THE NURSING CRISIS

MAINE INITIATIVES

February 1989

A Report by:

The Commission to Study the Status of Nursing Professions in Maine

Commission to Study the Status of Nursing Professions in Maine

(Resolve 1988, Ch. 106)

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I. INTRODUCTION

This Commission report does not profess to be the "Be all and end all" concerning all the problems and concerns of allied health professionals, nurses and prospective nurses in the State of Maine today. However, we believe it will serve as a vehicle for debate and discussion during the critical months and years ahead. Although our recommendations deal primarily with the nursing profession, there are several recommendations which will help many of the allied health professions as well as nurses in the State of Maine.

The report is divided into two parts. The first part is a current analysis of demographic, employment, and market trends which will affect the variety of problems and corresponding solutions enumerated within this report. Included in the first part is a brief synopsis of the current regulations relating to reimbursement for nursing staff in health care institutions in the state. An understanding of those regulations and how they function is crucial to any understanding of a significant portion of the problems we face as a state concerning nursing.

The second part of the report examines attitudinal, and demand/supply issues with corresponding Commission recommendations.

We want to express our deep appreciation to all those who attended our Commission meetings and those who took the time to express their opinions concerning the crisis either personally or via phone or mail.

We also want to thank the staff for their diligent work during these past 6 months. It should be noted that during that 6 month period, the Commission membership and staff logged some 87 hours of meeting time which included receiving thousands of pages of documents, 21 hours of public testimony in 5 locations around the state; 66 hours of testimony/discussion in Augusta, with 144 individual presenters and over 260 individuals who attended one or more of our 16 meetings.

We thank all those who participated in this process and express the hope that our work will be responsive to the concerns they raised.

PART ONE

II. MAINE DEMOGRAPHICS

The demographics of the State of Maine, as in the nation as a whole, will have a significant effect on the need for persons in the nursing occupations and the supply of persons for nursing occupations. By 1994, Maine's population of persons age 65 and over will number 173,550 which represents a 12.7 percent increase over the number in 1984. This population characteristically requires the most medical services.

The population age 45 and over will number 428,300 representing a 14.5 percent increase. This entire population often need medical services more than those persons 44 and younger.

In relation to the supply of persons for nursing occupations, the most important demographic trend affecting labor supply is the decreased number of young entry-level workers. Between 1984 and 1995, the number of persons ages 18 to 24 will decline by 24,020 or 18.8 percent. This will create a new challenge in meeting labor demand by increasingly focusing on people already in the labor force.

Population By Age Group, 1980, 1984 to 1994, Maine

Source: Maine Department of Human Services

Age	1980	1984	1994	Change 1984-1994 Net	Change 1984-1994 Percent
Total	969,265	1,156,680	1,220,710	64,030	5.5
Under 10	207,631	165,730	172,130	6,400	3.9
10-14	93,347	87,340	86,370	-970	-1.1
15-17	48,115	54,740	50,010	-4,730	-8.6
18-19	26,974	32,520	27,640	-4,880	-15.0
20-24	58,310	95,300	76,160	-19,140	-20.1
25-44	234,799	347,050	380,100	33,050	9.5
45-64	**193,545**	**219,950**	**254,750**	**34,800**	**15.8**
65+	**106,544**	**154,050**	**173,550**	**19,500**	**12.7**

III. WOMEN'S PARTICIPATION IN THE LABOR FORCE

Introduction

"The rise in the number of working women is probably the single most important change that has ever taken place in the American labor market."[1] The increase in sheer numbers of working women in the past 30 years dramatically emphasizes this change. "By 1986, nearly 52 million women were working (nationwide), about 200 percent more than at the end of World War II. In contrast, the number of men in the labor force increased by only 50 percent."[2] As the labor force participation rate for women has been rising, the rate for men has been declining and therefore suggesting a long term convergence in the participation rates for men and women.

In Maine the labor force participation rates for males and females in the younger age groups more closely parallel each other. That trend will gain more and more significance as these people grow older, producing a labor force influenced by an even greater proportion of women.

Later Marriage, Delayed Birth of Children, and Childlessness

One factor leading to a higher employment rate among younger women is the tendency to put off marriage. According to national figures 58.5 percent of women aged 20 to 24 had never married in 1985, up from 50 percent in 1980. Also more women are waiting longer to have children and childlessness is on the rise. Nationally, between 1976 and 1985, the percentage of women in the age group 25 to 29 who have never had children increased from 31 percent to 42 percent, age group 30 to 34 increased from 16 to 26 percent and for those 35 to 39 from 11 to 17 percent. From another point of view--the number of young childless couples increased by 75 percent between 1968 and 1985, while the number of young couples with children increased by only eight percent.

Women With Young Children in the Labor Force

Fifty-one percent of women with children younger than age three were working in 1986, up from 34 percent just since 1975. Fully 66 percent of these mothers work full-time, as mothers of infants and toddlers continue to be one of the most rapidly growing segments of the labor force. Among the nation's 33 million women with children under 18, 63 percent work and 72 percent of those mothers work full-time.

Dual-Earner Families

Dual-earner couples account for more than half of all marriages. Women with a greater number of years of schooling tend to be more attached to labor force. As the educational gender gap is disappearing, the economic role of women is growing.

More Education For Women

In the years 1984 and 1985, 1,989 men and 2,204 women received degrees from the University of Maine (all campuses). Degrees awarded to women (baccalaureate, masters and doctorate combined) outnumbered degrees awarded to men in Communications, Education, Fine Arts, Foreign Languages, Health Professions, Human Development, Letter, Psychology and Public Affairs.

According to a national survey, nearly half of all people in their late 20s have a least some college education, but among those in their 60s, the figure is only one in five. The more educated women tend to be more career and achievement oriented postponing childbirth and re-entering the job market soon after the birth of a child.

Families Headed By Single Parents and Divorce

Another factor bringing more women into the work force is that there are many more single mothers who have to work to support their families. Families headed by men or women without spouses are the fastest growing household type. There are approximately five times as many families headed by single women than those headed by single men. "At current rates, six out of ten American women now in their 30s will go through at least one divorce. Among the 70 percent who remarry, 52 percent will go through a second divorce."[3]

Displaced Homemakers

Displaced homemakers are women who often re-enter the work force because of economic necessity, usually because of divorce or their husband's death. National figures show that 42 percent of displaced homemakers are divorced or separated, 39 percent are married to a disabled or unemployed husband or 19 percent are widowed. Seventy-one percent of displaced homemakers are 35 to 54 year old; 29 percent are 55 to 64 years old. Almost half -- 45 percent -- of those women make less than $10,000 a year. Another 30 percent earn between $10,000 and $20,000.

Women's Earnings

According to 1980 Census figures for Maine, women who worked year round, full-time had median earnings of 63.9 percent of men's earnings. A Current Population Survey found women's median weekly earnings at 68.1 percent of men's median weekly earnings in 1985 when compared for more than 200 occupational categories. Both the 1980 Census data for Maine and the 1985 Current Population Survey data found no occupation where women's wages equaled or surpassed men's, no matter how high the concentration of male or female participation.

IV. YOUTH AND ELDERLY IN THE LABOR FORCE

Fewer Youth in 1990s

The abundance of young adults will wane in the 1990s. By 1994, the number of people aged 15-19 is projected to decrease by 27.7 percent, and the number aged 20-24 to fall by 22.6 percent from 1980. In Maine, the number of people aged 15-19 will fall from 107,412 in 1980 to 77,650 in 1994. Those aged 20-24 will fall from 98,438 in 1980 to 76,160 in 1994.

