risk

- Compared to other occupations, nursing personnel are among the highest at risk for musculoskeletal disorders. The Bureau of Labor Statistics lists RNs sixth in a list of at-risk occupations for strains and sprains that included nursing personnel, with nurses aides, orderlies and attendants (first); truck drivers (second); laborers (third); stock handlers and baggers (seventh); and construction workers (eighth).

- Additional estimates for the year 2000 show that the incidence rate for back injuries involving lost work days was 181.6 per 10,000 full-time workers in nursing homes and 90.1 per 10,000 full-time workers in hospitals, whereas incidence rates were 98.4 for truck drivers, 70.0 for construction workers, 56.3 for miners, and 47.1 for agriculture workers.

- Lower back injuries are also the most costly musculoskeletal disorder affecting workers. Studies of back-related workers compensation claims reveal that nursing personnel have the highest claim rates of any occupation or industry.

- Research on the impact of musculoskeletal injuries among nurses:
    - 52 percent complain of chronic back pain[1];
    - 12 percent of nurses "leaving for good" because of back pain as main contributory factor[2];
    - 20% transferred to a different unit, position, or employment because of lower back pain, 12 percent considering leaving profession[3];
    - 38 percent suffered occupational-related back pain severe enough to require leave from work[4]; and
    - 6 percent, 8 percent, and 11 percent of RNs reported even changing jobs for neck, shoulder and back problems, respectively.[5]

Effectiveness of Safe Patient Handling Equipment & Devices

- The development of assistive patient handling equipment and devices has essentially rendered the act of strict "manual" patient handling unnecessary as a function of nursing care.

- Assistive patient handling equipment and devices control the ergonomic hazard associated with patient handling by technologically "engineering out" the energy/force imposed onto the nurse worker during the act of lifting, transferring or repositioning patients.

- Application of assistive patient handling technology fulfills an ergonomic approach within nursing practice by designing and fitting the job or workplace to match the capabilities and limitations of the human body.

- A growing number of health care facilities have incorporated patient handling technology and have reported positive results. Injuries among nursing staffs have dramatically declined since implementing patient handling equipment and devices along with an institutional commitment to the safest available methods. As a result, the number of lost work days secondary to injury and staff turnover has declined. Cost-benefit analyses have also shown that assistive patient handling technology successfully reduces workers' compensation costs for musculoskeletal disorders.

Patient Benefit

- The weight of adult patients requiring lifting averages 169 lbs. (range 91-387 lbs.). Weights and sizes of patients can vary significantly, particularly considering geriatric patient populations.

- The potential for patient injury, such as falls and skin tears, as a consequence of a manual handling mishap is reduced by using assistive equipment and devices. They provide a more secure process for lifting, transferring, or repositioning tasks. Patients are afforded a safer means to progress through their care. Moreover, any anxiety patients may feel with having a person susceptible to injury perform the task can be relieved and increase confidence with the use of assistive equipment.

- Using assistive patient handling equipment contributes to patient comfort. Patients are less subjected to awkward or forceful handling that can be experienced when lifting, transferring, or repositioning is done manually. Rather than manipulating a patient's body parts, equipment and device parts are manipulated.

- Patient dignity is protected by using assistive equipment and devices. A patient's self-esteem and privacy can be compromised during difficult patient handling situations when performed manually. The use of technology for such circumstances can offer a considerate way of completing patient handling tasks that respects a patient's sense of dignity.

- Assistive patient handling equipment can be selected to match a patient's ability to assist in their own movement, thereby promoting the expression of patient autonomy.

Regulation/Legislation

- The Occupational Safety and Health Administration (OSHA) promulgated a standard intended to protect workers from ergonomic hazards, such as patient handling. In March 2001, Congress repealed the OSHA standard and ordered that the agency cease all work related to the standard.

- In March 2003, federal OSHA released its "Guidelines for Nursing Homes – Ergonomics for the Prevention of Musculoskeletal Disorders." In these "Guidelines," which are not requirements, OSHA recommends that "manual lifting of patients be minimized in all cases and eliminated when feasible."

- Legislation was introduced in three states in 2003 but was not enacted. For the latest updates, see http://nursingworld.org/gova/state/2003/ergo.pdf

Resources

- ANA's Handle with Care Campaign Web site www.NursingWorld.org/handlewithcare/

- ANA Position Statement – "Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders" http://nursingworld.org/readroom/position/workplac/pathand.htm

- ANA Brochure – "Preventing Back Injuries: Safe Patient Handling and Movement" http://nursingworld.org/osh/ergonomics.pdf

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- Nelson, A. et al (2003). "Safe Patient Handling and Movement." *American Journal of Nursing*, 103: 3.

- Patient Safety Center of Inquiry, Tampa Veterans' Health Administration www.patientsafetycenter.com

- OSHA's voluntary ergonomics guidelines for the prevention of musculoskeletal disorders in nursing homes http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

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"Handle with Care" Campaign

Organizational Support Response Form

_____ Yes, my organization agrees to participate.

Our organization agrees to [*please check all that apply*]:

_____ Draft and publish a position statement

_____ Endorse ANA's position statement

_____ Provide educational programs for nurses at upcoming conventions or other meetings

____ Publish articles in newsletters

____ Work in coalitions with nursing groups and others

_____ Publicize and distribute the campaign materials to your membership

____ Discuss issues with health care industry leaders and public policy makers

____ Host and partner with ANA on training programs

_____ Develop workplace strategies around the campaign

Other: _____

Contact person: _____

Name of organization: _____

Address: _____

_____

Telephone: _____

Fax: _____

E-mail address: _____

Fax back to:
Sheila Lindsay, Administrative Assistant
Communications Department
American Nurses Association
Fax: 202-651-7340
(**Phone**: 202-651-7197)

American Nurses Association

"Handle with Care" Campaign

Tip Sheet

Every day, nurses across the country are suffering from debilitating back injuries, strains and sprains – work-related musculoskeletal disorders – as a consequence of dealing with ergonomic hazards in health care settings. The majority of these injuries result from patient handling tasks – such as lifting, transferring, and repositioning. Others may occur from working in a poorly designed physical work environment. Back injuries and other musculoskeletal disorders are preventable with a safe patient handling and movement program. Breaking your back should not be a part of the job!

How can you institute a safe patient handling and movement program in your facility?

Create an ergonomics committee.

This can be an independent group or part of your organization's workplace health and safety committee. Members should include representatives from management, direct caregivers, purchasing, risk management, and employee/occupational health staff. Management support and frontline employee participation is vital to developing an effective team. The primary responsibility of the committee should be establishing, implementing, and monitoring a comprehensive ergonomics program.

Analyze the data, conduct a walk-through, survey employees.

Review OSHA 300 Injury/Illness Logs (which employers are required to make available on request), incident reports, and other reporting systems. Perform a walk-through for all units during all shifts to look for risk factors. Survey employees about their concerns, experiences, and suggestions. Examine patterns and trends of who is being injured and why.

Assess patient dependency levels.

Make decisions on which equipment and devices to use considering patient needs and abilities. Patient populations may have varying and distinct levels of providing assistance, bearing weight, upper and lower extremity strength, height and weight, as well as special circumstances and specific orders.

Assess risky patient handling tasks.
Perform an ergonomics hazard assessment based on information and data that is collected. Consider the variety of patient handling tasks, types of nursing units, patient populations, and physical environment. Determine which tasks pose a risk for injury on each unit. Is it frequent lifts of dependent patients in rehab? Multiple transfers for geriatric residents? Repositioning bariatric (obese) patients in the ICU?

Develop and adopt a safe patient handling policy.
Organizations can institute a "no lift" policy that discourages manual patient handling and requires the use of appropriate equipment and devices as necessary. This policy can be applied "facility-wide" or be tailored to be "unit-specific" to meet staff needs. Avoid language in the policy that disciplines employees.

Research, evaluate, select, pilot, & institute patient handling equipment and devices.
Involve frontline health care workers during every step to ensure optimal use of new equipment. When testing devices, like mechanical lifts, lateral transfer aids, gait belts, and transfer chairs, seek input from staff and patients. Use criteria to evaluate and select patient handling equipment, including patient comfort and safety, caregiver stability and safety, task appropriateness, efficiency, maintenance, storage, availability for use, and cost effectiveness. Contact a variety of equipment and device manufacturers to keep updated on the latest technology and establish a timeline for investing in capital equipment purchases.

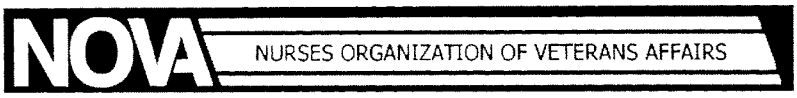
Provide comprehensive and interactive training for staff.
Train staff on policies and equipment and devices before implementing them. Consider the need to train new employees or health care workers whose staff assignments are changed. Identify and train peer back-injury prevention leaders.

Encourage reporting of back injuries, strains, and other musculoskeletal injuries.
Create a blame-free environment for reporting work-related injuries or illnesses. Staff must feel comfortable to report any injury or illness without negative consequences. Not only can employees be promptly treated, but corrective action can be taken to eliminate or minimize the hazard.

Track patient and worker injuries and evaluate the program.
Continue to routinely collect and analyze data and update the program with the latest policies, best practices, and technology.

For more information regarding ANA's Handle with Care campaign, go to www.nursingworld.org/handlewithcare/

9/03



STATEMENT OF
THE NURSES ORGANIZATION OF VETERANS AFFAIRS
(NOVA)

BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

NURSE SHORTAGE: RECRIUITMENT AND RETENTION

BY
SARAH MYERS, RN, PhD

OCTOBER 2, 2003

1726 M Street, N.W., Suite 1101 Washington, D.C. 20036 Phone (202) 296-0888 Fax (202)833-1577 nova@vanurse.org

Mr. Chairman and members of the Subcommittee on Oversight and Investigations, I am Sarah Myers, a doctorally prepared Nurse Executive in Geriatrics and Mental Health at the Atlanta Veterans Affairs Medical Center. I am presenting testimony in this capacity as well as the Immediate Past President of the Nurses Organization of Veterans Affairs (NOVA), the professional organization of the over 35,000 registered nurses employed by the Department of Veterans Affairs (DVA).

OVERVIEW

NOVA is very concerned about the national nursing shortage as well as the ability of the DVA to continue to recruit and retain highly qualified nurses to care for our Nation's veterans. National nursing leaders and health care organizations are projecting a shortage of registered nurses that is unprecedented. Both current and future projections of the numbers of professional nurses available are such that the Nation's demands for these services will be insufficient at best. At the same time, changes in health care delivery systems will require larger numbers of more educated nurses who will be performing increasingly complex functions both in hospitals and other health care settings in the community.

The DVA is already experiencing challenges in maintaining an adequate nursing workforce. If it is to stay adequate, the DVA must remain competitive in both pay and workforce innovations. It is no surprise, in the interim report of the VA Nursing Commission; the *staffing* theme is pervasive throughout the report.

Earlier this year, NOVA developed a document entitled, *Critical Need for a Strong Nursing Workforce*, which outlines several programs addressing recruitment efforts to be considered by this Subcommittee, the House Veterans Affairs Committee and the DVA for the upcoming decade.

NURSING RECRUITMENT INITIATIVE PROPOSAL
$35.45 Million/Year

Provision of flexible education opportunities, academic partnerships to increase numbers of nursing faculty and outreach programs directed at the high school students are positive recruitment efforts directed at aggressively addressing the nursing workforce shortage. No single strategy will be effective in reversing the nursing workforce crisis. This proposal presents a coordinated approach of a nursing recruitment grant program, a nursing education support program, and a marketing strategy designed to meet the current and future needs of VA nursing professionals.

The programs provide a variety of sources for generating RNs and LPNs ranging from current nursing students to existing VA employees to future nursing students through outreach in high schools and colleges. As is well documented in health care and VA literature, the shortage of nursing personnel currently being experienced will reach its most critical state in 2010 and beyond.

This Nursing Recruitment Grant Program, if implemented in 2004, is designed to provide immediate and ongoing impact through the VA Learning Opportunities Residency Scholarship (VALORS) Program and VA Nursing Education Faculty (VANEF) Program. The projected needs for 2005-2009 will be addressed through the VA Nursing Education for Employees Program (VANEEP). Long term impact for 2010 and beyond is affected through the VA Cadet Nurse Program.

Each of the Recruitment Grants is based in part on existing programs while adding features that are responsive to the environment of today and tomorrow. A minimal addition of 4.0 FTEE could manage the programs if consolidated in one site such as the Health Care Staff Development Office. Thus, the program maximizes existing resources and generates a cost efficient plan. In total, the programs would generate 1,000 new nurses per year.

VA Learning Opportunities Residency Scholarship (VALORS) - $7.2 Million. This program expands the existing VA Learning Opportunities Residency (VALOR) Program to provide tuition scholarship funds for participating nursing students. This program provides 400 registered nurses per year. Currently, the VALOR program funds the third year baccalaureate-nursing student for a maximum of 800 hours of work experience at the salary level of 80% of the Nurse I Level II pay scale and provides no scholarship funds.

The fiscal year 2003 funding provided $1.701 million for 290 students. The primary goal of the program is the recruitment of the new graduate from nursing school through a positive student-work experience with the VA. In 2002, seventeen percent of the eligible VALOR participants were hired by VA facilities.

Medical centers cited the inability to provide tuition support to the students as a primary barrier to retaining these senior level-nursing students. The proposed VALORS Program links an optional scholarship component to the existing VALORS program. The proposal recommends funding for 400 VALORS which represents a modest but achievable 1.5% of the approximately 26,000 students graduating from BSN programs annually.

VA Nursing Education Faculty (VANEF) - $2.0 Million. This program implements a nursing education faculty-sharing program, which combines VA employment with nursing education academic program faculty assignments. The VA Nursing Education Faculty program creates partnerships with schools of nursing. The program establishes specific positions for nursing faculty for those schools who have students participating in the VA Learning Opportunities Residency Scholarship program (VALORS) noted above. The schools of nursing establish clinical experiences with their VA partner, which would promote student selection of VA employment following graduation.

VA Nursing Education for Employees Program (VANEEP) - $17.15 Million. This program funds a tuition assistance (Upward Mobility) Program The initiative provides education and salary replacement funding for VA employees enrolled in Licensed Practical (or Vocational) Nurse (LPN/LVN), Associate Degree in Nursing and Bachelors Degree in Nursing programs. The proposed program would fund 75 LPNs per year beginning in 2005 and 200 RNs per year beginning in 2006.

VA Cadet Nurse Program (VACAN) - $8.7 Million. This outreach program is directed at providing mentored work experience in the nursing environment for the high school and beginning college student. The ultimate goal is to increase the number of young people choosing a nursing career, thus, building the cohort of nurses available in 2010 and beyond.

While the critical nature of this issue has been extensively discussed, there is a paucity of programs established to provide young people with a positive nursing experience. This initiative provides a tiered program of volunteer work experience for the youngster 14-16 years of age and paid work experience beginning at age 16 and continuing through college years.

The VA Cadet Nurse Program combines VA Volunteer work and the Student Educational Employment Program (5CFR Part 213.3202). It offers a progressive work experience program which the student may enter at varying levels. The VA Volunteer role enables students under the age of 16 to gain initial training and experience in working in the nursing environment. After age 16, the student can transition to a paid appointment under the Student Education Employment Program as a certified nursing assistant, which could be continued through graduation from a vocational (LPN/LVN), associate degree in nursing or bachelor's degree in nursing program. Thus, the graduating baccalaureate degree nursing student who begins a VA work experience as a Volunteer at age 14 would have built eight years of familiarity and organizational loyalty with the VA.

Administrative Support - $0.4 Million. This amount includes four full-time employee equivalent (FTEE) personnel as well as supplies.

SUMMARY

The DVA has implemented several positive initiatives to impact staffing, including: establishment of the Commission on VA Nursing; the establishment of the VA Nursing Workforce Group as well as the adoption of their recommendations; recent enhancements to locality pay; and changes to the Nurse Qualifications Standards.

Recommendations to utilize many of these innovations discussed above require sufficient and designated funds, Central Office support, VISN as well as medical center level support. Nursing does not operate in isolation and is understanding of the need to be efficient and effective with the current budget challenges. Nursing is the key to quality care for our Nation's veterans.

I thank the members of the Oversight and Investigations Committee for the opportunity to share you with ideas how to address the recruitment and retention facing the Department of Veterans Affairs during the coming decade. Consideration of these proposals will go a long way to enhancing a bright future for the dedicated nurses who care for America's heroes.

Testimony by Ann Converso, RN
Vice President, United American Nurses, AFL-CIO

Before the
House Committee on Veterans' Affairs
Oversight and Investigations Subcommittee

On the
Impact of the Nursing Shortage on the VA

Oct. 2, 2003

Good afternoon. Thank you, committee members, for this opportunity to draw attention to the very important issue of the nurse staffing shortage in VA medical facilities. My name is Ann Converso, and I have been a registered nurse in acute medical/surgical units and later I.V. therapy at the VA Western New York Health Care in New York's VISN 2 region for more than 30 years. I have also been an active member of my union, the New York State Nurses Association and its national, the United American Nurses, AFL-CIO, during that time. I now serve as vice president for the 100,000 nurses of the UAN – 6,000 of whom are VA nurses.

In my years as a VA nurse, I have experienced several nursing shortages firsthand. I believe I do speak for other VA nurses when I say that we love our jobs and the important work we do in caring for our nation's veterans. But because of deteriorating working conditions and a lack of respect, registered nurses are leaving the bedside in favor of the many other job options now available to us, from clinic jobs, outpatient jobs, computer jobs, quality management, doctors' offices, pharmaceutical jobs or leaving nursing entirely.

A 2002 report by the Health Resources and Services Administration states that by 2020, hospitals will be short 808,416 RNs. In a 2002 survey by the United American Nurses, three out of every ten nurses said it was unlikely they would be a hospital staff nurse in five years. The VA health care system has by no means been immune to the shortage.

As nurses leave the VA system, new nurses are not joining the VA at comparable rates, and patient load is increasing. In its own report, "A Call to Action," the VA states that it must replace up to 5.3 percent of its RN workforce per year to keep up with RNs retiring. By all accounts, that is not happening. In its website documentation of system-wide capacities, VA statistics show that between 1996 and 2002 the number of full-time-equivalent RNs went down by 8.4 percent. During that same time period, the number of "unique patients" treated at the VA went up by 55 percent. We are caring for more patients, who are often sicker, with fewer nurses at the bedside.

Clearly, VA nurses have choices. I believe I and other VA nurses can shed some light on why nurses are leaving the bedside, and what we can do together to make the VA a more attractive place for nurses to stay and work.

Through my role in my union and my position on the National Commission on VA Nursing, I hear daily from VA nurses about the problems they face at their workplaces. Staff nurses, who play a pivotal role as caregivers at their VA facilities, say their experience, knowledge and expertise are not being respected. Nurses are functioning at staffing levels that are unsafe at best, downright dangerous at worst. Many VA facilities do not meet the threshold medical/surgical ratio of four patients per nurse that is cited in Linda Aiken's landmark 2002 study on nurse-to-patient ratios. The Joint Commission on Accreditation of Health Care Organizations (JCAHO), among others, has pointed out the unanticipated problems faced by patients who are cared for by too few nurses.

Some VA facilities, like their counterparts outside government, have responded to this staffing crisis by mandating overtime that is unsafe for patients and nurses, forcing nurses to work understaffed or floating RNs to different units without proper training. Additionally, nurses at the bedside are not being involved in decision-making processes. UAN's 2002 poll found that 95 percent of hospital staff nurses surveyed thought it was important to be consulted before decisions are made, but saw little evidence of that happening.

We also must address the inequities that cause the VA medical system to lag behind civilian facilities as an employer of choice. Compensation under the Nurse Pay Act of 1990 has not kept pace with the private sector's ability to provide multiple salary increases per year and an innovative structure of non-salary perks and benefits. And too often, qualified, experienced nurses in the VA system are denied promotion solely on the type of nursing education received.

Rather than spend all my time discussing the many challenges VA nurses face as the nursing shortage worsens, I'd like to talk about how we meet them, because I firmly believe we do have solutions available to us. Staff nurses know, and are willing to share, their solutions.

As a longtime nurse activist, I know there is a place where staff nurses' knowledge and views are solicited, respected and acted upon: in our unions.

Staff nurses have a seat at the table, a voice in decision-making and the respect we deserve because of our union. Nurses are organizing themselves into unions as never before, and it's easy to see why: Nurses who are organized on average earn a higher salary, have better staffing levels and have more of a say in their workplace. As a VA union nurse, I have input into bar code medication procedures; representation on my health and safety committee; access to a fair and equitable disciplinary and grievance process; and, valuable guidance through the VA promotions process.

In the VA system, we must cultivate an environment where nurses are respected for the invaluable work we do. Actively involving staff nurses in the decision-making process in their VA facilities must be a priority if we are to keep more staff nurses in the VA system. As VA nurses, we know firsthand that we can most effectively give our input on the many issues critical to quality patient care through our unions.

VA nurses in my union have made a difference in the quality of care in their facilities by advising on the best safety devices to use through their health and safety committees... on inadequate staffing levels, through submission of assignment despite objection forms ... through support for legislation like the VA Medical Workforce Enhancement Act, H.R. 1951. This bill gives the Secretary of the VA the flexibility to empower staff nurses with greater decision-making on staffing levels, nurse-to-patient ratios and patient caseloads. Finally, our VA nurses use their union voice to have a say in the restructuring and organizational change currently underway in the VA.

Some facilities are exploring ways to involve nurses in decision-making processes through the Magnet Program, administered by the American Nurses Credentialing Center. In the years since its inception, the magnet designation has become a sought-after credential among hospitals. What is equally, if not more, important to me is the process a facility must demonstrate it has gone through to achieve magnet status: A magnet facility's administration must talk to, and listen to, its nurses. It must show evidence that staff nurses are involved in decision-making and care-giving processes. To me and the nurses I represent, the process, criteria and culture that a hospital must develop – involving staff nurses in decision-making – in its magnet application is even more important than the piece of paper that finally grants the hospital magnet status.

Both magnet facilities and VA facilities where RNs have a union are excellent models for involving nurses – the people providing round-the-clock care for our veterans – in the decision-making loop. Our veterans deserve no less.

If we are to encourage staff nurses not only to come to the VA, but to stay at VA facilities, we must work to give them a voice in the challenges and changes faced in our VA facilities. VA Secretary Anthony Principi has said that he is making quality patient care a priority. That cannot happen with fewer nurses at the bedside. If we truly seek to attract and retain skilled, experienced registered nurses to the VA system, we must respect frontline RNs who deliver bedside care by giving them greater input into their work environments.

Thank you.

# # #

Magnet Status as a Tool for Recruiting and Retaining Nurses

Testimony:

The Subcommittee on Oversight and Investigation, U.S. House of Representatives, 10/2/03

Julie C. Novak, DNSc, RN, CPNP, Head, Purdue University School of Nursing, Associate Dean, Pharmacy, Nursing, and Health Sciences, 502. N. University, West Lafayette, IN 47907 jnovak@nursing.purdue.edu

ANCC Magnet Program--
Recognizing excellence in nursing services

Regardless of the health care organization's size, setting, or location, achieving Magnet designation serves to attract and retain quality employees. Magnet designation helps consumers locate health care organizations that have a proven level of excellence in nursing care. "In an environment rife with controversy about patient safety in hospitals, medical error rates, and nursing shortages, consumers need to know how good the care is at their local hospitals. [Magnet is] a seal of approval for quality nursing care." (From: *The Magnet Nursing Services Recognition Program: A Comparison of Two Groups of Magnet Hospitals.*)

Why was the Magnet Recognition Program™ developed?

The Magnet Recognition Program was developed by the American Nurses Credentialing Center, the credentialing arm of the American Nurses Association, to recognize health care organizations that provide the very best in nursing care and uphold the tradition within nursing of professional nursing practice. The program also provides a vehicle for disseminating successful practices and strategies among nursing systems.

The Magnet Recognition Program™ is based on quality indicators and standards of nursing practice as defined in the American Nurses Association's *Scope and Standards for Nurse Administrators* (1996). The Magnet designation process includes the appraisal of both qualitative, e.g., leadership roles and shared decision-making, and quantitative, e.g., nurse/patient ratios, factors in nursing.

Recognizing quality patient care and nursing excellence, the Magnet Recognition Program™ provides consumers with the ultimate benchmark to measure the quality of care that they can expect to receive. As a natural outcome of this, the program improves the positive work environment and elevates the standards of the nursing profession.

Objectives of the Magnet Recognition Program™

- Recognize nursing services that use the Scope and Standards for Nurse Administrators (ANA, 1996) to build programs of nursing excellence for the delivery of nursing care to patients

- Promote quality in a milieu that supports professional nursing practice
- Provide a vehicle for the dissemination of successful nursing practices and strategies among health care organizations using the services of registered professional nurses
- Promote positive patient outcomes

The Benefits of Becoming a Magnet Designated Facility

Magnet Designation is an important Recognition of Nurses' Worth
Designation recognizes the quality of a nursing program and demonstrates its importance, and the importance of nurses to the success of the entire organization. *"This is one of the highest achievements a hospital can attain in the nursing world. Magnet status recognizes the caliber of the nursing staff, and what that professionalism translates into in terms of patient care and health care services. I am extremely proud of our nurses and our growing reputation as a first-rate hospital."* Colleen Goode, RN, PhD, vice president for patient services, University of Colorado Hospital, Denver, CO (Magnet designated January 2002)

Magnet Designation is a Major Factor in Nursing Recruitment and Retention
Dr. Linda Aiken's independent research shows that Magnet designated facilities consistently out perform their peers in recruiting and retaining nurses. *"The label 'Magnet hospitals' originally was given to a group of U.S. hospitals that were able to successfully recruit and retain professional nurses during a national nursing shortage in the early 1980s. Studies of Magnet hospitals highlight the leadership characteristics and professional practice attributes of nurses within these organizations... Hospitals selected met the following criteria: 1) nurses within the hospitals considered them good places to practice nursing, 2) the hospitals had low turnover and vacancy rates, and 3) the hospitals were located in areas where there was significant regional competition for nursing services."* (JONA, January 1999) These "nurse friendly" organizations benefit from reduced costs due to low turnover, which results in greater institutional stability.

Magnet designated health care organizations consistently outperform their peers in recruiting and retaining nurses, resulting in increased stability in patient care systems across the organization.

Magnet Designation Means a Competitive Advantage
A national survey conducted in March 1999 by Wirthlin Worldwide, dramatically illustrates the competitive edge enjoyed by Magnet-designated facilities. The survey found that 93% of the public would have more confidence in the overall quality of a hospital if that hospital had passed the nursing standards required to be a Magnet Program. The same survey found that 85% of the public would have more confidence in a long-term care facility that had passed similar nursing standards. Thus, in addition to the quality of nursing care, the Magnet Designation speaks to a facility's overall quality. Magnet facilities use this benefit to their advantage in the market place. For example, Hackensack University Medical Center, a Magnet-designated facility, routinely highlights the designation in their hospital-wide promotional campaigns. *"The Magnet process is incredibly valuable because it helps to validate the programs that you have in place."* Elaine Graf, magnet coordinator, Children's Memorial Hospital, Chicago, IL (Magnet designated December 2001). *"We asked a visitor*

from Mayo (Mayo-Rochester Hospitals) how he was able to attract nurses in the middle of Minnesota. He said, 'we have Magnet status, that is the important thing.' I then had the great pleasure of showing him our award for Magnet status." Dr. Stephen Hall, medical director, North Shore University Hospital, Manhasset, NY (Magnet designated, December 2001).

NOTE: Mayo recruits 5-8 of the nurses from each of Purdue's baccalaureate nursing graduating classes of 100. Their magnet status is one of the criteria that the graduates use for choosing their place of employment from among 5-10 offers per graduate.

Magnet Designation Attracts High Quality Physicians and Specialists
Research documents that high quality nurses is one of the most important attributes in attracting high quality physicians. Therefore, achieving this status creates a positive "halo" effect beyond the nursing services department that permeates the entire health care team.

Magnet Designation Reinforces Positive Collaborative Relationships
A basic premise of the Magnet Designation is a climate that reinforces collaborative working relationships. As Dr. Aiken and Donna Sullivan Havens reported, *"They foster respect and caring for the individual (patients and staff), and actively bring out the best in people."* (JONA, February 1999, pg. 16) *"Our team work and hard work really paid off. It was very rewarding."* Debbie Bothe, RN, staff nurse, North Shore University Hospital, Manhassett, NY (Magnet designated December, 2001)

The Magnet Designation Process Creates a "Magnet Culture"
The "Magnet Culture" is holistic in creating a dynamic and positive milieu for professional nurses. Core values such as empowerment, pride, mentoring, nurturing, respect, integrity, and teamwork are demonstrated in Magnet facilities. *"Thus, these hospitals have been cited as cultures of excellence, the measure of goodness, and the 'gold standard' in nursing."* (JONA, February 1999, pg. 14)

"[Magnet hospitals] are infused with values of quality care, nurse autonomy, informal, non-rigid verbal communication, innovation, bringing out the best in each individual, and striving for excellence." (Kramer, M., Schmalenberg. C. Magnet Hospitals: Part II: Institutions of excellence. *Journal of Nursing Administration,* 1988, 18(2): 17.)

Magnet Designation Improves Patient Quality Outcomes
"The Magnet process facilitated an intense look at the way we organized and delivered nursing care. It encouraged each of us to take responsibility for improving our service" Tracey Williamson, research nurse, Pennine Acute Services NHS Trust: Rochdale Infirmary & Birch Hill Hospital, Rochdale, Lancashire, United Kingdom (Magnet designated March, 2002). *"We created nursing consuls that establish policy, and established every nursing unit as a nursing department so that each department didn't have layers of bureaucracy."* Harvey Yorke, chief executive officer, Southwestern Vermont Medical Center, Bennington, VT (Magnet designated March 2002).