The contraction of the 15-24 year old age group reflects the low birth rate years in the early 1960s and mid 1970s. Compared to the peak of the baby boom when 23,900 babies were born in 1947, only 15,000 were born in 1976. The low number of births in these years reflects both a smaller number of women of child-bearing age and a small number of children per woman.

Shortage of Youth for 1990's Labor Force

The decrease in the number of youth projected for the 1990s will be reflected in the supply of entry-level workers in the labor force. Fewer young entry-level workers will be available to employers than in past decades. Employers may be able to partially alleviate the shortage of entry-level workers by tapping into an underutilized source of labor--the disadvantaged youth, such as high school dropouts. These youth, if educated in the basic skills, may be drawn into the economic mainstream to help meet the projected labor shortage. New entry-level workers have traditionally been a significant source of new skills needed by employers to respond to changing technologies and other innovations. In the future, however, employers will have to become more active in providing training to experienced workers to meet demand for new skills.

Elderly

In contrast to the diminishing youth cohort, the older population segment is expanding. Maine's 65 and over age group has increased steadily from 106,544 in 1960 to 140,918 in 1980. Population projections developed by the Maine Department of Human Services show that this age group will grow from 154,050 in 1984 to 173,550 by 1994, an increase of 12.7 percent. This projected growth represents a rate of 23.2 over 1980.

Labor force participation of the elderly has consistently fallen for at least twenty years, a trend which will most likely be reversed in the coming decade. Since 1960 the percentage of people 65 and over in the labor force dropped from 19.0 percent to 10.9 percent in 1980. In the 1990s we can expect that more people in this age group will continue working. Not only has advanced medical care prolonged the good health and productivity of older workers, but they will be more in demand as well.

The shortage of youth in the 1990s labor market will create new job opportunities for the elderly. Employers are expected to focus on the more abundant older workers to meet labor needs formerly filled by new young workers. The shift in demand to older workers for entry-level jobs is already evident as employers in the fast food business are now making special recruiting drives aimed at senior citizens.

Overall, the increasingly aging work force is expected to result in personnel objectives being directed towards retaining and training older workers. For those 65 and over, employers will focus on redesigning retirement plans to give people incentives to continue working in some capacity.

V. THE MAINE JOB MARKET IN 1995

The most current forecasts show that Maine's labor force is expected to increase by about 114,000 (20.6 percent) between 1985 and 1995. At the same time, total employment is expected to increase by 117,000 (22.4 percent). The implications are an even lower unemployment rate by 1995, and a much tighter labor market with more competition for workers--particularly younger workers.

At the same time the workplace is expected to change significantly. Some manufacturing jobs will be restructured. Many of the job openings will require individuals with different education and skills as new technologies replace old methods. Much of the employment gain between 1985 and 1995 will come from the trade and services sectors, but even in those sectors many jobs will become obsolete and replaced by jobs requiring new and different skills and abilities.

To the extent that employers cannot depend on the skills of new entrants, retraining of those already in the labor force will be required. In addition there is an apparent growing misalignment between those jobs requiring education and skills and many Maine workers who often lack the necessary skills and education. This often leaves high skill jobs unfilled.

At the same time, many of the new jobs, particularly in trade and services, will be low-wage, part-time jobs offering less opportunity for advancement. Competition for workers to fill these jobs is expected to be intense due to the shortage of younger workers. This should not detract from the need to educate and upgrade the skills of Maine workers to provide the healthy business climate necessary to attract industries needing a skilled and creative work force.

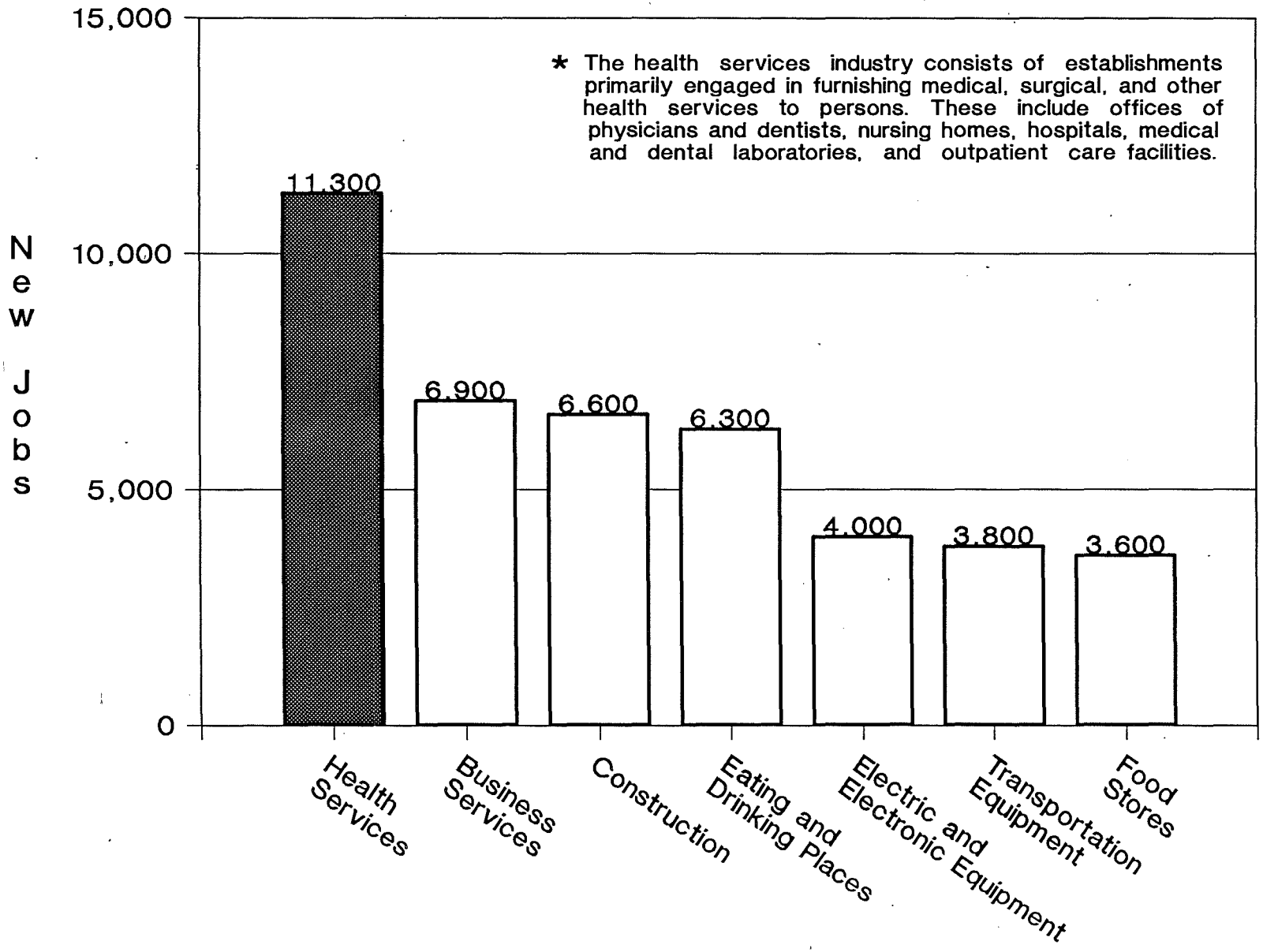
Of all the industries in the state, the health services industry is expected to add the most new jobs during this projection period.