The Magnet Recognition Program establishes standards of excellence, which health care organizations must attain. According to a study conducted at the Center for Health Outcomes

and Policy Research at the University of Pennsylvania School of Nursing, Philadelphia, *"Magnet hospitals ... consistently provide the highest quality of care."* (Bensing, K. Magnet hospitals provide havens for quality care and happy nurses. ADVANCE for Nurses (DC/Baltimore): April 10, 2000: 27)

When marketed effectively, Magnet designation increases use of the health care organization by consumers and health care plans.
Of respondents in a recent survey, 93% indicated that knowing that a hospital has passed rigorous standards regarding quality of hospital nursing care would increase their confidence in the overall care provided by the hospital. Through recognition of an organization as being among the best in the nation for nursing care, consumers can be sure they have chosen the best provider, and health plans can be assured of the organization's commitment to high-quality patient care.

The Magnet Application and Appraisal Process

The Magnet Recognition Program™ application and appraisal process is recognition of a health care organization's attainment of excellence. It is also a rewarding and valuable educational experience for an organization seeking focus and direction for growth and development. The process is thorough and lengthy, demanding widespread participation within the applicant nursing service. Health care organizations find this to be a revealing self-assessment, creating opportunities for organizational advancement, team building, and enhancement of individuals' professional self-esteem.

Eligibility Requirements (ANCC Web site)

To apply, a health care organization must meet the following eligibility criteria:

1. The applicant nursing service system exists within a health care organization.
2. The applicant organizations' nursing service must include one or more nursing settings with a single governing authority and one individual serving as the Chief Nursing Officer (CNO). The CNO must be ultimately responsible for all areas in which nursing is practiced. The CNO must participate on the applicant organization's highest governing decision-making and strategic planning body. Each applicant applying as a system will have at each facility and setting a designated on-site RN leader who is prepared in nursing at a baccalaureate or higher level, responsible for nursing services at that facility.

NOTE: The Veteran's Health Administration's support for the BSN in nursing for positions beyond entry level is consistent with other progressive health care facilities and Magnet designation that place a high value on learning. Aiken, et al. Published in JAMA, September 24, 2003-Vol 290, No.12 concluded that in hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients (232,342) experienced lower mortality and failure-to-rescue rates.

3. The CNO must possess a master's degree. The CNO's baccalaureate or master's degree must be in nursing. Except in the receipt of military orders, the CNO must have been in that position for at least one year at the time of the submission of the organization's written documentation for initial designation and must remain in that position throughout the appraisal process.
4. Scope and Standards for Nurse Administrators (ANA Publishing) must be currently implemented by the nursing system.
5. In the five (5) years preceding application, the applicant nursing service must not have committed an unfair labor practice as determined in a fully and finally adjudicated arbitration proceeding or before the National Labor Relations Board (NLRB) or state or international regulatory agency within jurisdiction over labor relations and/or a reviewing federal, state or international court. If an unfair labor charge or grievance related to nursing or patient/resident/client care is pending before an arbitrator, the NLRB or other appropriate governing body at the time an application is being processed, no action will be taken on the written documentation until arbitration, the NLRB or appropriate governing/regulatory body finally resolves the dispute.
6. Applicants for Magnet recognition are required to participate in a national database that benchmarks nurse-sensitive quality indicator at the unit level.

Criteria Used for the Magnet Application Process

The Magnet Recognition Program™ is based on the American Nurses Association's *Scope and Standards for Nurse Administrators* (ANA Publishing) and upon the Forces of Magnetism as described in the publication *Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses*. **The applicant facility provides documentation and evidence that support and verify that they are implementing the standards throughout the nursing service.**

An applicant must purchase The Magnet Recognition Program For Excellence in Nursing Service, Health Care Organization, Instructions and Application Process (ANCC, 2003, Pub#MAGMAN03). It outlines the entire application process and contains the application form and all necessary directions for preparing the written documentation. This manual costs $100 plus shipping and handling.

All of these publications are available through American Nurses Publishing (toll free 1-800/637-0323). In addition, the application manual can be ordered online at Magnet's E-Store.

The Application Process

The application process consists of four phases:

In the ***First Phase (The Application Phase)*** the applicant completes the one-page (double-sided) application form indicating the anticipated date for submission of the appraisal documents. This submission date must be a minimum of three months AFTER submitting the application to enable Magnet Program Office time to select and schedule appropriate

appraisers. A nonrefundable payment of $2,500 for the application fee must accompany the application. The active application period, within which the written appraisal documentation must be submitted, is two years from the date the application is submitted to the Magnet Program Office.

To obtain a Microsoft Word version of the two-page Magnet Recognition Program Application via e-mail, send request to Twelch@ana.org. Save and fill in the form, then submit the completed application to via return e-mail.

In the ***Second Phase (Submission of Written Documentation and Evaluation Phase)*** the nursing service applicant completes appraisal documentation as outlined in the program instruction and application manual. This written documentation must reflect the innovative, dynamic, excellence-focused features of the organization. It also must demonstrate how the health care organization implements the Scope and Standards for Nurse Administrators within the organizations' structure, leadership, and management philosophy, as well as how the standards are incorporated within the nursing service. The instruction manual provides guidance in selecting evidence that supports the requirements of the written documentation. Once completed, the written documentation is then submitted to the Magnet Program Office with the required appraisal fee, which is based on the licensed bed size, and/or patient encounters of the applicant health care organization.

The ***Third Phase (Site Visit)*** occurs if the documents of the Organizational Overview are present and adequate, and the scores for the measurement criteria fall within a range of excellence. The purpose of the site visit is to verify, clarify, and amplify the content of the written documentation and evaluate the organizational milieu in which nursing is practice. The site visit process also involves a process of community participation and public comment in which the written documentation is open for public review and comment, and the applicant submits the names of reference. The site visit expenses are the responsibility of the applicant and include travel and lodging expenses for a minimum of two appraisers plus an honorarium of $1,500 per day per appraiser. Most site visits are at least two days in duration.

Professional registered nurses conduct both the review of the written documentation and the site appraisal with experience in quality indicators, nursing services administration, and nursing care.

The ***Fourth Phase (Internal Operations at the Magnet Program Office)*** involves appraisers submitting a final report and recommendations, the Commission on Magnet Recognition reviewing the findings, and determining if Magnet Recognition status will be awarded. The Commission on Magnet Recognition meets quarterly to determine if Magnet status will be awarded.

Once Magnet Designation is awarded

The health care organization is notified immediately if the Commission on Magnet Recognition votes to extend Magnet designation. A nationwide press release is issued by ANCC. Organizations use this opportunity to advertise their designation and recognize their

nursing staff in any variety of ways. Designation is an overall boost not only for the nursing staff but also for the staff of the entire organization. As stated by Rob Muilenberg, Executive Director, University of Washington Medical Center, Seattle, WA, *"A real cause for celebration. Instilled a sense of pride and accomplishment in the nursing service and to the institution as a whole. ...Built a sense of team and commitment to mission, vision, and values– patient focused care."*

Public Notice of Magnet Applicant Evaluations by ANCC Magnet Recognition Program Appraisers

Input from the patients, families, clients, staff, and public with who health care organizations interact is sought to assist Magnet program appraisers in the evaluation of nursing services that have applied for Magnet designation.

ANCC evaluates the environment in which nursing is practiced as well as the nursing service's compliance with standards promulgated by the American Nurses Association. The written documentation is available for public review at the health care organization. Its exact location is indicated in the public notice posted at entrances throughout the organization's facility.

Anyone who would like to participate in this evaluation process is encouraged to do so. Comments are confidential and may be made anonymously. Comments should be forwarded to ANCC before the comment deadline date indicated below. All comments must be in writing, and forwarded to ANCC via e-mail, fax, or direct mail to the addresses and/or numbers listed below. Comments may include request to meet with or talk to the appraiser should the evaluation of the written documentation progress to an on-site review.

American Nurses Credentialing Center (ANCC)
Magnet Recognition Program Office
600 Maryland Avenue, SW, Suite 100W
Washington, DC 20024-2571
Fax: 202/651-7004
E-Mail: magnet@ana.org *(Please indicate "Public Notice Comment" in the subject line.)*

As the Head of the Purdue University School of Nursing in West Lafayette, Indiana and Associate Dean of the Schools of Pharmacy, Nursing and health Sciences, I know that our undergraduate and graduate nursing students select from among five to ten employment opportunities each year. If they are not geographically bound to the greater Lafayette area, they begin their search with an examination of the ANA web site list of Magnet-designated hospitals. The hospitals with whom we partner are applying for Magnet designation and those are the institutions with which we are expanding our partnerships in learning, engagement, and discovery.

Statement of

Regina Foley, MBA, RN, CNAA

Vice President of Nursing, Chief Nurse Executive

Meridian Health System

Ocean Medical Center

Before the United States House of Representatives Committee on Veterans' Affairs

Concerning the Importance of Magnet Recognition in Recruiting and Retaining Nurses

October 2, 2003

Mr. Chairman and Members of the Subcommittee:

I am Regina Foley, a Registered Nurse and Vice President for Patient Care Services and Chief Nurse Executive of Ocean Medical Center, a 237 bed hospital in Brick, Ocean County, New Jersey. Ocean Medical Center is a member hospital of Meridian Health, a health system consisting of three hospitals and a number of partner companies including long-term care and home care. As a Nurse executive, I have been directly involved with nursing workforce issues and the development of a wide range of short and long term nursing recruitment and retention strategies and programs.

My responsibilities at Ocean Medical Center include recruiting, maintaining, and developing a nursing work force that is appropriately prepared to deliver quality nursing care to our medically diverse patient population. In this testimony, I will discuss Meridian Health's and specifically Ocean Medical Center's commitment to nursing excellence through participation in the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program as well as other strategic initiatives that have enhanced the work environment for our nursing staff. I firmly believe that these initiatives have resulted in our lower than state average vacancy and turnover rates and have led to improved staff and patient outcomes. Currently, Ocean Medical Center's nursing vacancy rate stands at one and one half per cent, far below New Jersey's statewide average vacancy rate of 15 per cent.

The Magnet Recognition Program for Excellence in Nursing Services was developed by the ANCC in 1994 to recognize facilities that provide the very best in nursing care and uphold the tradition within nursing that supports professional nursing practice. The program is based on quality indicators and standards of nursing practice as defined in the American Nurses Association's Scope and Standards for Nurse Administrators. Magnet status is important because it acknowledges hospitals that act as "magnets" for excellence by creating a work environment that recognizes, rewards, and promotes professional nursing.

Ocean Medical Center first applied and received Magnet recognition in 1998 and was the Magnet program's 12th hospital to achieve this award. Just this past year, I am pleased to report we were re-designated as a Magnet hospital. All three hospitals in the Meridian Health family have achieved this recognition and we take particular pride in being the first health system in the country to be awarded this honor.

Our purpose in seeking this recognition originally was to highlight the quality of our nursing department and the importance of our nursing staff to our health care organization. Through the application process, we were able to reflect on our strengths as a nursing department. The in depth self study process provided us with focus and direction and helped to facilitate our growth in meeting and maintaining the highest standards of excellence. The site visit reinforced what we had learned and afforded us the opportunity to receive outside validation of the quality of the environment of practice at Ocean Medical Center. During our latest site visit, the appraisers cited three areas that were particularly noteworthy: nursing research, initiatives to care for the older adult, and nursing utilization of information technologies.

Receiving the Magnet Award, and being a part of a health system that values nursing and its contributions, has had a significant impact on our ability to recruit and retain nursing staff. Most nurses now recognize that the Magnet Award is the highest achievement that a nursing service can attain, and that it signifies nursing excellence and the highest quality of nursing care. Nurses identify a Magnet hospital as an organizational

environment that is supportive of nursing practice. Attributes include a value system incorporating continuing education, research, collegiality, and collaborative practice. When asked why they chose to come to work at Ocean Medical Center, many of our new nurses tell us that they wanted to work in a Magnet designated facility for these very reasons.

All of our nurses participated in the preparation of the Magnet application and many interacted with the Magnet appraisers during the site visit. Going through the Magnet application process has promoted a greater sense of teamwork and camaraderie among them. In addition, the Magnet process has fostered in our nurses a sense of ownership because they understand that with this recognition comes responsibility as well as accountability to uphold these standards of excellence. I believe our turnover rates and vacancy rates have improved as the nurses have become more involved in decision-making and in improving their own practice environment.

New Care Model and Clinical Recognition Program.

Our participation in the Magnet Recognition program has led to a reassessment of our care delivery model to further enhance the work environment and promote staff retention. Across Meridian Health, the Nurse Executives with input from the nursing staff have developed a new model of care. To test the model of care, we have instituted a model "magnet" unit at each of our hospital campuses with increased staffing, a no float policy, enhanced technology (cell phones, lap top computers), and a dedicated nurse educator and physician champion. Nurses on these units are expected to achieve national certification in their area of specialty and to participate in the new CARE program (Clinical Advancement and Recognition of Excellence program). Nurse and patient outcomes are being monitored monthly to evaluate the impact of these enhancements. The CARE program, an outcomes based clinical recognition program, has been developed by staff to replace the process oriented clinical ladder. With this new clinical recognition program, nurses prepare portfolios that demonstrate achievement of

increasing levels of clinical expertise. Through these initiatives, we hope to improve the nurses work environment, keep our nurses at the bedside, and better demonstrate nursing's impact on quality patient outcomes.

Other Recruitment Activities:

In addition to our participation in the Magnet program, we have engaged in a number of recruitment and retention activities that have assisted in reducing our vacancy and turnover rates. I will briefly reference a few of the more successful programs:

- A active professional recruitment department who have developed a number of creative recruitment strategies including:
    - The Boomerang Program: This program reinstates former employees with full benefits and seniority
    - On and off site open houses, dinners and luncheons with guest speakers
    - Salary Market adjustments
- Summer Student Nurse Externships with ability to stay on as per diem staff or participate in the OFFER program
- Scholarships: Meridian Health awards about $250,000 per year in nursing scholarships for students who are entering the profession and for nurses seeking to attain advanced degrees
- OFFER program: A program for employees enrolled in nursing programs to work Baylor hours on the weekend (two twelve hour shifts), received full time pay and benefits including tuition reimbursement in exchange for a two year work commitment.
- Revised Clinical Recognition Program with increased salary for advancement
- Salary increments for national certifications and Bachelors degrees

Other Retention Initiatives:

- At Ocean Medical Center we live the philosophy "Hire for Talent, train for skill."

- We contract with Human Capital Management's Talent Bank. The Talent Plus® screening tool is utilized to select quality employees.
- Peer interviewing is required for all applicants.
- Introductory interviews are completed within three months of hire to gage employee's satisfaction with the organization.