The health services industry consists of establishments primarily engaged in furnishing medical, surgical, and other health services to persons. These include offices of physicians, offices of dentists, nursing and personal care facilities, hospitals, medical and dental laboratories, home health care services and out patient care facilities. Growth in this industry is expected to create 11,300 jobs as employment increases from 39,200 in 1984 to 50,500 in 1995, representing a 28.8 percent gain. This is a faster growth rate than the average for all occupations, and represents a vast number of job opportunities for workers in the health fields.

Historically, the health services industry has made tremendous gains in employment. Over the past 14 years from 1974 to 1988, employment has increased by 80 percent from 24,400 workers to 43,900.

Following is a table showing the seven industries which are expected to add the most new jobs during the projection period:

Seven Industries with the Greatest Number of New Jobs Expected Between 1984 and 1995 Maine



Window of Opportunity

The job market between now and the year 2000 in Maine and the United States is expected to grow at a faster rate than the number of available workers. This development is in contrast with the experience of the 1970s and most of the 1980s when the growth in the number of available workers exceeded the increase in the number of available jobs. The labor market of the future opens a **window of opportunity** for those population groups who have not been able to participate more fully in the growing economy of the past because of their disadvantaged situation or dislocation. Practitioners in the employment and training community, as effective intermediaries in the job market, will see their roles increase substantially. The bottom line is that a very special opportunity is developing whereby we can bring more of the disadvantaged and others seeking employment into the economic mainstream for their personal growth while contributing to business profitability and industrial and industrial vitality.

VI. EMPLOYMENT OF SELECTED NURSING OCCUPATIONS*

Registered Nurses

Employment of registered nurses is expected to increase at a rate faster than the average for all occupation. In 1984, there were an estimated 6,950 registered nurses employed in Maine, including both full and part time, by 1995 there will be 9,300 employed. This represents a 34 percent increase over the projection period. Over 63 percent of all RNs are employed in hospitals, 8 percent in nursing and personal care facilities, and 4 percent in offices of physicians. The fastest employment growth for RNs is expected in nursing and personal care facilities and offices of physicians. However, the increase in employment expected in hospitals will produce the most job opportunities since such a great proportion of hospital employment (about 1/4) consists of RN's. Not only will there be over 200 new positions for registered nurses created each year by growth of employment in the health services industry, but an additional 350 will be needed to replace registered nurses through attrition from the labor market. And still additional workers will be needed to replace those who leave due to occupational and geographical mobility. This could represent another significant need for more registered nurses.

Licensed Practical Nurses

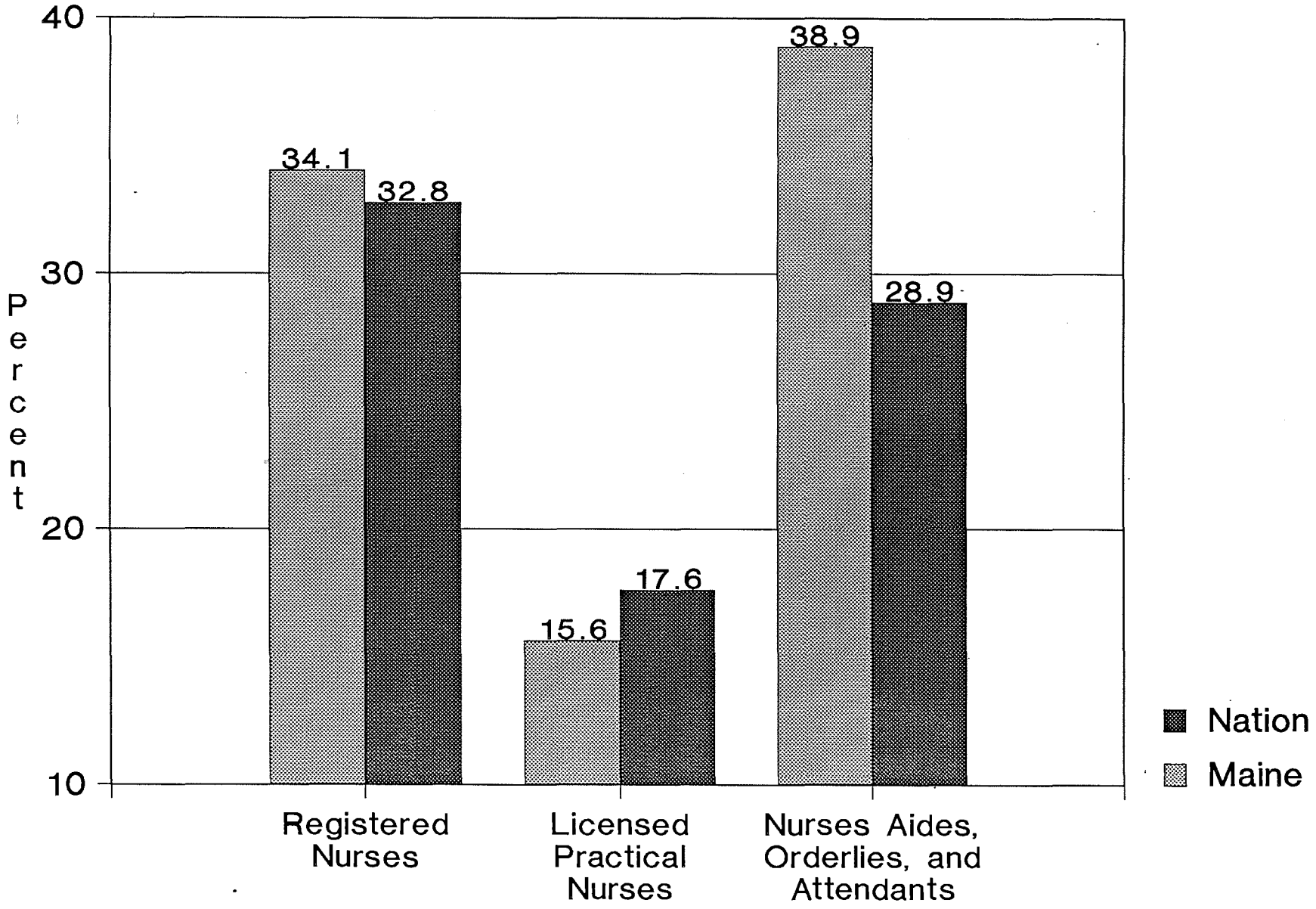
In 1984, there were an estimated 2,950 licensed practical nurses employed in Maine, including both full and part time. By 1995 there will be 3,400 employed. This represents a 15 percent increase over the projection period. Hospitals employ 63 percent of LPNs and nursing and personal care facilities employ 21 percent. Industrial growth will create a need for 50 LPN positions each year, while attrition needs will produce 150 openings each year.

Nurse Aids and Orderlies

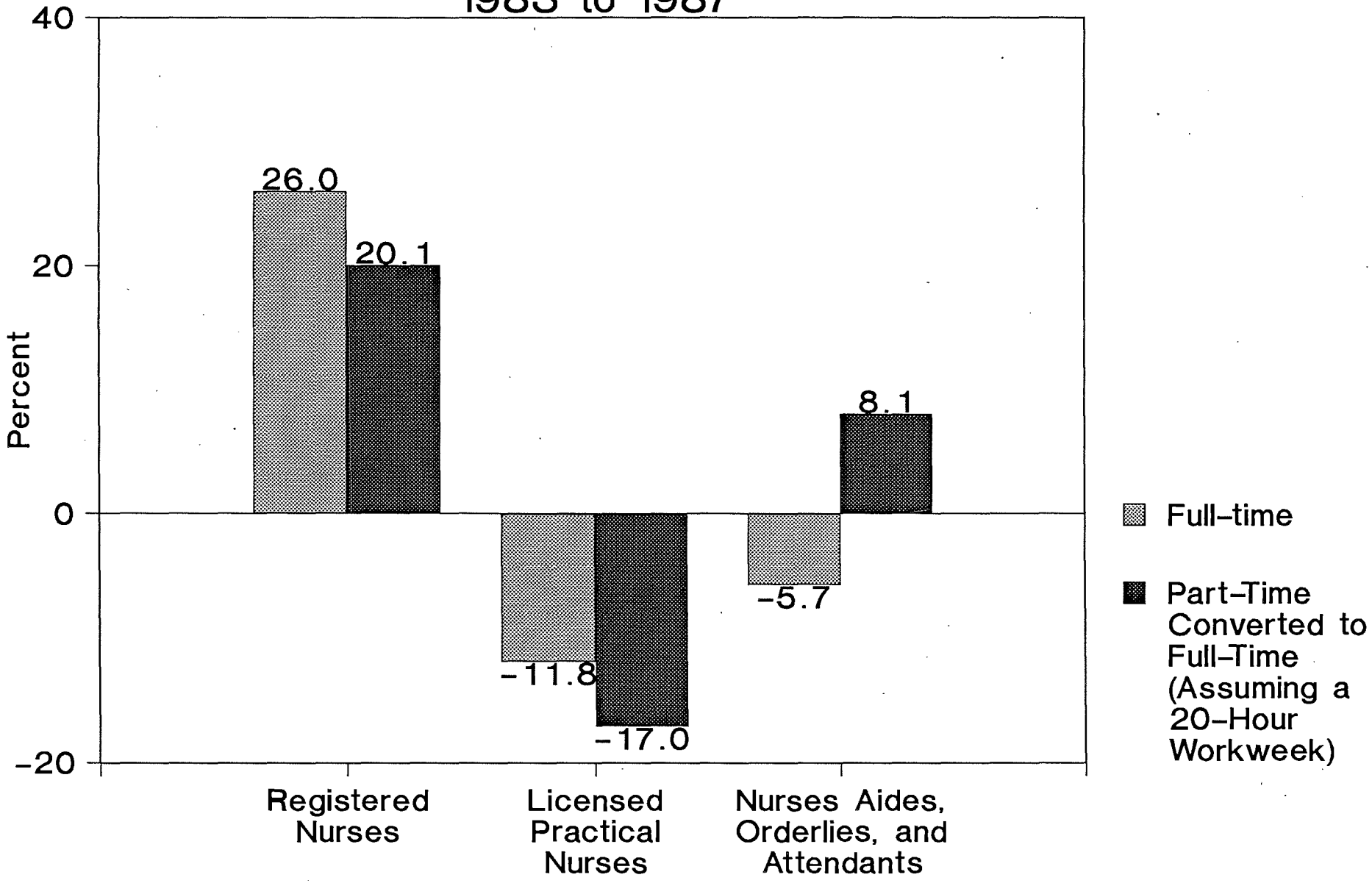
Employment of nurse aides and orderlies was estimated at 8,500 in 1984, including both full and part time. This is expected to grow to 11,900 by 1995, representing 39 percent increase over the projection period. This is one of the largest occupations in terms of employment in the State of Maine. It ranks third in terms of openings in the job market. This growth is expected to create 300 new jobs each year through the projection period. Attrition will create nearly 400 additional job opportunities each year for prospective nurse aides and orderlies. In addition, vacancies created by workers leaving their positions to accept jobs in other areas or other occupations is a very significant figure.

*See appendix (A)

Projected Percent Increase of Employment in Nursing Occupations 1984 to 1995 Maine and Nation



Percent Change in Total Employment for Selected Nursing Occupations in Maine Hospitals 1983 to 1987



Ten Occupations with the Largest Amount of Projected Growth in Maine and the Nation Annually Between 1984 and 1995

Occupations	Average Annual Number of New Jobs Expected Between 1984 and 1995
Maine	
Cashiers	330
Janitors and Cleaners	313
Nursing Aides, Orderlies, and Attendants	**304**
Sales Clerks	269
Carpenters	233
Registered Nurses	**215**
Teachers, Preschool and/or Elementary School	209
Food Preparation and Service Workers, Fast Food Restaurant	177
Managers, Store	174
General Clerks, Office	158
United States	
Cashiers	50,500
Registered Nurses	**41,100**
Janitors and Cleaners	40,300
Truck Drivers	38,900
Waiters and Waitresses	38,500
Wholesale Trade Salesworkers	33,500
Nursing Aides, Orderlies, and Attendants	**31,600**
Salespersons, Retail	31,200
Accountants and Auditors	27,900
Teachers, Kindergarten and Elementary	25,500

Source: Maine Department of Labor

Projected Employment Growth Rates of Selected Occupations, 1984-1995, Maine and Nation

Occupation	Rate	
	Maine	U.S.
Paralegal Personnel	89.5	97.5
Medical Assistants	58.8	62.0
Computer Programmers	54.5	71.7
Computer Systems Analysts, Electronic Data Processing	51.3	68.7
Nurse Aides and Orderlies	**38.9**	**28.9**
Accountants and Auditors	38.2	34.8
Lawyers	38.2	36.6
Mechanical Engineers	37.6	34.0
Registered Nurses	**34.1**	**32.8**
Physical Therapists	**27.5**	**42.2**
Licensed Practical Nurses	**15.6**	**17.6**

Source: Maine Department of Labor

VII. HEALTH LABOR REIMBURSEMENT
(Current Provisions of Law)

Hospitals

A. Adjustment for Economic Trends

Each year the Maine Health Care Finance Commission must determine a hospital's reasonable financial requirements and establish a revenue limit that is sufficient to yield the income the hospital needs. The manner in which a hospital's financial requirements are determined is defined in the statute and the Commission's rules. As required by 22 MRSA Section 396-D (1), the Commission adjusts a hospital's financial requirements to accommodate the impact of economic trends such as inflation on the prices the hospital must pay for necessary goods and services including the services of its employees. The manner in which this adjustment is computed is defined in Chapter 322 of the Commission's rules.

Each hospital divides its expenses into ten categories or "cost components." The proportion of the hospital's expenses included in each category is known as the "cost component weight." As required by law, the Commission has identified a "proxy" to measure and project the effect of economic trends on each category of expenses. For example, the proxy that is used to measure and project changes in the price of "Food" is the "Consumer Price Index, Food at Home, Boston, Massachusetts." The projected change during a year is known as the "proxy value."

The cost component with the greatest weight is "Wages, Salaries and Fringe Benefits." It rarely included less than 50% of a hospital's expenses. Many small hospitals report that it includes more than 60% of their expenses.

The Commission has divided this cost component into four sub-categories and used studies of hospitals' compensation expenses conducted by the Prospective Payment Assessment Commission to assign a weight to each of them. These sub-categories and weights are identified in the following table:

Sub Category	Weight
Professional & Technical employees salaries and wages	50.30%
Managers' salaries and wages	6.26%
All other employees' salaries and wages	29.29%
Fringe benefits	14.15%
	100.00%

Proxies are used to measure and project change in each sub-category. The "Average Hourly Earnings of Hospital Workers" in the Northeast, which is published quarterly by Data Resources, Inc. (D.R.I.) of Lexington, Massachusetts, is used to measure and project change in the first sub-category, the salaries and wages of professional and technical employees. The use of this proxy assures that the additional amounts made available to Maine hospitals match the increases granted by the hospitals throughout the region with which they now compete for the services of nurses and other professional and technical personnel. The proxy used to measure and project change in the salaries and wages of managers is the "Employment Cost Index, Managers and Administrators, National." The Commission has engaged

Data Resources, Inc. to produce quarterly measurements and projections of change in the average weekly earnings of retail trade and service workers in each of four Maine regions. These projections are used as the proxies for the third sub-category, the salaries and wages of all other hospital workers. The proxy for the fourth sub-category, employee benefits, is the "Supplements to Wages and Salaries Per Employee in Non-Agricultural Settings, New England."