In conclusion, at Ocean Medical Center we recognized the significance of the current and impending nursing shortage, our aging nursing workforce, and our aging patient populations and have taken steps to improve our recruitment and retention efforts. Effective recruitment and retention plans, however, must go beyond immediate necessity to fill vacant positions. The environment where nurses practice must be enhanced so that nursing is seen as an attractive profession that offers professional growth and satisfaction. Participation in the Magnet Recognition program has helped us to enhance our efforts in improving the nursing work environment.

Thank you

WRITTEN STATEMENT OF

TOM L. McKIBBAN, CRNA, MS

PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA)

AND

CAROL M. CRAIG, CRNA

PRESIDENT, ASSOCIATION OF VA NURSE ANESTHETISTS (AVANA)

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

OCTOBER 2, 2003
WASHINGTON, DC

Chairman Buyer, Ranking Member Hooley, and members of the Subcommittee:

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 30,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. Over 530 full time CRNAs are employed by the Department of Veterans Affairs (DVA) health care system. The Association of Veterans Affairs Nurse Anesthetists (AVANA) represents over 200 VA CRNAs across the United States and Puerto Rico. We appreciate the opportunity to present our testimony to the Subcommittee. We want you to know that the profession of nurse anesthesia is working creatively and effectively with the DVA to improve its retention and recruitment of CRNAs, so that high quality anesthesia services remain available and accessible for our nation's Veterans.

CRNAs AND THE VA: A TRADITION OF SERVICE

Let us begin by describing the profession of nurse anesthesia, and its history and role with the Veterans Administration health system.

In the administration of anesthesia, CRNAs perform the same functions as physician anesthetists (anesthesiologists) and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today CRNAs administer approximately 65 percent of the anesthetics given to patients each year in the United States. Nurse anesthetists are also the sole anesthesia providers in more than 65 percent of rural hospitals, assuring access to surgical, obstetrical and other healthcare services for millions of rural Americans.

Since the mid-19th Century, our profession of nurse anesthesia has been proud and honored to provide anesthesia care for our past and present military personnel and their families. From the Civil War to the present day, nurse anesthetists have been the principal anesthesia providers in

combat areas of every war in which the United States has been engaged. As of May 2003, 364 CRNAs have been deployed to the Middle East to ensure military medical readiness capabilities during "Operation Iraqi Freedom." For decades CRNAs have staffed ships, remote US military bases, and forward surgical teams without physician anesthesiologist support. The US Army Joint Special Operations Command Medical Team and all Army Forward Surgical Teams are staffed solely by CRNAs.

Then, as our military personnel advance from active service to retired and Veteran status, their anesthesia care in VA facilities is provided predominantly by nurse anesthetists. In 20 percent of VA healthcare facilities, the necessary anesthesia services are provided solely by CRNAs, ensuring our Veterans the safe anesthesia care that they deserve and have earned.

Our tradition of service to the military and our Veterans is buttressed by our personal, professional commitment to patient safety, made evident through research into our practice. In our professional associations, we state emphatically "our members' only business is patient safety." Safety is assured through education, high standards of professional practice, and commitment to continuing education. Having first practiced as registered nurses, CRNAs are educated to the master's degree level and meet the most stringent continuing education and recertification standards in the field. Thanks to this tradition of advanced education and clinical practice excellence, we are humbled and honored to note that anesthesia is 50 times safer now than 20 years ago (National Academy of Sciences, 2000). Research further demonstrates that the care delivered by CRNAs, physician anesthesiologists, or by both working together yields similar patient safety outcomes. In addition to studies performed by the National Academy of Sciences in 1977, Forrest in 1980, Bechtholdt in 1981, the Minnesota Department of Health in 1994, and others, Dr. Michael Pine MD MBA recently concluded once again that among CRNAs and physician anesthesiologists, "the type of anesthesia provider does not affect inpatient surgical mortality." (Pine, 2003) Thus, the practice of anesthesia is a recognized specialty in nursing and medicine. Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures from the simplest to the most complex, either as single providers or together.

NURSE ANESTHESIA PROVIDER SUPPLY AND DEMAND: SOLUTIONS FOR RECRUITMENT AND RETENTION IN THE DVA

While both types of health professionals can provide the same high quality anesthesia care, CRNAs are significantly more cost effective than anesthesiologists for the Department of Veterans Affairs (DVA). Consequently, both our Veterans and our VA health system are best served by policies and initiatives that secure adequate numbers of CRNA employees in the DVA. We believe that this Committee can help accomplish this objective by supporting nurse anesthesia education programs, both within the VA itself and in partnership with military and civilian schools of nurse anesthesia.

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA and AVANA both anticipated growing demand for CRNAs. Our evidence suggests that while vacancies exist, there is not a crisis in the number of anesthesia providers. The profession of nurse anesthesia has increased its number of accredited CRNA schools, from 85 to 88 the past two years. The number of qualified registered nurses applying for CRNA school continues to climb, with each CRNA school turning away an average of 23 qualified applicants in 2002. The growth in the number of schools, the number of applicants, and in production capacity, has yielded significant growth in the number of nurse anesthetists graduating and being certified into the profession. The Council on Certification of Nurse Anesthetists reports that in 1997, our schools produced 934 new graduates. By 2002, that number had increased to 1,333, a 42 percent increase in just five years.

Of the VA vacancies that exist, we believe that they can be filled through creative partnership between the VA system and the profession of nurse anesthesia. In the fall of 2002, members of the VA Field Advisory Committee contacted all VA healthcare facilities, finding 45 CRNA vacancies, representing 8 percent of the VA CRNA workforce. As the nurse anesthesia profession is working to meet the demand for CRNAs generally, we believe that the DVA specifically can meet its CRNA recruitment needs by pursuing two strategies. First, DVA should

expand its relationships with existing CRNA schools. Second, the DVA should jointly establish CRNA educational programs together with the Department of Defense health system.

To a degree, both of these strategies are already under way and achieving results for the VA health system. A recent AANA survey shows our nurse education programs use some 59 VA hospitals and healthcare facilities as clinical practice education sites, helping to educate CRNAs, provide superior patient care, and aid the VA in recruiting nurse anesthetists. In addition, the DVA is pursuing nurse anesthesia resource sharing programs with civilian CRNA schools through faculty exchange initiatives. The University of Alabama, Birmingham, has expressed a strong desire to create such a relationship. Its CRNA school is considering enrolling up to three VA CRNA students for their didactic education. Then, for the clinical portion of their education, the Birmingham VA hospital would provide a site for a clinical rotation in geriatric care that would be made available for both the VA and civilian student nurse anesthetists.

VA-DOD NURSE ANESTHESIA SCHOOL: UNIVERSITY OF TEXAS HOUSTON HEALTH SCIENCE CENTER, HOUSTON, TX

The establishment of a joint VA-Department of Defense program in nurse anesthesia education holds the promise of making significant improvements in the VA CRNA workforce, and improving retention of VA registered nurses, while cost-effectively making use of existing U.S. government resources and programs. We understand that the DVA is in the final stages of starting a nurse anesthesia graduate program beginning June 2004, with both the Army and DVA at the Ft. Sam Houston Nurse Anesthesia program in San Antonio, Texas. This VA nurse anesthesia program would begin by creating three openings for VA registered nurses to apply to and earn an Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. The 30-month program is broken down into two phases. Phase I, 12 months, is the didactic portion of the anesthesia training at the U.S. AMEDD Center and School (U.S. Army School for Nurse Anesthesia). Phase II, 18 months, is clinical practice education, in which VA facilities and their affiliates would serve as clinical practice sites. The agency envisions using VA hospitals in Augusta, Georgia, and Dayton, Ohio. Similar to military CRNAs who repay their educational investment through a service obligation to the U.S. Armed Forces, graduating VA CRNAs would serve a three-year obligation to the VA health system. Through this kind of Department of Defense – DVA resource sharing, the VA will have an additional source of qualified CRNAs to meet anesthesia care staffing requirements.

We are pleased to note that Dr. Michael J. Kussman, MD MS FACP (Department of Veterans' Affairs Chief Consultant, Acute Care) has approved $35,000 in funding to start this VA nurse anesthesia school beginning in June 2004. With modest levels of additional funding, this joint VA-DOD nurse anesthesia education initiative can grow and thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

CONCLUSION

In conclusion, we recognize that the VA has nurse anesthesia staffing needs. Through an effective partnership with the nurse anesthesia profession, you can see that the DVA can meet its future CRNA workforce requirements through three cost-effective models, which exist today and can be expanded. Our VA hospitals can serve as clinical practice sites for CRNA schools. Going one step further, the VA health system can pursue resource sharing and faculty exchange agreements with nurse anesthesia schools. Further still, the VA and DOD can share resources outright to educate nurse anesthetists for the Veterans and military settings alike. This VA commitment to CRNA education helps secure the nurse anesthesia workforce our Veterans need. Last, it attracts registered nurses into VA service, by sending RNs the strong message that the VA is committed to their professional and educational advancement.

Thank you. If you have further questions, please contact the AANA Federal Government Affairs Office at 202-484-8400.

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Tom McKibban, CRNA, MS

1819 Terrace Drive, El Dorado, KS 67042

Professional Affiliations

American Association of Nurse Anesthetists

- AANA President, AANA Finance Committee chairman, AANA Ad Hoc Committee on Federal Services chairman, AANA Strategic Planning Committee member, present.
- Past positions include AANA President-elect (2003), Treasurer (2002), Ad Hoc Committee on State Organizational Development (2002), AANA Strategic Planning Committee (1999-2002), AANA Region 4 Director (1999-2001), AANA Finance Committee (chairman 1998, member 1993, 1997-98, 2002), Council on Recertification of Nurse Anesthetists (chairman 1996-97, member 1990-97) AANA Finance Committee (1993, 1997-98, 2002), AANA Education Committee (1991-92).

Kansas Association of Nurse Anesthetists

- Member, present
- Past positions include President, President-Elect, Treasurer, Secretary, Board Member; committees on Government Relations, Finance, Practice, Program, Bylaws, Publications, Continuing Education, Nominating, Kansas CRNA-PAC, and editor of *Kanesthesia*.

Butler County Anesthesia Services, LLC, El Dorado, KS

- Certified Registered Nurse Anesthetist, Senior Partner (1977-present)
- Affiliated with Susan B. Allen Memorial Hospital, El Dorado, KS
- Licensed by the Kansas State Board of Nursing as a Registered Nurse #13-034990-072, Advanced Registered Nurse Practitioner #54002, and Registered Nurse Anesthetist #54002; by the Council on Certification of Nurse Anesthetists #27681 (1977); and by the Council on Recertification #27681 (2002).

Education

MS Nurse Anesthesia

- University of Kansas, Lawrence, KS (1987-89)

BA Health Care Administration

- Ottawa University, Ottawa, KS (1985-86)

Diploma in Nurse Anesthesia

- Wichita Physicians School of Nurse Anesthesia, Wichita, KS (1975-77)

Diploma in Nursing

- St. Francis School of Nursing, Wichita, KS (1972-74)

Associate Degree

- Butler County Community College, El Dorado, KS (1970-72)

1237 South Fiftieth Street
Birmingham, Alabama 35222

Phone Res: 205/595-7926
Work: 205/933-810x6636
Fax: 205/558-4721
E-mail ccraig1237@aol.com
Carol.Craig@med.va.gov

Carol M. Craig, CRNA

Work experience

CRNA 1993 – Present VAMC, Birmingham, Alabama

- Implement the approved anesthetic plan, including general, regional or monitored anesthetic care. Placement of invasive and noninvasive monitoring. Respond to airway emergencies throughout VAMC. Plan, gather and analyze data for multiple research projects and committees. Serve as clinical preceptor to nurse anesthesia students.
- 1987 – 91 **RN** Operating Room - Staff Nurse - VAMC, Birmingham, AL
- 1985 – 87 **RN** Surgical Intensive Care Unit – Staff Nurse - VAMC Birmingham, AL
- 1984 – 85 **RN** Medical/Surgical Unit – Staff Nurse – VAMC, Birmingham, AL

Education

BS 1993 Nurse Anesthesia Program, University of Alabama at Birmingham

- BSN 1990 University of Alabama at Birmingham
- ADN 1984 Jefferson State Junior College, Birmingham, AL

Accreditation

Certified Registered Nurse Anesthetist

Registered Nurse
Certified Nurse Operating Room
Instructor, Advanced Cardiac Life Support

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

STATEMENT ON THE IMPACT OF THE NURSING SHORTAGE

presented to

The House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

October 2, 2003

The National Association of Clinical Nurse Specialists (NACNS) appreciates this opportunity to address the Subcommittee on Oversight and Investigations about the impact of the nursing shortage on the Department of Veterans Affairs. NACNS is the only organization that represents Clinical Nurse Specialists (CNSs), regardless of their specialty area of practice.

A Clinical Nurse Specialist (CNS) is a Registered Nurse (RN) who holds a masters degree in nursing from an accredited School of Nursing that prepares CNSs for specialty practice in nursing. Our 1500 members represent over 40 different nursing specialties.

CNS practice is characterized by:

- Provision of research/theory-based "direct" patient care for patients who need specialty nursing care;
- Bridging gaps between new knowledge and actual practice at the bedside by staff nurses – advancing the practice of nursing; and
- Facilitating "system" changes on a multi-disciplinary level that help hospitals and other health care facilities improve patient outcomes cost-effectively.

Research about Clinical Nurse Specialist practice demonstrates such outcomes as:

- Reduced hospital costs and length of stay
- Reduced frequency of emergency room visits
- Improved pain management practices
- Increased patient satisfaction with nursing care
- Reduced medical complication in hospitalized patients

CNSs practicing in the Veterans Administration (VA) system improve the quality, safety, and cost effectiveness of health care delivered to our nation's veterans. As the demand

3969 Green Street Harrisburg, PA 17110 Phone 717-234-6799 Fax: 717-234-6798
E-mail: info@nacns.org Web Site: http://www.nacns.org

for CNSs services increases nationwide, the shortage of nurses prepared at the Bachelor's degree level means a shortage of candidates to attain advanced (Master's degree) education required for Clinical Nurse Specialist practice.

The lack of access to CNS services because of the nursing shortage is compounded by policies in some VA facilities that prevent CNSs from practicing within their full legal scope of practice. For example:

- Some CNSs practice in VA facilities located in states where inappropriate licensure regulations restrict CNS practice. For example, in Ohio the law prohibits any CNS from practicing without board certification and a collaborating physician. Regardless of Federal policy under which VA licensed personnel practice, CNSs face barriers posed by such restrictive state regulations and do not feel free to practice with the confidence that Federal policy will protect them from potential disciplinary action by the state licensing board.

NACNS encourages the Veterans Administration to fully support Clinical Nurse Specialists to practice without restrictions and barriers posed by state statutes and regulations.

- In some settings, CNSs employed by the VA are paid less than other advanced practice nurses who have similar responsibilities. This inequity in pay compared to other master's prepared advanced practice nurses is a disincentive for CNSs.

NACNS encourages the VA to address this inequity in compensation in order to attract and retain Clinical Nurse Specialists.