An example of the manner in which a hospital's financial requirements are adjusted to accommodate the expected impact of economic trends on its compensation expenses is presented below. The proxy values reflected in this example are identical to those that will be issued in determining the financial requirements of hospitals in southern Maine that will begin their fifth payment year on July 1, 1989.

Step #1. Compute the aggregate proxy value for the "Wages, Salaries and Fringe Benefits" cost component.

Sub-Category	Weight		Proxy Value		Weighted Value
Professional & Technical employees' wages	.5030	x	.07	=	.0352
Managers' wages	.0626	x	.052	=	.0032
All other employees' wages	.2929	x	.078	=	.0228
Fringe Benefits	.1415	x	.058	=	.0082
Aggregate proxy value					.0695 or 6.95%

Step #2 Determine the product of the hospital's current financial requirements, the proportion of its expenses included in the "Wages, Salaries and Fringe Benefits" cost component, and the aggregate proxy value for that cost component.

Financial Requirements		Cost Component Weight		Proxy Value		Adjustment
$10,000,000	x	.55	x	.0695	=	$382,250

In this example, the hospital would receive an additional $382,250 to accommodate the expected impact of inflation and other economic trends on its employee compensation expenses. However, the Commission does not limit the manner in which the hospital uses the income it receives from the delivery of patient care services. Thus, the hospital could choose to divert some or all of these resources to other purposes or, conversely, grant its employees even greater increases to be supported by savings in other areas of its operation.

In order to assure that neither the hospital nor payers are adversely affected by a discrepancy between the projected and actual impact of inflation and other economic trends on employee compensation expenses, the Commission adjusts its calculation of the hospital's financial requirements during the subsequent payment

year to correct any discrepancy. For example, if the actual impact of such trends during the year beginning July 1, 1989 is 7.45 % rather than the projected 6.95%, the projected increase for the year beginning July 1, 1990 will be increased by 0.5%.

B. Special Adjustments For Necessary Increases In The Compensation Of Nurses And Other Medical Professionals.

In July of 1988, the statute was amended to authorize the Commission to adjust a hospital's financial requirements to accommodate increases in compensation that are necessary to recruit or retain nurses and other medical professionals in short supply. The specific tests a hospital must meet to receive such an adjustment are found in 22 MRSA Section 396-D (9)(G). The hospital must demonstrate:

1) That the increase for which the adjustment are sought is reasonably necessary to recruit or retain the classes of employees to which they are granted;

2) That such increases are in excess of the increases attributable to the proxy value for "Wages, Salaries and Fringe Benefits" included in the hospital's adjustment for economic trends;

3) That the hospital has granted such employees increases in compensation equal to the proxy value for "Wages, Salaries and Fringe Benefits" during prior payment years; and

4) That the hospital will experience an "economic hardship" in the absence of the requested adjustment.

The statute defines the term "economic hardship" to mean that the hospital's reasonable non-capital operating expenses will exceed the amount the Commission has determined it to need for its daily operations. For example, if a hospital grants its nurses wage increases that will increase its non-capital expenses by $1 million to $10 million and the Commission has previously determined it to need $9.5 million, its "economic hardship" is $500,000. The maximum amount the statute permits the Commission to add to the hospital's financial requirements is the amount of its economic hardship. Thus, in this example, if the hospital is able to show that it meets each of the tests described above, the Commission would add $500,000 to its financial requirements.

The Commission does not require that a hospital seek and receive approval prior to granting increases for which it seeks an adjustment. Under the Commission's rules, hospitals are permitted to increase their charges during the course of a payment year as long as they do not exceed the higher of their prospectively established revenue limit or the final revenue limit computed after their payment year has ended. The majority of hospitals that have applied for adjustments have been granted the increases they deemed necessary to retain or recruit the employees in question prior to the filing of their applications. As long as they have filed a completed application before their payment year has ended, they are accorded the same treatment as those hospitals that choose to hold any compensation increases in abeyance until their applications have been approved.

The Commission has now approved 12 hospitals' applications. In each case, discussions between the applicant, the Commission's staff and interveners have produced an agreement that has been presented to the Commission by its Executive Director and approved. Formal evidentiary hearings have been needed in only one case, which has not yet been concluded. The adjustments granted hospitals reflect

salary increases, increased shift differentials, bonuses, the creation of clinical ladders, changes within established salary ranges, and innovative staffing arrangements such as the "Baylor Plan." They also reflect any increases in the cost of fringe benefits that are directly related to the approved increases in compensation. Thus, for example, the adjustment granted a hospital that has increased its nurses' wages by $1 million a year will typically include the resulting increases in social security taxes, unemployment compensation taxes, contributions to the hospital's pension program and the premiums it pays for group life insurance.

The adjustments granted hospitals under this provision of the statute are expected to add approximately $13 million to their financial requirements during the fourth payment year cycle. Their annual impact is expected to increase to at least $28 million during the fifth payment year cycle.

Skilled Nursing Facilities

Skilled nursing facilities provide long-term and short-term nursing care to individuals who require the presence of a nurse twenty-four hours a day, or whose condition is such that they require the higher level of nursing care provided in these facilities. Both Medicare and Medicaid cover skilled nursing services when medically necessary, as do many private insurance plans. There are presently 23 Medicare and Medicaid certified skilled nursing facilities in Maine with 536 beds, located in distinct parts of hospitals or in free-standing nursing homes. Reimbursement for skilled nursing facilities is established under the Medicare Principles of Reimbursement. This is a retrospective system under which an interim per diem rate is established based on allowable costs, and adjustments are made in the form of either additional payments to the facility or money owed the program following audits. All payments must be the lower of cost or charges and Medicaid payments cannot exceed the "Medicare Upper Limit," established on a state-wide basis. This is an aggregate of all facilities. There is also a routine service cost limit (Section 223 of the Social Security Act) that is computed on a regional basis related to urban vs. rural areas.* These rates are established by annual publication in the Federal Register. Medicaid payments for SNF care are based on the Medicare system, and therefore subject to retrospective adjustments.

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* Region I included York, Cumberland, Sagadahoc, Lincoln and Knox Counties.
Region II included Androscoggin, Kennebec, Oxford, Franklin and Comerset Counties.
Region III included Penobscot, Piscataquis, Waldo, Hancock and Washington Counties.
Region IV includes Aroostook County.

Intermediate Care Facilities

Intermediate care facilities (ICF) provide long-term care to persons who do not require the degree of care provided by a skilled nursing facility. There are presently 134 ICF's for the elderly and disabled with 9,118 beds and 43 ICF/MR facilities with 724 beds. All nursing homes of 50 beds or more are required by state licensure regulations to have licensed nurses twenty-four hours a day. Medicaid is the primary funding source for ICF care, covering about 75% of the patient days at any given time. In 1983 Maine adopted a prospective payment system for ICF's for routine operating costs in which the rate was established on the "base year" of fiscal years ending between 7/1/82 and 6/30/83. Thereafter the rate was increased each year according to an inflation factor computed by Data Resources, Inc. (D.R.I.)on the "market basket" for skilled nursing facilities. Until 1988, adjustments were also made in the per diem rate when a facility experienced "savings," or excess revenues

over allowable costs. These "savings" were shared with the State, and the rate "ratcheded down" to reflect actual costs. In November, 1986 regulations were adopted to allow adjustments in the per diem rate for facilities experiencing recruitment and retention problems in nursing staff. At that time, the costs of basic Certified Nursing Assistant training programs were also added as allowable costs as a "pass-through." All capital costs and certain other costs were paid separately as "fixed costs" based on actual, plus a return on equity and depreciation. Since the regulations allowing adjustments for wage increases were adopted, the Department has approved additional Medicaid costs of $7.1M, of which the State share is $2.4M. The Department is proposing a change in the Principles of Reimbursement that will provide for reimbursement for actual wages and hours worked, with adjustments to be made at the time of audit. Intermediate care facilities are subject to the same Federal limits, in that Medicaid reimbursement cannot exceed the "Medicare Upper Limit," determined by establishing what the costs would be under the Medicare Principles of Reimbursement. This is a state-wide limit based on an aggregate of all facilities. ICF's are also subject to the routine service cost limit (Section 223 of the Social Security Act) computed on a regional basis related to urban vs. rural areas and published annually in the Federal Register. Facilities may request exceptions to the upper limit but in the aggregate State Medicaid payments for ICF's may not exceed the upper limit.

Intermediate care facilities for the mentally retarded are exempt from the Medicare Upper Limit constraints and the Section 223 Upper Limits.

Boarding Care Facilities

All State-assisted boarding homes for the elderly of six beds or less are reimbursed at a flat monthly rate of $483. Boarding homes for the mentally retarded of any size and homes of more than six beds are reimbursed based on costs. There are presently 123 boarding homes with 2,309 beds reimbursed on a cost basis. The rate includes routine operating costs up to a monthly cap of $711 plus the actual "fixed costs," for capital and certain other expenses. Recently a 12% increase was granted to the administrative allowance. Payments to cost-reimbursed boarding homes are subject to retrospective adjustments following audits. Any increase in the cap above the annual inflationary adjustment would require an additional appropriation from the General Fund.

The table below shows the expenditures under the Medicaid Program for skilled nursing and intermediate care facilities and the costs to the State for cost-reimbursed boarding homes: (Figures shown in thousands)

	Actual SFY 1985	Actual SFY 1988	% of Increase	Projected SFY 1990	% of Increase
SNF	**$3,579**	**$4,336**	**21.2**	**$4,643**	**7.1**
ICF (Gen)	**$90,884**	**$110,720**	**21.8**	**$128,699**	**16.2**
ICF/MR	**$25,127**	**$28,262**	**12.5**	**$31,710**	**12.2**
Boarding Care	**$8,710**	**$9,640**	**10.0**	**$12,100**	**25.0**

Home Health Care Agencies

Sixteen home health agencies are certified for participation in both the Medicare and Medicaid Programs. These agencies are reimbursed on a per visit basis for all services provided by nurses, home health aides, therapists and medical social workers. The rate is established by the Medicare fiscal intermediary using the Medicare Principles of Reimbursement, and the same rate is paid under the Medicaid Program. This is a retrospective payment system subject to adjustments following audits. Home health agencies are also subject to Medicare Upper Limits established by Federal regulation.

Home health services are also provided under the Elderly Waiver for Home and Community-Based Services and the Private Duty Nursing/Personal Care Services (PDN/PCS) options under the Medicaid Program. Fourteen providers participated in the PDN/PCS Program in SFY'88. Reimbursement for these services is according to a fee schedule which was first established based on fees being paid as a result of negotiations under the State-funded Home Base Care Program. Since then the fees have been increased periodically as a result of cost information submitted by home health agencies and negotiations with the Maine Home Care Alliance. The most recent increase in fees was effective 1/1/89.

The table below is a summary of expenditures for Home Health Agency and Private Duty Nursing/Personal Care Services:

	Actual SFY 1985	Actual SFY 1988	% of Increase	Projected SFY 1990	% of Increase
Home Health	**$6,191,664**	**$ 5,030.850**	**10.1**	**$5,686,000**	**13.0**
PDN/PCS	**Not Covered**	**1,785,000**	**----**	**2,000,000**	**12.0**

PART TWO

VIII. A CRISIS IN CARING

"Contemporary social conditions present challenges to those committed to caring for each other--whether as members of communities or through their chosen work. Most nurses, and those who study nursing, would recognize caring as the essence of nurses' work and an integral component of their professional identities. In fact, a common shorthand phrase for distinguishing between nursing and medicine has been that `doctors cure disease and nurses care for people.' The social historian, Susan Reverby, for example, identifies the nursing profession's central dilemma as `being ordered to care in a society that refuses to value caring.'"[4]

Over the past decade, low pay, poor working conditions, and limited opportunities for advancement combined to create an exodus from the helping professions and discouraged recruits from entering them. Observers have argued, further, that the crisis in caring has been exacerbated by the expansion of job opportunities for women. Once freed from the confines of low-paying, low-status "female" work, why would a woman who could be a stockbroker choose instead to be an early-childhood educator? Why would a woman who could be a doctor decide to become a nurse?

"A more in-depth look reveals, however, that women themselves are not to blame for America's increasingly serious crisis in caring. Rather, the shortages that our society is experiencing, and will continue to experience, in the caring professions are a result of deeper social and political trends. Over the past decades, American's traditional ambivalence toward altruism, its devaluation of the meaning of human relationships, and its emphasis on competitive individualism and self reliance have created a situation in which care giving is an endangered activity and care givers are an endangered species."[5]

A change in society's attitude toward a particular profession can obviously affect the supply of new entrants into that particular profession. The following section will focus on institutional changes that have affected the supply of and demand for nursing professions.

IX. DEMAND/SUPPLY ISSUES

The Commission has found that there is a shortage of health labor (nurses) by using as a definition--a shortage exists when the demand for labor exceeds the supply available at the price offered.

In mid 1987 an American Hospital Association (AHA), survey found that 54.3% of hospitals encountered a "moderate" or "severe" nursing shortage, experiencing vacancy rates of 10% or greater. Department of Labor statistics show that Maine's hospitals presently employ about 5,200 registered nurses. In 1988 the vacancy rate among Maine hospitals was 11 percent. The current 1989 figures are a little more encouraging at 7.1 percent, down 34 percent from 1988.

In 1987 the American Health Care Association, which represents the long term care industry, surveyed its members and found 51% of the respondents reported an average of 3 months or longer to recruit an RN. Also 54% indicated they were experiencing a "moderate" or "severe" nursing shortage.

As detailed earlier in this report, demand for health labor will continue to increase at a rate faster than the supply. In fact, the supply and demographic projections indicate a more severe shortage in the future. If we are to meet the demand with a sufficient supply we must find pools of workers other than the traditional source of young, bright females entering the workforce for the first time.