NACNS commends the Subcommittee for seeking input about strategies for recruitment and retention which are crucial for maintaining a qualified nursing workforce. We believe that it is critical for the VA system to address the problems described in this testimony that prevent both full access to Clinical Nurse Specialist services and the full benefit that CNS expert nursing services offer to the public and our nation's veterans.

Thank you for inviting NACNS to contribute to this important public discussion.

Christine Carson Filipovich, MSN, RN
Executive Director

Janet S. Fulton, PhD, RN
President

3969 Green Street Harrisburg, PA 17110 Phone 717-234-6799 Fax: 717-234-6798
E-mail: info@nacns.org Web Site: http://www.nacns.org

Testimony of Sarah Atkins, RN, MS, OCN®

I have been a registered nurse (RN) at the Portland, Oregon VA Medical Center (PVAMC) for approximately 13 years, my entire career as an RN. I chose to work at the VA over several other offers of employment because not only do I truly enjoy the Veteran population, but as the daughter of a decorated World War II Veteran, I am honored to serve these American heroes.

I began my career in 1990 with an associate degree in nursing (ADN). In 1998 I earned a bachelor of science degree in nursing (BSN), and in December of 2002 I completed my master of science degree in nursing (MS), a leadership masters degree with a specialty track in teaching. I am certified in oncology nursing (that's the OCN® in my credentials) and in 2002 became recertified in oncology nursing for the third time. My background is in medical-surgical and inpatient & outpatient oncology nursing. I am privileged to have been elected by my peers to represent them as their Professional Unit Vice President for AFGE Local 2157.

Areas of Concern

BSN Requirement for Registered Nurses

The undue emphasis on the BSN degree is contrary to findings in the literature, not keeping with community standards and practice, violates known principles of adult learning, and adversely impacts the recruitment and retention of excellent RN's.

One's initial educational preparation in nursing is meant to prepare a nurse for entry into practice, and regardless of educational preparation, all nurses entering practice take the same licensing examination. It is not meant to be the most significant factor that defines a nurse for the rest of his or her career. On the contrary: consider that only initially is education what makes someone eligible to

be licensed as an RN. For subsequent licensure, practice as a nurse is required. One cannot continue to be licensed as an RN solely on educational attainment alone. In fact, although some states require some continuing education related to nursing practice for relicensure, ALL states require the *practice* of nursing for relicensure. When a nurse with an ADN or diploma in nursing earns a BSN, he or she doesn't get a different license, he or she continues with the same RN license as before. This is consistent with principles of adult learning that recognize that most relevant learning occurs outside of a classroom setting.

The unfortunate over-emphasis on the BSN in the VA disregards the fact that basic nursing education becomes obsolete within a few years and the nurse only remains competent to practice if he or she is practicing nursing. In the State of Oregon, for example, a nurse who has not practiced for 15 years must repeat his or her entire nursing education in order to be relicensed.

The relevance in the VA is that we under-value the experience gained in nursing practice. I've know VA nurses who have practiced nursing longer than some of their younger colleagues have been alive. Yet the BSN that the less experienced nurse has allows them to be promoted to a level where they stand side by side their vastly experienced colleague who has an ADN or diploma in nursing. We know that older nurses (as well as nurses of color) are less likely to have the BSN degree and are less likely to return to school to obtain it. The private sector does not do this. It makes no sense to value years of experience to a lesser extent than a BSN degree, or worse, to penalize a vastly experienced nurse for lack of the BSN degree.

One of the best nurses I ever worked with, an ADN-prepared RN with15 years of experience, left the VA to work in the private sector after continually failing to be promoted for her lack of a BSN. She told me how amazing it was to be valued in her new job for her skills and expertise and not to be judged she was deficient simply because she didn't have a BSN. We cannot afford to continue to enforce an elitist standard of BSN preference when it does not benefit the Veterans we serve and may cost us in recruitment and retention of the best nurses.

There is money available for VA nurses to continue their education, but there are a number of problems with this system. First and foremost, there is no provision made for staffing in units where a nurse must be absent to attend classes. Some nurses receive modifications to their schedule to allow them to attend class; many do not and must abandon the idea of continuing their education as a result. There is also inconsistency and wait times for reimbursement that creates hardship. Nurses in Portland have had to charge tuition on their personal credit cards and incur interest, or obtain other loans while they wait for reimbursement from NNEI or other programs.

I am aware of several nurses in Portland who became nurse practitioners using funding provided by the VA but were refused hire as nurse practitioners in the VA because they "don't have experience", yet the Portland VA has nurse practitioner vacancies! These nurses are actually being told to leave the VA to get experience – and then they would be welcome to reapply. This is not only a waste of the monies used to educate these nurse practitioners, it is shocking that the VA would usher some of its best nursing resources out of the VA and into the community.

Obviously I value education, as I have obtained both a BSN and an MS after my initial ADN. However, it is through this education that I have had the opportunity to examine the literature and learn that research does not show that BSN-prepared nurses perform better than ADN or diploma-prepared nurses. I would also like you to know that I did not learn one thing in my BSN program that changed or improved my nursing practice. The kinds of things that have changed or improved my practice have only been learned on the job, in the practice of nursing.

I have read the JAMA article that came out this week that, on the surface, suggests that BSN-prepared nurses are able to provide better patient outcomes. This is actually not what the data in the article prove. There is no way to ensure that the initial educational preparation of the nurses in the study is in any way responsible for the patient outcomes, especially in light of the fact that the length of the nursing experience that the study subjects had was 12.5 –14.9 years. In

addition, the data in the article that described more deaths where each RN cared for 8 patients and 20% had a BSN vs. less deaths where each RN cared for 4 patients and 60% had a BSN is a feature of unrealistic workload rather than educational preparation. Finally, this study is not really applicable to the VA, because it studied hospitals with very different characteristics and patient populations. The percentage of male patients was less than 50%, and VA patients are overwhelmingly male. Similarly, the mean age of the study patients was 57.3 – 61.3, which is younger than much of the VA population. Most importantly, no conclusion can be drawn about the relationship between education and patient outcomes until and unless this study is replicated with the same results.

I urge you to remove the BSN requirement.

Magnet Hospital

The principles espoused by Magnet Hospital proponents, called "The Forces of Magnetism", are promoted as if they are unique, original, and innovative. In fact, these are well-known, tried-and-true, basic principles long recognized by many disciplines to successfully promote excellence and employee satisfaction in the workplace. They are simply good practices reworked to apply to a nursing environment. However, there are a number of drawbacks to pursing the Magnet credential in VA hospitals.

There is already a plan in place in VA Hospitals to ensure the kind of excellence that Magnet proponents say they want. It is called Partnership, and the VA National Partnership Agreement (attached) is endorsed and promoted by Anthony Principi, Secretary of the VA. If followed, the labor-management collaboration of Partnership has been proven to create just the kind of workplace that the Magnet concept is promoting. It makes no sense to ignore VA's own plan for workplace excellence in favor of another substantially similar and very expensive program.

If the idea of some sort of formal recognition is important to the VA, there are programs (Baldridge, for example) that would be much better suited as they

evaluate the entire team that cares for Veterans. The Magnet credential only evaluates Registered Nurses (RN's), thereby creating a culture of exclusion and elitism.

The cost of obtaining the Magnet credential is very high, estimated for Portland to be over $10,000. This sort of expense is an extreme dissatisfier to employees in these lean budget times to see a great expenditure going to exalt one discipline and not all of the Veterans' caregivers. Our employees who are also Veterans have been particularly vocal opponents, as they have seen their own services cut and cannot see the value of such a major expenditure for the Magnet credential.

Our employees have also verbalized concern that the process of obtaining the Magnet credential will be a "sham", where changes are made just long enough to earn the credential and then the old ways will return. Many of the nurses have seen this happen over their careers, with programs that have been touted and allotted human and financial resources, only to disappear. They have said that this is what happens every time the Joint Commission (JCHAO) comes for its credentialing visit. There is further concern that nurse executives and mangers stand to gain personal and professional recognition as a result of receiving this credential, and possibly promotions. While these managers can reap the rewards of this "feather in their cap", it is believed to be unlikely that any front-line employee will reap any personal or professional reward.

Nurses in Portland are represented by AFGE Local 2157. The Magnet credential is owned by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), which represents RN's in collective bargaining via its union, United American Nurses (UAN). In a VA hospital where the employees have selected AFGE as their exclusive representative, it is a problem for management to ask a subsidiary of another labor union (ANCC) to come in, have input and direction into establishing working conditions, and enter into a contract with ANCC to allow further evaluation by them.

I want to share what has happened in Portland as a result of management's interest in obtaining the Magnet credential.

Last summer management began to hold meetings to plan for obtaining the Magnet credential. I was invited to these meetings, along with the representative from AFGE Local 2583, which represents Registered Nurses at our Vancouver campus.

At the Magnet planning meeting in November of 2002, AFGE expressed concern and opposition to obtaining the Magnet credential for the same reasons I have just outlined. Management responded in the meeting by threatening to "get rid of" and "decertify" AFGE as the exclusive representative of the employees. This resulted in the filing of an Unfair Labor Practice (ULP) charge and a complaint against the Portland VA Medical Center by the Federal Labor Relations Authority.

After AFGE filed the ULP, we realized we were no longer being invited to the Magnet planning committee meetings. As this appeared to be retaliation for the union expressing its concerns and opposition and filing the ULP charge, we asked management to be sure that we were invited to all of the meetings. Management, via the Chief of Human Resources, responded by telling us there was no longer a Magnet planning committee. Recently we heard that the Magnet committee was meeting again, and we again asked to be included and were told by the Chief of Human Resources that there was no Magnet planning committee, just some discussion between members of management. Last week the Chief Nurse Executive gave a presentation from the supposedly nonexistent Magnet committee on the Portland VA Medical Center's plan to seek the Magnet credential. This committee consisted of at least one bargaining unit employee. It was revealed that a preliminary application for the Magnet credential has already been filed. All of management's planning and the making of the application were done without the involvement of AFGE and after telling AFGE there was no committee.

At best, this reveals that management at the Portland VA Medical Center is unprepared to "walk the talk" and practice the "Forces of Magnetism" and

collaborate with AFGE, the employees' chosen exclusive representative. At worst, this lends credence to the fears our employees have expressed about the Magnet credential being a very expensive "sham".

I urge you to reject the introduction of the Magnet credential in VA hospitals. The VA has a proven process in place via Partnership that was designed to create both excellence and employee satisfaction in the workplace. Partnership already belongs to the VA and won't cost thousands of dollars to implement. Partnership is truly the best avenue to pursue in creating a culture that will allow VA nurses to do what they do best – deliver excellent care to Veterans.

Respectfully submitted,

Sarah Atkins, RN, MS, OCN®
Professional Vice President
AFGE Local 2157
Portland VA Medical Center
Portland, Oregon
(503) 220-8262 x51946
(503) 721-7987 fax

Conclusion

Several times, I have suggested that changes be made to 38 USC 7422 in order to allow staff nurses from the frontlines to have a voice at the decision making table. This would be such an advantage to the VA as a whole. As the law now stands, with management and staff prohibited from coming together to collaborate over these issues, the VA is disadvantaged. All of the expertise available in staff nurses across the country is unused. One of the great things about nurses is that we are programmed by our education to use "the nursing process". This means that we expertly assess, plan, implement, and evaluate when presented with a problem. Therefore, nurses make the very best of partners when problems need to be worked out. Please consider what a huge advantage and flexibility it would be for the Secretary of the VA to have the participation of frontline nurses collaborating with VA management in working out these important issues!

Respectfully submitted,

Sarah Atkins, RN, MS, OCN®

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
January 9, 2003

MEMORANDUM FOR UNDER SECRETARIES, ASSISTANT SECRETARIES, AND OTHER KEY OFFICIALS

SUBJECT: National Partnership Agreement

Last year, I made a decision to retain VA's National Partnership Council as an advisory body to me and our leadership team. I asked the Council, made up of VA's five national unions and VA leaders, to develop a new partnership agreement that I could sign.

In doing so, I also asked the Council to review their past accomplishments and to identify those factors which produced positive results on behalf of employees and veterans. From there, they were to ensure that the Council's objectives were realistic and attainable and its purpose clear.

I am pleased to inform you that the Council has completed its work and has produced a new partnership agreement that I have signed The attached agreement focuses on cooperative labor-management relations that result in improved services to veterans and a positive workplace for employees.

The Council will carry out its purpose by developing advisory opinions on policies, programs and initiatives that affect employees and customer services. In addition, it will be an advocate for predecisional involvement with labor, alternative dispute resolution, and employee training.

Please support the Council in their efforts to help improve the Department's performance. They are available to you as an advisor, particularly where changes in working conditions are contemplated as a part of that improvement.

Anthony J. Principi

Attachment

The Department of Veterans Affairs, American Federation of Government Employees (AFGE), National Federation of Federal Employees (NFFE), Service Employees International Union (SEIU), National Association of Government Employees (NAGE), and the United American Nurses (UAN) enter into this partnership agreement in the spirit of cooperative labor-management relations.

PURPOSE

The purpose of the VA National Partnership Council (NPC) is to advise the Secretary and VA leadership on matters associated with labor-management relations VA wide and VA initiatives which impact employees, and to promote cooperative labor-management relations which result in improved services to veterans and a positive workplace for employees.

OBJECTIVES

In order to achieve this purpose, the partners agree to the following objectives:

1. Develop advisory opinions and recommendations on policies, programs, and initiatives that affect employees and customer services;
2. Promote a positive work environment for all employees;
3. Promote cooperative labor-management relations, including partnerships throughout VA;
4. Advocate a full exchange of views and sharing of information between labor and management to include predecisional involvement;
5. Support the use of alternative dispute resolution as appropriate; and
6. Encourage training that promotes cooperative labor-management relations.

STRUCTURE /OPERATION

The Council will be comprised of representatives from the following organizations:

Management	Union
Labor Management Relations	American Federation of Government Employees
General Counsel	United American Nurses
National Cemetery Administration	National Association of Government Employees
Veterans Health Administration	National Federation of Federal Employees
Veterans Benefits Administration	Service Employees International Union

There will be 4 members from AFGE and 2 members from each of the other unions (total 12) and 10 management members.

The Council will have two Co-Chairpersons representing labor and management, respectively. Management and labor will each select their Co-Chair every two years. Either party may also designate an alternate.

Meetings will be held quarterly. The Co-Chairpersons may call additional meetings as are necessary.

The NPC may establish committees, task forces, or work groups as appropriate to carry out the work of the council.

The Department of Veterans Affairs will be responsible for all council members' travel and per diem expenses.

All NPC members will be in a duty status while participating in council business. National partnership activities beyond or outside normal duty hours of those involved will be considered as official duty.

NPC decisions will be made using a consensus approach.

COMMITMENT

This agreement is a commitment by the partners to make the best efforts to ensure that cooperative labor-management relations are maintained in the interests of the employees and the veterans we serve.