"Several other groups have been identified as contributing to the pool of potential nurses: males in general (currently 3% of nurses); mature women who return to college once their families have been established; nursing aides and licensed practical nurses (LPNs) who want to advance; and foreign-educated nurses. Although each subgroup is important and needs to be expanded, nursing cannot replenish its ranks without holding onto its core group, the young females. Because of the abundance of career options for graduates of four-year colleges, attracting this group is difficult."[6]

Nursing faces the risk of brain drain as the most talented potential nurses select other fields that offer not only higher salaries but also opportunities for career development and a share in policy decisions. "Clinical Ladder Development should acknowledge the expert practice of nurses in their health care setting. Society generally rewards worthwhile, meaningful work monetarily, and yet historically, caring professions have not been valued by society. Nurses need to be recognized for accomplishing quality work. They need the availability of opportunities to advance in the organization on career tracks which reward expertise in parctice. Historically, advancement within the nursing profession occurred along two lines--the management track and the educational track. A third track should also be emphasized and encouraged, that which acknowledges and rewards expert nursing practice."[7]

Beyond the ability of the profession to attract new entrants, is the ability of the nursing profession to return those already within the profession. Participation rates, the

percentage of the total available to work in their chosen profession who are actually working, are good indicators of the ability of a particular profession to attract and retain its work force.

National data shows "almost 1.6 million of the 2 million RNs who are licensed are working as nurses. This represents a labor force participation rate nation-wide of nearly 80%, a rate higher than most job categories dominated by women (97% of nurses are female)."[8]

However, preliminary data from the Maine Department of Human Services shows that as of June 1987 there were 11,315 registered nurses living in Maine. Those who were also working as RNs were 6,526. This represents a participation rate of 58%, considerably below the national rate of 80% and also 11% less than the Maine participation rate in January of 1981. Data published by DHS in 1981 showed that of the 9,145 RNs living in Maine, 6,312 were working as RNs in Maine. That represented a participation rate of nearly 69%.

This data underlines the importance of efforts to recruit registered professional nurses who are not currently working as RNs in Maine. These efforts must stress retraining, entitlements, recognition and rewards commensurate with knowledge, skill and responsibility.

Professional development is very important for anyone who chooses a dynamic profession such as nursing. However, if one expends the time, energy and often money to attain such professional status, increases in wages should follow.

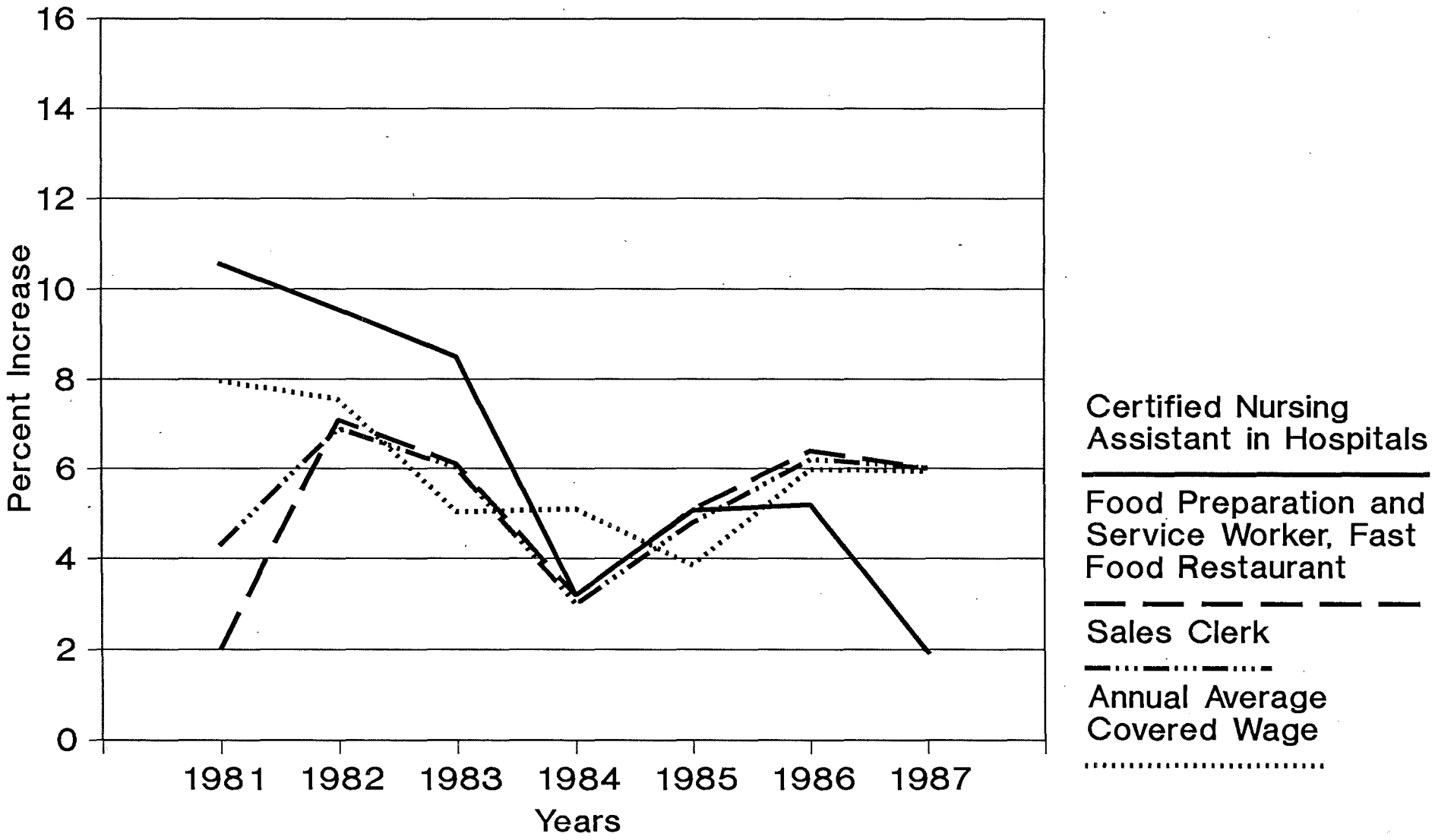
"Historically, as pressures increase for more nurses, an above-average pay increase is implemented to overcome the artificially low salaries. This `ratchet' pay system has fueled the boom and bust supply cycles of hospital nurses. (In cycle terms, we are currently in the phase which is characterized by a substantial salary boost, increased use of registries, recruiting bonuses, subsidy of educational programs, legislative pressure for loosening requirements for foreign-educated nurses, day care centers, refresher courses, debates about the primacy of pay and autonomy, and publicity.)"[9]

Salary compression is even more detrimental to the nursing supply than the ratcheding phenomenon described above. Because professionally oriented women no longer use wages of female-dominated occupations as their reference, analysts should place the nursing salary structure into perspective by examining the pay structure of male-dominated fields.