Anthony J. Principi

Anthony J. Principi
Secretary

January 9, 2003
Date

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Written Statement to the
House of Representatives Committee on Veterans Affairs
Subcommittee on Oversight and Investigation

Impact of the Nursing Shortage on the Department of Veterans Affairs and Proposed Solutions
October 2, 2003

Mr. Chairman and Members of the Committee, it is a privilege for the American Association of Critical-Care Nurses (AACN) to contribute to the success of this committee's important work. We commend the committee for giving this critical issue the high level of attention that it warrants.

The American Association of Critical-Care Nurses is the world's largest specialty nursing organization. With a mission of providing and inspiring leadership to establish work and care environments that are respectful, healing and humane, AACN is dedicated to the vision of *a healthcare system driven by the needs of patients and families, where critical care nurses can make their optimal contribution.*

The nursing shortage is already more pronounced in specialty areas, such as critical care, and is expected to considerably worsen.[1] Having the appropriate number and mix of nurses is a critical factor in achieving positive patient outcomes in any healthcare setting: it is especially essential for patients who are critically ill.[2] For these patients, and for the nurses who care for them, we must work together to mitigate the potentially devastating effects of this nursing shortage.

Due to the complexity of the issue, it will require the combined efforts of all stakeholders in the healthcare industry to identify and implement strategies that will increase the supply of registered nurses and nurse educators. AACN is an active participant in the nation's leading forums brought together to combat staffing shortages in a collaborative manner. Among them are Nursing's Agenda for the Future and the Framing Options for Critical Care in the United States (FOCCUS) task force. We are pleased to share with the committee the recommendations that have emerged in our work with these and other groups.

BACKGROUND: CRITICAL CARE NURSING

Critical care nursing is the specialty that deals with actual or potential human responses to life-threatening problems. Of the 2.2 million working registered nurses in the United States, nearly 1.3 million take care of hospitalized patients. Of these, an estimated 403,000 are critical care nurses whose clinical practice is directly influenced by our association.[3]

They work wherever critically ill patients require care–intensive care units for adults, children and newborns, cardiac care units, air and ground transport, cardiac catheterization laboratories, progressive care and telemetry units, emergency departments and post-surgery recovery rooms, to name a few. With severely shortened hospital stays, critical care nurses also apply their skills in long term care, home health, outpatient surgery centers and clinics. AACN counts nearly 65,000 critical care nurses as members.

CREATING HEALTHY WORK ENVIRONMENTS "THE #1 PRIORITY"

In our extensive review of the literature, our proprietary research, and member feedback, we have concluded that the health of the environments in which nurses care for their patients is the single most important factor in their level of job satisfaction. Unfortunately, our research tells us that these environments are increasingly unhealthy for nurses, their colleagues, and for the patients and families for whom they care.

AACN believes that creating healthy work environments is the one factor upon which rests the success of all other solutions to mitigating the nursing shortage. As a result, we have made a Healthy Work Environment Initiative our top strategic priority. We believe that creating healthy work environments should be the foremost strategy that employers utilize in their efforts to create a culture of retention. Our initiative has three goals:

- Underscore the danger that toxic work environments pose to patients
- Mobilize nurses in identifying the biggest challenges in their environments
- Urge nurses to engage their colleagues in finding and implementing solutions to these challenges.

AACN has identified five interrelated areas that must be addressed if a hospital is to create and maintain a healthy work environment. They are:

- Effective communication
- Effective collaboration
- Meaningful recognition of nurses' unique contribution
- Nurses' participation in decisions that impact patient care
- Appropriate staffing

Most of today's safety initiatives seek to correct deficient systems and processes. However, those systems and processes are developed and implemented by people and, consequently, are often held hostage by the complexity of human relationships. It is those relationships that are at the heart of the five factors in creating healthy work environments.

Nurses from across the country contact AACN with increasing regularity seeking guidance in navigating toxic work environments. Places where abusive and disrespectful interactions between colleagues are the norm. Places where nurses are being left out of the very decisions that affect the patient care for which they are responsible. Places where nurses are not adequately recognized for their critical contribution to patient outcomes. And, especially, where nurses are practicing in units with woefully inadequate staffing.

Ironically, an organization assumes little or no financial burden by choosing to focus on these elements of a healthy work environment. Rather, fostering improvement in these areas will save untold millions in direct and indirect expense. Put simply, it is a question of establishing an organizational and personal commitment anchored in the inherent and unarguable values of quality healthcare.

RECOMMENDATIONS: PRACTICAL STEPS FOR CREATING CULTURES OF RETENTION

AACN commends the Department of Veterans Affairs for its significant efforts in creating a culture of retention. A nurse turnover rate in VA facilities that is significantly lower than the national average attests to the investment the Department has made. We respectfully urge the department to maintain current initiatives in those areas below where it has begun work and to initiate work in those areas where attention and resources may not yet be focused.

1. Adopt characteristics of excellence as defined by national recognition programs such as Baldrige, AACN Beacon Awards, and Magnet Recognition Program™ to foster a workplace that respects and empowers nurses.

It is our understanding that many VA hospitals are adopting principles promoted in the Magnet Recognition Program™. We applaud this. While we recognize that there are multiple paths to achieving and being recognized for organizational excellence, embracing the characteristics put forward by such programs is a strong step in creating a culture of retention for nurses.

Recognizing that defining and fostering excellence at the clinical unit level is an important element in achieving organizational excellence, the American Association of Critical-Care Nurses has launched a national recognition program: The Beacon Award for Critical Care Excellence. And whether or not a unit chooses, the award standards provide a clear path to excellence in creating healthy work and care environments.

2. Support nurse managers and executives, providing training where it is needed.

Nurse Manager Leadership Collaborative—Of any leadership role in healthcare today, a nurse manager has the most direct impact on the care and services that patients and families require throughout their healthcare experience. Nurse managers require well-honed skills in coaching, motivating and leading a professional team so that safe and effective care is delivered, supported by systems where quality improvement and effective stewardship of scarce resources are complementary. Regrettably, learning resources are limited and on-the-job learning is the norm for most nurse managers.

A partnership of AACN, AONE–the American Organization of Nurse Executives and AORN–the Association of periOperative Registered Nurses is developing the Nurse Manager Leadership Collaborative. The collaborative is a comprehensive and sustainable national professional development initiative through which nurse managers can acquire and deepen the knowledge and skills needed for optimal performance. It will offer products and services that support career-long development within a framework of collaborative partnership and evidence-based best practices.

Blueprint for Clinical Practice—*It's All About You; A Blueprint for Influencing Practice*, was prepared by AACN based on a national survey of more than 700 critical care nurses who identified factors that would help them meet the challenges of influencing their work environment. The blueprint guides nurse managers in developing skills of self-awareness, dialogue, conflict resolution and navigating change, which the respondents identified as specific skills that are essential to exerting that influence.[4]

3. Positively transform nursing work through the use of information and ergonomic technologies.

The VA has been a leader in acquiring and adopting equipment to create a healthy ergonomic environment for nurses. This is imperative considering the increasing age of nurses who are called upon to perform work that is physically challenging and often dangerous. The VA's Barcode Medication Administration System and Patient Safety programs are two notable investments that enable nurses and their colleagues to better care for patients.

While the VA has been a leader in these initiatives, AACN does urge greater diligence in ensuring that, from the outset, nurses are included as key members of the teams that select and acquire important technology. Such critical participation improves the likelihood that expensive purchases will be the most appropriate for all members of the healthcare team. For example, computerized patient record systems must genuinely seek to create a *patient* record that reaches beyond a traditional physician-focused framework to accommodate the vital assessments for which nurses are responsible.

4.Set staffing levels based on nurse competency and skill mix relative to patient mix and acuity.

AACN Synergy Model for Patient Care—Clinical leaders are responsible for establishing an environment where a patient's needs are matched with a caregiver's competencies. The American Association of Critical-Care Nurses' *Synergy Model for Patient Care* is a practical organizational framework that leaders in every clinical area can use to organize the work of nurses and create an environment of safety.[5-6] The model's premise is a simple one–synergy occurs when patients' needs drive nurses' characteristics resulting in optimal patient outcomes.

The AACN Synergy Model identifies eight characteristics of patients that include complexity, vulnerability, predictability, stability, resiliency, resource availability, participation in care and participation in decision making. As a patient's needs evolve, so does the depth of a nurse's competence in eight characteristics that include clinical judgment and reasoning, advocacy, caring practices, collaboration, systems thinking, response to diversity, inquiry and facilitation of learning.

Patient-Focused Staffing Decisions—There is widespread agreement and a quickly growing body of evidence supporting the negative effect of staff shortages on patient safety. Legally mandated nurse-patient ratios have been introduced as a solution to staff shortages in some jurisdictions.

Although appearing to solve the problem, mandatory staffing ratios are known to be a quick-fix that fails to recognize staffing is both a process and an outcome. The components of staffing a clinical area are intertwined and complex, often reflecting highly charged emotional issues.

Considering the fundamental belief that a patient's needs must be matched with a caregiver's competencies, the appropriate number and type of staff would be difficult to express in staffing numbers or patterns as a single acceptable national, even regional or local, ratio or mix. A preset ratio does not address the needs of a specific group of patients at a specific time.

AACN's *Staffing Blueprint: Constructing Your Staffing Solutions* was released in 1999 and was designed to bridge communication, facilitate problem solving and promote patient-focused care when making staffing decisions.[7] The blueprint emphasizes that the solution to a staffing problem is a comprehensive strategic plan that links cost, implementation, competency and staff mix with patient outcomes. This will allow direct comparisons to be made between healthcare plans, hospitals and providers.

Critical Care Education for Nurses—However, as critical as adequate staffing may be to assure patient safety, there also is a glaring need for consistency in and easy access to the fundamental knowledge nurses must acquire to safely care for critically ill patients and their families. For more than 30 years, AACN has been the leader in delineating core content for critical care nursing.

More recently the association invested nearly $1 million of its own resources to develop ECCO™—the first of its kind Internet-based Essentials of Critical Care Orientation. Launched in August 2002, ECCO is an interactive and self-paced program focusing on the fundamental knowledge needed for a nurse's orientation to the care of critically ill patients. It is designed to orient novice nurses to critical care practice more efficiently and expediently in a consistent way across clinical units and hospitals nationwide. ECCO offers hospitals just-in-time learning as a complement or substitute to traditional labor-intensive classroom courses.

In a second clinical education initiative funded in part by the U.S. Department of Education Fund for the Improvement of Post-Secondary Education, AACN has partnered with Indiana University School of Nursing and Clarian Health Partners to develop a comprehensive online critical care nursing course that will complement ECCO and be especially appropriate for academic institutions.

5. Adopt zero tolerance policies for abusive behaviors.

Incidents of verbal abuse of nurses—whether by physicians, other nurses, patients or patient family members—are unfortunately well known, even commonplace. Less well known is the impact of this disruptive behavior on nurse satisfaction and retention levels.

The impact of abusive incidents can have grave consequences for patients as well. The abuse breeds intimidation, and may consequently inhibit nurses from communicating with colleagues even when communication may be vital to the quality and safety of care. One such case, reported in *Hospitals and Health Networks*, resulted in a fatal medication error when a nurse was rebuffed when she called a physician to clarify an order.[8]

With growing awareness of the issue, more is being done to create "zero tolerance" workplaces. Experts suggest using a collaborative, educational approach to raise understanding and awareness of the appropriate codes of conduct and enforcing expected behaviors with clear and strong policies.[8]

6. *Foster an environment of professionalism by supporting continuing education and certification.*

Industry studies have shown that nurses identify employer support for CE and certification as a valued benefit.[9-10] Significant support for these benefits must be part of every hospital's nurse recruitment and retention plan. Additionally, continuing education and certification—and their links to continuing competency of caregivers—contributes to improved patient safety. [10]

The Institute of Medicine's Committee on Quality of Health Care in America linked patient safety with continuing competency. Recommendation 7.2 of its report *To Err Is Human: Building a Safer Health System* suggests that performance standards for health professionals should focus greater attention on patient safety and "health professional licensing bodies should implement periodic re-examinations and re-licensing of doctors, nurses and other key providers."[11]

Because wide divergence about the requirements for re-licensure exists among state boards of nursing, specialty certification fulfills the IOM's recommendation.

Through CCRN® and CCNS certification, the AACN Certification Corporation provides the gold standard in specialty certification for critical care staff nurses and advanced practice nurses. *Safeguarding the Patient and the Profession*, a white paper, describes the significant benefits that specialty certification for nurses brings to the public, employers and nurses themselves.[10]

Hospitals that create a culture of professionalism, respect and retention–including support for continuing education and certification–are more likely to have the optimal supply and mix of experienced nurses to assure patient safety. From the consumer's perspective, in a November 2002 nationwide poll by Harris Interactive, nearly eight of 10 respondents in a representative sample of the American public were aware that nurses could be certified. Higher, in fact, than their awareness that teachers or physicians could be certified. Three of four respondents also said they were much more likely to select a hospital that employs a high percentage of nurses with specialty certification.[12]

CONCLUSION

Optimal care for critically ill patients and their families requires that the nurses who care for them have a healthy work environment where there are sufficient numbers of expert clinicians who base their practice on the ethics and values of the nursing profession and on accepted evidence-based standards for clinical practice. Those clinicians must work in environments that are safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of everyone involved.

Thank you for inviting the American Association of Critical-Care Nurses to support the committee's work. AACN is available for continued dialogue as necessary and looks forward to collaborating with the Department of Veterans Affairs in implementing the solutions offered within this testimony.

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Statement of the National Association of Orthopaedic Nurses

The National Association of Orthopaedic Nurses believes the nation is facing a potentially dangerous nursing shortage. We believe this shortage will have a harsh impact on the Department of Veterans Affairs because of a large number of aging patients who require extensive hands-on care. Today more than one in seven hospitals report an RN vacancy rate above 20%. A study last year in The Journal of the American Medical Association said patient mortality increases by 7 % whenever a nurse is forced to care for more than five patients. Currently, 1.89 million nurses are working full time, but an additional 110,000 are needed, according to a 2002 study by the Department of Health and Human Services. By 2020, if current trends keep up, nearly 3 million nurses will be needed, but only 2 million will be available.

Some 490,000 licensed nurses no longer work in the profession, up from 438,000 in 1996. Much of the exodus is due to burn out because of the shortage. Nurses are working overtime to see that their patients are cared for. Not only does this affect the nurse and her burnout ratio but it also affects the safety of the patient, which is of prime concern to the JCAHO.

The nursing shortage is responsible for higher costs of delivering care to our patients and bed closures in hospitals. It is contributing to emergency department overcrowding and diversion of more than four hours per week. It is increasing wait times for surgeries and causing us to reduce or eliminate services.

It is the nurse who most influences a patient's perception of quality and service as care is delivered. We are the people at the patient's bedside who are readily available to answer their questions and help them when they are hurting. Many of your patient's are orthopedic injuries and for this the VA will need many well trained Orthopaedic nurses.

The orthopaedic nurse diagnoses and treats human responses to actual and potential health problems related to musculoskeletal function. Orthopaedic nursing practice facilitates the promotion of wellness and self-care, the maintenance of health, and the prevention of injury and illness in the care of individuals of all ages with degenerative, traumatic, inflammatory, neuromuscular, congenital, metabolic, and oncologic disorders of the musculoskeletal system. The professional orthopaedic nurse bases clinical judgment and decision making on the nursing process, nursing theory, and research, as well as specific orthopaedic knowledge. The professional

orthopaedic nurse provides direct care or collaborates with other health care professionals to provide appropriate, effective, and efficient care and education.

Unfortunately with the nursing shortage affecting each and every specialty the VA, like all other medical organizations, will have a hard time recruiting nurse of the caliber they need to care for these very critically ill patients. We must work together to find ways to not only recruit people into the field of nursing, but we must work to retain these people. It is only through the effort to retain our nurses will this profession grow to the numbers we need to care for the growing population who will require healthcare in the future.

Robin S. Voss, BS, MHA, AACHE, TNCC-P
President-Elect, National Association of Orthopaedic Nurses

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Steve Buyer, Chairman
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
October 2, 2003

The Impact of the Current and Future Nursing Shortage

Question 1: The ANA testimony stated that during the period 1995 through 2000, the VA cut ten percent of the nursing staff. Could you explain the rationale of that decision and the impact of that decision today?

Response: The average number of full-time registered nurses decreased by 9.78 percent between FY 1995 and 2000 (see table).

FY	Average Full-Time
1995	35450
1996	34757
1997	33084
1998	32357
1999	32156
2000	31982

The decrease was partially the result of structural changes within the Veterans Health Administration (VHA), e.g., implementation of universal primary care, the shift from in-patient to outpatient care, establishment of community based out-patient clinics, and inauguration of regional and multi-institutional service lines. However, decreases for registered nurses were actually less than overall employment decreases during the same period both for all of VA and for VHA (16 percent and 18 percent, respectively). Since FY 2000, employment of registered nurses increased significantly. As of June 30, 2003, VHA had 35,581 registered nurses on board.

Question 2: The Magnet Recognition Program began in 1991. Why did it take the VA ten years to finally achieve this status at the Tampa VAMC?

Response: 1994 marked the year that the first U.S. hospital received magnet designation. As of August 2003, 85 U.S. hospitals out of 5,801 American Hospital Association (AHA) registered hospitals are designated as magnet facilities (1.4 per cent). In 2001, the Tampa VA Medical Center (VAMC) became the first of the 162 VHA facilities to achieve Magnet Designation.

Prior to making a decision to begin the application process for obtaining magnet status, it was necessary for VAMC Tampa's administrative leadership to examine the requirements for magnet status and to carefully assess its organizational readiness for the application process and to ensure that all requirements are in

place to support the application. Thus, the process of attaining magnet status begins long before a facility formally applies. After beginning the application process, Tampa's 3-year preparation, referred to by the American Nurses Credentialing Center, as the "magnet journey" is common for most hospitals that have attained magnet recognition. This two-step process followed by VAMC Tampa is consistent with that followed by most of the designated magnet hospitals across the country.

Question 3: Please elaborate on your legislative proposal for flexible tours of duty.

Response: Specifically, we are proposing to give VAMCs the flexibility to offer the following tours of duty:

A) three 12-hour tours (36 hours) paid as 40 hours;
B) 9 months of work with 3 months off, with pay apportioned over a 12-month period; and
C) 7 ten-hour days/7 days off, with pay for 80 hours.

Providing VAMCs with this type of flexibility would enable local facilities to be more competitive employers. Such flexibility would reflect recommendations made by the AHA to foster meaningful work and encourage the redesign of job responsibilities, processes, and procedures. The availability of such schedules can be noted in job advertisements in a number of large, moderate, and smaller job markets.

A 2000 survey conducted by the American Organization of Nurse Executives (AONE), found that after salary, a top benefit sought by nurses was "flexible scheduling and control over shifts." AONE states that hospitals should examine different options for scheduling as a way of bringing more nurses into the workplace.

All shifts noted in VA's legislative proposal represent current practice in the professional nursing community. The flexible shifts are necessary to maintain VA's competitiveness in hiring and retaining staff. In local markets, hospitals change hiring and pay policies frequently and rapidly to maintain a competitive edge. The work environment (hours of work, pay and amenities) is commonly structured to meet the life style needs of nurses, and nurses shop for the most suitable. VAMC administrators need the authority to offer flexible tours to truly be competitive in their geographic areas.

Question 4: It is my understanding that VA facilities in Houston, San Diego, Washington, DC, and New York are in the process of filing their magnet applications and that approximately 11 other facilities have begun the planning process. What has the Veterans Health Administration done to implement this

program at the other 142 facilities? And what is your vision for a timetable for this program expansion?

Response: With the magnet designation of Tampa VAMC, the VA magnet rate is presently 0.6 percent, compared with the U.S. rate of 1.4 per cent. It is our vision that 50 percent of all VAMCs will be eligible for magnet status by FY 2007 and that 90 per cent will be eligible for magnet status by FY 2010. Consistent with its significant commitment to Baldrige standards, VA recognizes the value of the magnet recognition process. The Office of Nursing Services will serve as a catalyst to support and assist VA facilities in their journey to magnet recognition. We recognize that while all facilities may not attain magnet status, the "magnet journey" process itself is valuable.

VHA has implemented a number of programs that now form the foundation for facility magnet recognition. Among these programs are:

- Leadership Development Programs for both nurse executives and nurse managers are in process. These programs enhance leadership skills and abilities specific to creating and fostering work environments found in magnet hospitals.

- VA Nursing Outcomes Database Project (VANOD), which is a 16-month project for creating a database of nursing sensitive quality indicators that will enable exploration of relationships between nurse staffing and patient outcomes, evidence-based decision-making, and benchmarking for testing best practices. The resulting database will yield information required by VA medical centers in their magnet applications. The nursing sensitive quality indicators include falls, pressure ulcers, skill mix, staffing, staff musculoskeletal injuries, patient satisfaction, and RN satisfaction. Twelve randomly selected VA hospitals are included in this pilot project. Two VA Health Services Research teams are participating in the building of the database: VA Puget Sound in Seattle is creating data submission methods and database structure while the Management Decision and Research Center in Boston is creating reporting formats from the data. Future planning is underway to establish nation-wide VA roll out, development of more indicators, and expansion to other care settings such as long term care and ambulatory care.

The Tampa VA Medical Center nursing staff are playing pivotal roles as consultants, trainers and coaches to assist their VA colleagues in preparation for magnet recognition. Office of Nursing Services supports the Tampa VAMC "Building a Business Case for Magnet Designation" designed to evaluate the outcomes resulting from magnet designation. These data will reach a worldwide audience since the American Nurses Credentialing Center has elected to partner with VAMC Tampa in this endeavor.

In the future, VA's support will take the form of staff support, education, consultation and the development and distribution of toolkits. Further, the Office of Nursing Services will work closely with VHA's National Leadership Board to ensure that the resources needed by VA facilities to implement the cultural and organizational changes necessary to magnet attainment are in place.

October 17, 2003

Mr. Arthur K. Wu
Staff Director
Subcommittee on Oversight and Investigations
House Veterans' Affairs Committee
337A Cannon Building
Washington, DC 20515

Dear Mr. Wu:

This letter is in response to a series of questions submitted by Chairman Buyer to American Nurses Association's President Barbara Blakeney.

> 1. In the Health and Safety section of your testimony, you state that 83% of the nurse respondents continue to work despite experiencing back pain. What is being done to address safe patient handling and prevention of these musculosketal problems? What other initiatives are being utilized to address unsafe patient lifting?

ANA recently launched a "Handle with Care" ergonomics campaign aimed at promoting safe patient handling and preventing musculoskeletal disorders (MSDs) among nurses. The campaign will involve collaboration with ANA-related groups, other nursing and specialty organizations, the research and academic community and health care systems in a united effort to prevent back and other musculoskeletal injuries through greater education and training, and increased use of assistive equipment and patient-handling devices. The campaign also seeks to reshape nursing education and federal and state ergonomics policy by highlighting the ways in which technology-oriented, safe-patient-handling techniques benefit patients and the nursing workforce. A folder with additional information on this initiative is attached for your further review.

> 2) In your testimony you stated that ANA represents the nation's 2.7 million registered nurses through its 54 constituent member associations. How many registered nurses are there in the United States?

According to the March 2000 findings from the National Sample Survey of Registered Nurses, U.S. Department of Health and Human Services, there are approximately 2.7 million registered nurses in the United States.

3. The National Commission on VA Nursing was established through P.L. 107-35 to address the current and future nursing shortages at the Department of Veterans' Affairs. The Commission has indicated that the final report is due in May 2004. In ANA's opinion, what should the top three recommendations for legislative and organizational policy changes be to enhance recruitment and retention in the VA?

The first recommendation that the ANA supports is continued support of the National Nursing Education Initiative (NNEI). Established in January 2000, the NNEI ensures that the VA workforce can meet the challenges of an intense, complex and changing work environment. The NNEI program awards tuition support to nurses to obtain baccalaureate or post-graduate degrees and training.

Second, the VA should continue to support the Nurse Qualifications Standards, established in 1999. The Nurse Qualification Standards are focused on both the standard of care provided by nurses as well as the level of education.

Finally, the VA should actively encourage its facilities to attain Magnet Recognition Status. The Magnet recognition Program for Excellence in Nursing Services was developed by the American Nurses Credentialing Center (ANCC) in 1994 to recognize facilities that provide the very best in nursing care and uphold the tradition within nursing that supports professional nursing practice. Magnet facilities have better patient outcomes and higher rates of nurse retention than non-magnet facilities.

Once again, thank you for allowing the American Nurses Association to comment on the issues facing nurses in the VA healthcare system. If you need additional information, please do not hesitate to contact me at (202) 651-7088 or rgonzale@ana.org

Sincerely,

Rose Gonzalez, MPS, RN
Director, Government Affairs

November 3, 2003

The Honorable Steve Buyer
Chairman, House Veteran's Affairs
Subcommittee on Oversight and Investigations
337A Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

On the behalf of the 100,000 staff nurses of the United American Nurses, AFL-CIO (UAN), I would like to thank you for the opportunity to address your follow-up questions to the testimony that I presented at the hearing to review the impact of the current and future nursing shortage on the Department of Veterans Affairs held on October 2, 2003. As you requested, I have included each of your questions, followed by my reply.

Question 1

You stated in your testimony that the number of "unique patients" treated in the VA is up by 55 percent and that VA nurses are caring for more patients, who are often sicker with fewer nurses at the bedside. It appears that more patients are being seen and many are sicker. However, would you not agree that most patients are actually being seen on an outpatient basis?

Answer 1

As I stated in my testimony, VA statistics show that between 1996 and 2002 the number of full-time equivalent RNs went down 8.4 percent. During the same time period, the number of "unique patients" treated at VA went up by 55 percent. While I understand the VA has increased its reliance on out-patient care, the role of VA's inpatient services has not decreased, but has become more focused. Advances in medical technology and research have allowed the treatment of diseases and conditions that were not treatable just a few years ago. As a result, patients are sicker at the bedside. The veteran population is also aging, which means patients will need more critical care provided by registered nurses. At the same time, the VA continues to decrease the length of stay for patients and discharges them sooner. This means that there are more patients on the floor that used to be in the ICU. Another factor in the staff nurse shortage in the VA is senior experienced RNs are moving to outpatient facilities, leaving new inexperienced nurses to provide inpatient care. While very qualified, new nurses are unable to provide the same level of inpatient care as senior experienced nurses.

Question 2

Do we need more "bedside" or inpatient professional nursing staff, or do we need more care nurses? How many in your estimation?

Answer 2

In UAN's opinion, the VA needs to increase the number of register nurses to take care of patients' critical needs. While it is difficult to give you an exact number of nurses that are needed, the UAN strongly supports minimum direct-care nurse-to-patient ratios. The UAN suggests the following minimum direct-care nurse-to-patient ratios:

(1) 1 nurse to 1 patient in operating room and trauma emergency units;

(2) 1 nurse to 2 patients in all critical care units, including emergency critical care and all intensive care units, labor and delivery units and postanesthesia units;

(3) 1 nurse to 3 patients in antepartum, emergency room, pediatrics, step-down, and telemetry units;

(4) 1 nurse to 4 patients in intermediate care nursery, medical/surgical and acute care psychiatric units;

(5) 1 nurse to 5 patients in rehabilitation units; and

(6) 1 nurse to 5 patients in postpartum (3 couplets) and well-baby nursery units.

Similar nurse staffing ratios have been enacted in California (AB395).

Research backs-up the need for the VA to implement minimum direct-care nurse-to-patient ratios. In her landmark study on nurse-to-patient ratios, Linda Aiken concludes, "In hospitals with high patient-to-nurse ratios, surgical patients experienced higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burn-out and job dissatisfaction." The Aiken study also suggests that;

> "results suggest that the California hospital nurse staffing legislation represents a credible approach to reducing mortality and increasing nurse retention in hospital practice, if it can be successfully implemented. Moreover, our findings suggest that California officials were wise to reject ratios favored by hospital stakeholder groups of 10 patients to each nurse on medical and surgical general units in favor of more generous staffing requirements of 5 or 6 per nurse."

I have attached a copy of Linda Aiken's study for your review.

Question 3

Given the success of the magnet recognition program, is the UAN in support of this program? If not, why not?

Answer 3

The UAN supports any system that would improve care to patients, elicit nurse input, and produce better patient outcomes. Specifically, the UAN supports the magnet recognition program when it is properly implemented, with strong nurse representation and input. Since its inception, the Magnet Program has had significant growth in the private sector. To address some of the issues that have arisen from member states whose hospitals have undergone the Magnet process, the UAN has developed and has submitted a list of labor standards to the Magnet Program. The UAN is currently working cooperatively with the Magnet program to reach an agreement. We hope these standards will be incorporated in the Magnet Program to ensure nurse representation and increase patient safety. Major emphasis should be placed on the Magnet program's continued work with the state nurses associations who can provide the program confidential information from registered nurses at the on-site magnet hospitals.

The UAN supports the criteria and culture of the Magnet Program. We believe that the program will be successful if the Magnet program implements the UAN labor standards and works closely with state nurses associations. While the UAN feels that the Magnet Program is a positive step forward, we believe that it should not be a substitute for the legal voice of nurses brought through their unions.

Thank you again for the opportunity to address your questions. The UAN looks forward to working with you and your staff to address the important issue of VA's nurse staffing shortage. If you have any further questions or need additional information, please let me know.

Sincerely,

Ann Converso, RN
Vice President
United American Nurses, AFL-CIO

November 3, 2003

Arthur K. Wu, Staff Director
Subcommittee on Investigations
Room 337a

1. Please provide the Subcommittee with the success rate of the other recruitment programs you referenced in your testimony.

   - In 2001 Meridian Health System (MHS) started the Boomerang Program. This program reinstates former employees, who have left the system, with full benefits and seniority. Since the program commenced 17 RN's have returned to MHS.
   - MHS Recruitment initiatives include publicized events including Dinners at area restaurants with prominent guest speakers targeted to draw seasoned nurses.
   - MHS also hosts semiannual new graduate dinner recruiting events. At our most recent event 50 new graduates attended and 23 were hired as a result.
   - For the past several years MHS has expanded its externship program. This program allows senior nursing students the opportunity to shadow a staff RN over the course of their last summer. While these soon to be RN's are gaining valuable clinical experience to prepare them for the future, they are also compensated for their time, become acquainted with our working environment, build professional relationships and have the opportunity to work with future mentors. Currently 45% of nurse externs choose employment at Ocean Medical Center after graduation.
   - The employee referral program is an initiative that compensates current employees for referring a nurse to work at OMC. After the new staff members 90 introductory period, the referring staff member receives between $1000 and $6000 dollars depending on staffing needs. For example, the employee bonus for referral of a critical care nurse is $2000.
   - The C.A.R.E. program, which stands for Clinical Advancement and Recognition of Excellence, was created and developed by registered nurses in the Meridian family to show our nurses just how valuable their contributions are. This outcomes based clinical recognition program distinguishes and compensates nursing professionals who have readily achieved and consistently demonstrated increased levels of expertise while simultaneously making real, positive impact on patient outcomes. During its introductory year this program has received numerous

applications from staff who previously would have been excluded from recognition and salary advancement

- Nurses are compensated for Bachelors and Masters Degrees and achieving national certifications
- Up to $5000 annual tuition Reimbursement is offered to all nurses pursuing advanced nursing education.
- Scholarships: Meridian Health awards about $250,000 per year in nursing scholarships for students who are entering the profession and for nurses seeking to attain advanced degrees
- OFFER program: A program for employees enrolled in nursing programs to work Baylor hours on the weekend (two twelve hour shifts), receive full time pay and benefits including tuition reimbursement in exchange for a two year work commitment.

2. How do these programs compare with the results you have gotten with the Magnet Program?

Ocean Medical Center's nursing vacancy rate is 1.5%. Prior to achieving Magnet Status our rate was 9.2%. Since our initial Magnet accreditation in 1998 we have developed and expanded the initiatives in the first question. While there is no one magic bullet to address recruitment and retention, OMC has strived to create a comprehensive recruitment and retention plan through a network of multiple initiatives and marketing of our many opportunities. As a result, our vacancy rates continue to be well below national averages.

The greatest strategy employed by OMC is the working environment. Achieving Magnet Status has placed a spotlight on the importance of nursing services and highlighted its position within the organization. OMC strives for autonomous nursing practice and a blame free environment. The potential for error is always present. Our nurses report actual and potentials for errors through our blame free reporting mechanism. This has changed the culture to one of professional respect with an emphasis on safety and support.

3. In your statement you talked about the Human Capital Management's Talent Bank and the Talent Plus screening tool used to select employees. Could you elaborate on this and give more details about this screening mechanism?

Ocean Medical Center utilizes a program called Talent plus. This selection tool was designed by Talent +, a Lincoln, Nebraska Human Resource consulting firm. The tool has been in effect for over three years. Human Resources were trained to conduct both support and supervisory interviews.

Each Talent Plus Interview is carefully researched and validated to ensure that the questions differentiate the best performers from those who are mediocre or poor performers. Each Talent Plus interview is made up of behavioral elements or life themes, which research has shown to be essential to successful job performance. Following the completion of the interview questions, the interviewer has a "profile" of the varying strengths of the interviewee's life themes. This allows the interviewer to identify the success potential of the candidate in the particular position prior to making the hiring decision, avoiding costly hiring mistakes.

As previously mentioned the, life themes become a model for the interview design and describe the most important attributes for the identification of talent. Themes of Values, Work Intensity, Achievement, Positivity, Relationship and Resourcefulness are the foundation for the interview questions.

When a person's *Value* theme is intense, they are honest and straightforward in their dealing with others and find satisfaction in their work.

Work Intensity Strength in this theme indicates that this person thinks about work regardless of the time of day. This person is continuously productive.

An individual with a high *Achievement* theme needs to feel a sense of accomplishment and needs to make a significant contribution to the organization.

Positivity A person with strength in this theme understands that a positive attitude has an effect on morale and will do whatever has to be done with an enthusiastic, upbeat approach.

An individual with an intense *Relationship* theme is a service-oriented person who likes to work with other people and who works best when their relationships are on track.

Resourcefulness When this theme is intense, the individuals will utilize whatever means possible to achieve success at work.

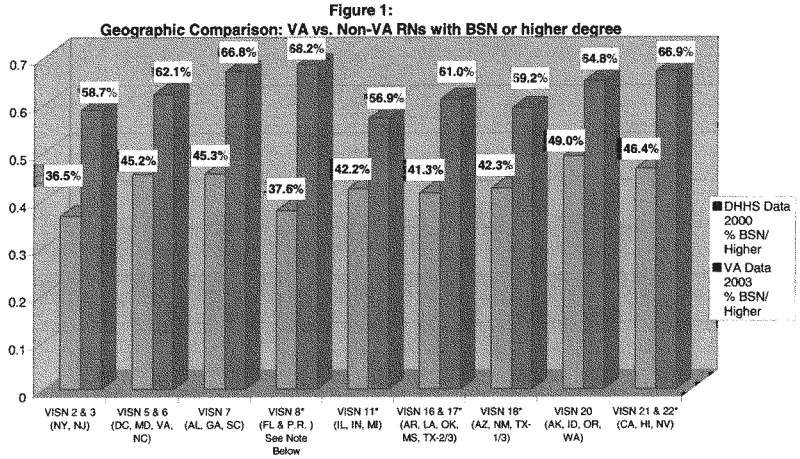
Respectfully Submitted,
Regina Foley
Vice President Nursing/Chief Nurse Executive
Ocean Medical Center
Brick, NJ 08724

Attached are the responses to verbal questions from Cong. Buyer and Cong. Hooley at the October 2, 2003, hearing re nursing shortages issues. These are separate from the "official" responses to the written questions. These are the deliverables from verbal questions during the hearing.

Deliverables from October 2, 2003 Hearing on Nursing Shortage

1. Cong. Buyer specifically requested information about how VA compares with the private sector in regard to percentage of nurses who have baccalaureate degrees on a geographic basis, vacancies, and turnover (e.g., VA nurses in Florida compared to private sector nurses in Florida).

Figure 1:
Geographic Comparison: VA vs. Non-VA RNs with BSN or higher degree



* VA Regions are called Veterans Integrated Service Networks or VISNs. VISNs do not explicitly correspond to state borders. Therefore, the closest approximation of geographic area has been included from DHHS data (provided by State/Region) to correspond as closely as possible to VA VISN boundaries. *Note: VA data for VISN 8 includes Puerto Rico; DHHS does not report data for Puerto Rico.*

Sources:
US Dept of Health and Human Services' Findings from the National Sample Survey of Registered Nurses, **March 2000.**
1/ Includes 4,077 nurses for whom highest nursing-related education was not known.

Figure 2:
Geographic Comparison: VA vs. Non VA RN Turnover Rates

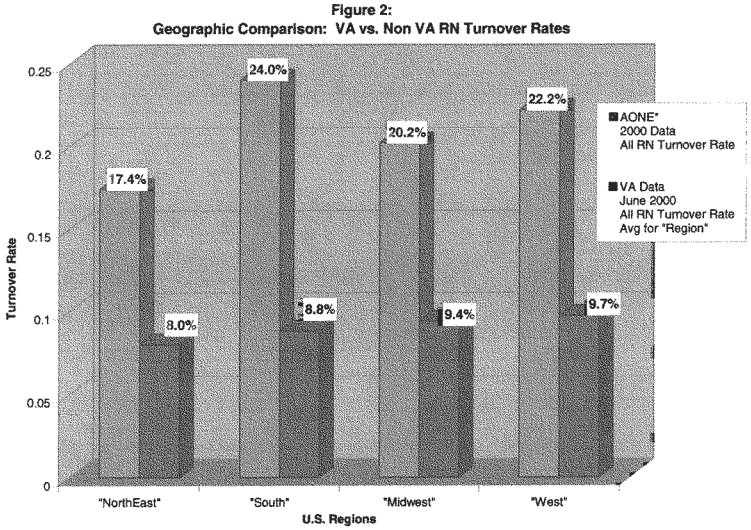
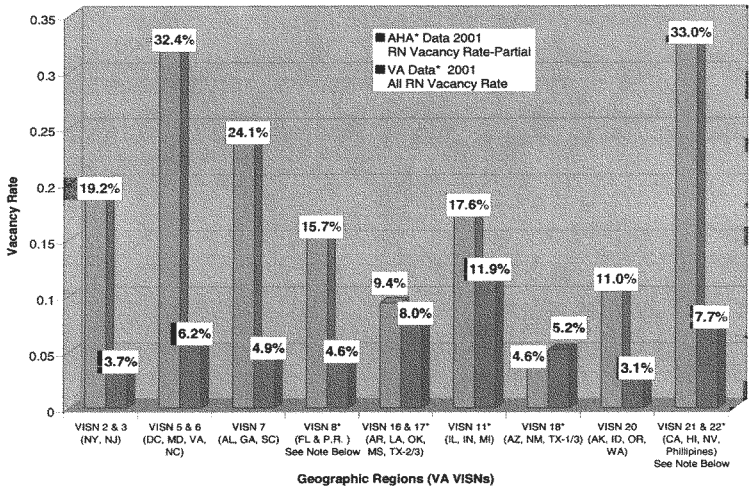


Figure 3:
Geographic Comparison: VA vs. non-VA, RN Vacancy Rates



2. Cong. Hooley requested information about how many VA nurses have joint faculty appointments and what VA is doing to assist nursing schools to increase the numbers of faculty.

At this time VA has no count of what is believed to be a growing number of VA nurses holding joint or shared faculty positions. VA is in active partnership with both the American Association of Colleges of Nursing and The National Organization for Associate Degree Nursing to support the growth of joint or shared faculty models in which clinically employed masters prepared nurses assume faculty responsibilities for didactic or clinical teaching as part of their VA role. In the spring of 2002, Office of Nursing Services staff made site visits to VA medical centers and schools of nursing with strong joint/shared faculty models. Based on the information gained from these visits, a nationally televised broadcast (VA internal TV network, October 29, 2002) was produced to encourage VAMCs to enter into such models with local colleges and universities. Videos of the broadcast were distributed to all VA medical centers following the broadcast. Videos of this broadcast were sent to the House Veterans Affairs Committee prior to the October 2, 2003 hearing on the National Nursing Shortage. In addition, VA is in the early stages of developing a proposal through which masters prepared registered nurses would receive the formal training in academic and teaching skills that would enable them to assume joint/shared faculty roles in schools of nursing. At this time, we cannot say when the proposal will be complete. VA views such relationships as "win-win" opportunities-faculty numbers are augmented at schools of nursing, and an increased number of students have positive clinical and classroom experiences with VA staff that can later lead to the students' seeking VA employment.

3. Cong. John Boozman (R-AR) requested information about whether the operating expenses for a program such as VAMC Tampa with magnet status is more or less expensive than a program without the status or use of strategies used in magnet programs.

VA has recognized the need for information regarding the costs and outcomes of a magnet recognized facility. As a result, the Office of Nursing Services supports the Tampa VAMC "Building a Business Case for Magnet Designation" designed to evaluate costs and outcomes resulting from magnet designation. These data will reach a worldwide audience since the American Nurses Credentialing Center has elected to partner with VAMC Tampa in this endeavor.

4. Cong. Buyer requested statistical information about the outcomes for the educational and other programs described by Ms. Raymer. He asked for data about how they have improved retention.

The VHA Office of Health Care Staff Development and Retention is collecting this data. Based on the design of the database being implemented, it is anticipated the data will be available in January 2004.

5. Cong. Hooley asked for information VA works with its labor partners in applications for magnet status and other areas.

Consistent with a philosophy of partnership, VA formed a National Partnership Council that meets face-to-face quarterly and by teleconference on the other months. The Council is made up of representatives of each of VA's nationally recognized bargaining units (American Federation of Government Employees, Service Employees International Union, United American Nurses, National Federation of Federal Employees and National Association of Government Employees). Issues that impact the work environment and patient care are routinely discussed and recommendations from such discussions are forwarded to the Secretary and/or appropriate VA administrators. Pursuit of Magnet status for VA's medical centers has been discussed with the leadership and members of this group. The Office of Nursing Services plans to brief the Partnership Council on VHA's Vision for Magnet Recognition. In addition, the magnet application process is one of involvement of nursing staff at all levels from the initial stages of exploring whether magnet status will be pursued through the development, application and review process, and beyond. VA medical centers pursuing magnet status are actively involving all nursing staff in the process including their labor partners.

6. Cong. Buyer requested that Ms. Rick provide a plan about how VA would encourage medical centers and other VA facilities to achieve magnet status.

With the magnet designation of Tampa VAMC, the VA magnet rate is presently 0.6 per cent, compared with the U.S. rate of 1.4 per cent (see Response #2 above). It is our vision that 50 per cent of all VA medical centers will be eligible for magnet status by FY 2007 and 90 per cent of all VA medical centers will be eligible for magnet status by FY 2010. Consistent with its significant commitment to Baldrige standards, VA recognizes the value of the magnet recognition process. The Office of Nursing Services will serve as a catalyst to support and assist VA facilities in their journey to magnet recognition. We recognize that while all facilities may not attain magnet status, the "magnet journey" process itself is valuable.

The Veterans Health Administration has implemented a number of programs that now form the foundation for facility magnet recognition, among these are:

- Leadership Development Programs for both nurse executives and nurse managers are in process. These programs enhance leadership skills and abilities specific to creating and fostering work environments found in magnet hospitals.

- VA Nursing Outcomes Database Project (VANOD) is a 16-month project for creating a database of nursing sensitive quality indicators that will enable exploration of relationships between nurse staffing and patient outcomes, evidence-based decision-making, and benchmarking for testing

best practices. The resulting database will yield information required by VA medical centers in their magnet applications. The nursing sensitive quality indicators include falls, pressure ulcers, skill mix, staffing, staff musculoskeletal injuries, patient satisfaction, and RN satisfaction. Twelve randomly selected VA hospitals are included in this pilot project. Two VA Health Services Research teams are participating in the building of the database: VA Puget Sound in Seattle is creating data submission methods and database structure while the Management Decision and Research Center in Boston is creating reporting formats from the data. Future planning is underway to establish nation-wide VA roll out, development of more indicators, and expansion to other care settings such as long-term care and ambulatory care.

- The Tampa VA Medical Center nursing staff are playing pivotal roles as consultants, trainers and coaches to assist their VA colleagues in preparation for magnet recognition.

In the future, VA's support will take the form of staff support, education, consultation and the development and distribution of toolkits. Further, the Office of Nursing Services will work closely with VHA's National Leadership Board to ensure that the resources needed by VA facilities to implement the cultural and organizational changes necessary to magnet attainment are in place.

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