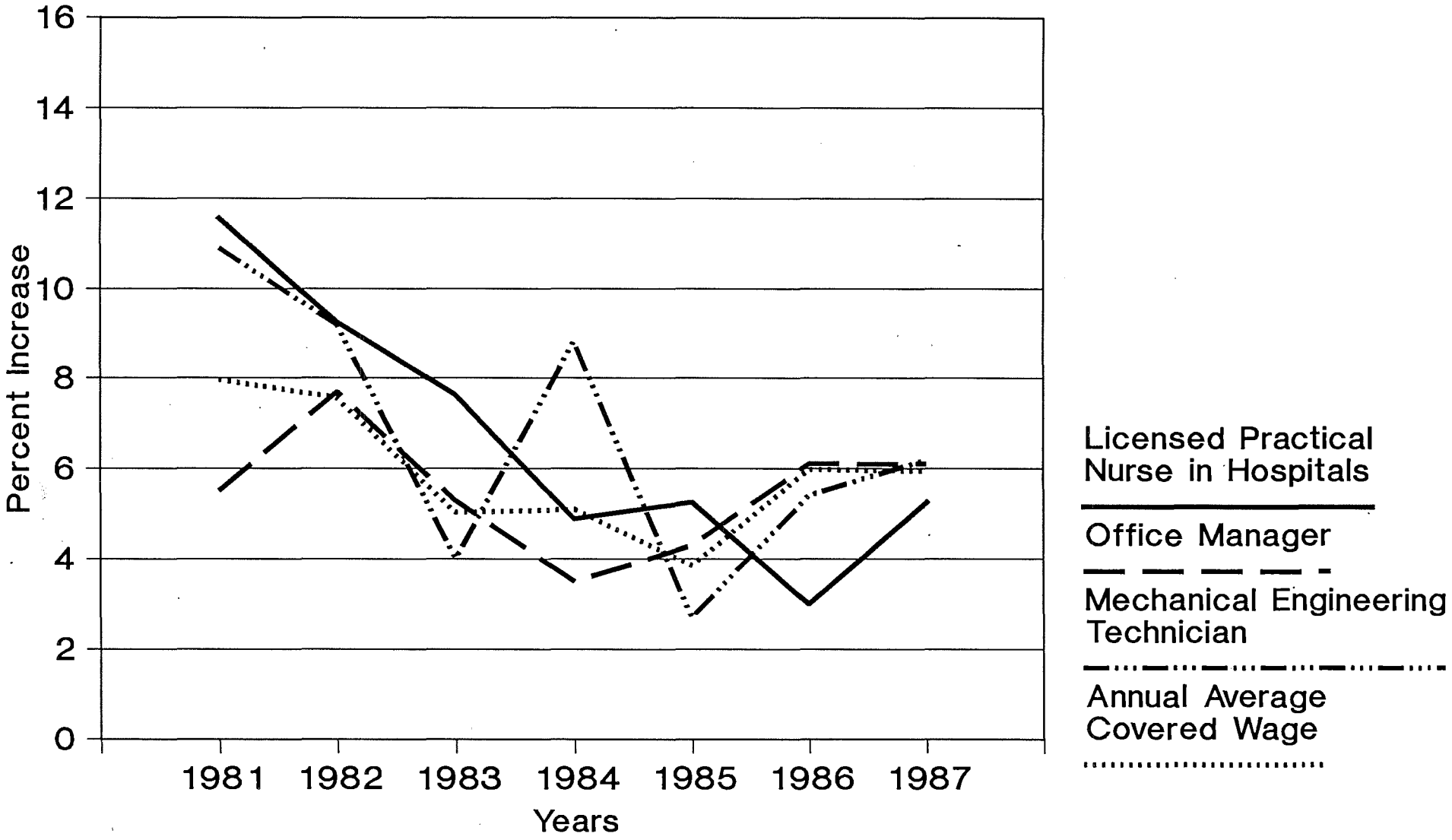
In nursing, wages have traditionally been used to attract new entrants into the work force without any direct tie to a career oriented wage scale. "With the typical starting and maximum salary of a staff nurse having a differentiation of less than 40% and only 62% even with additional education, a nurse's career path is less lucrative than even a secretary and far less certainly then other professions for which career earnings double or triple."[10]

The graphs on the following pages show the percent increase of the average wages for three nursing occupations in hospitals and nursing homes compared to the percent increase for similar occupations often held by men, and the average annual wage of all of Maine's workers who are covered by the Maine Employment Security Law (which includes 98 percent of nonfarm wage and salary workers), from 1980 to 1987. Comparisons of actual wage levels is difficult because the wages for the different occupations are not collected on the same base. That is, some are computed hourly, some weekly, and some annually. For comparisons sake, assuming a 40-hour week and 52-week year, the following tables can be compiled:

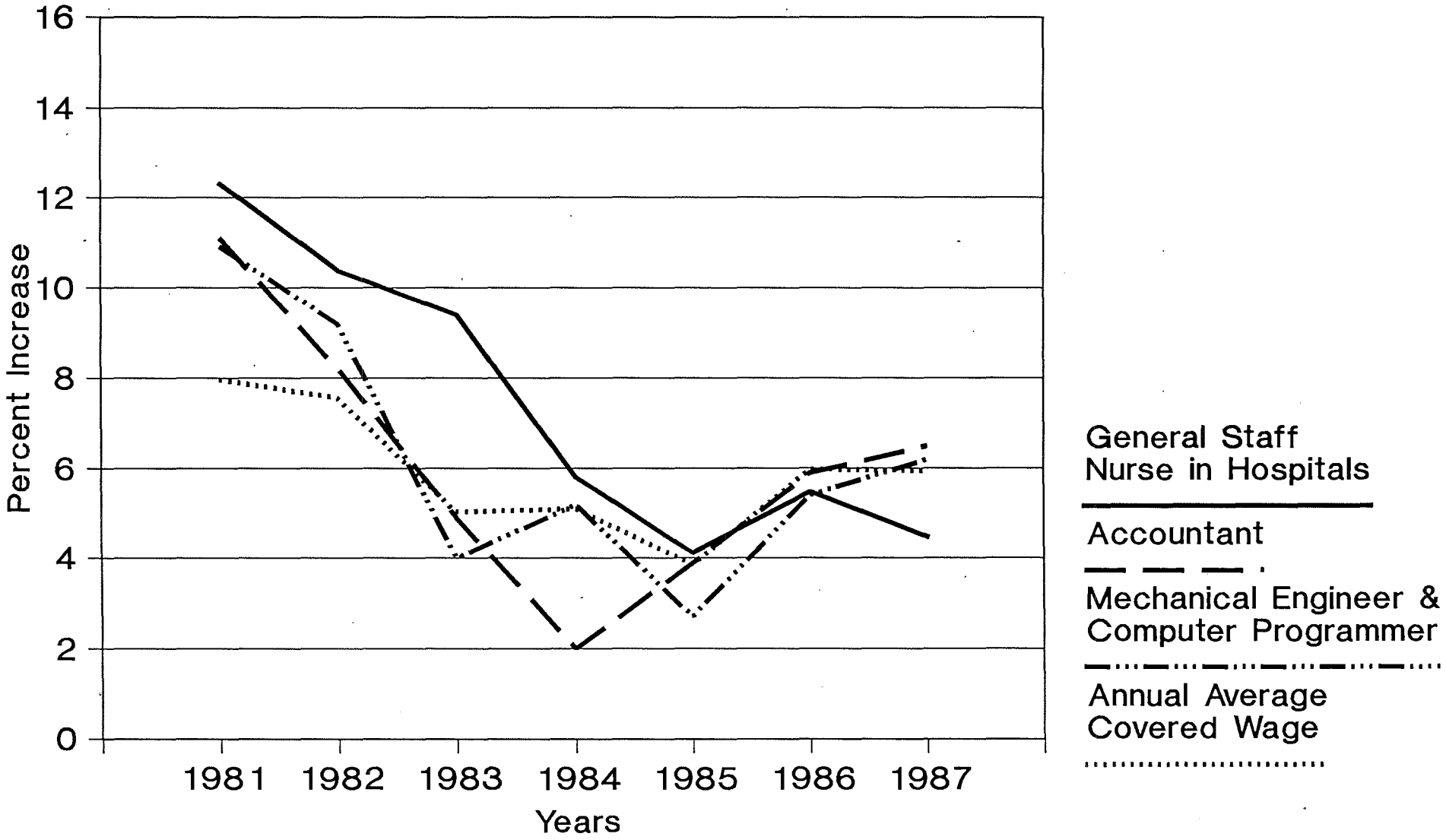
Annual Percent Increase in the Hourly Wage of Certified Nursing Assistants in Hospitals, Other Selected Occupations, and the Annual Average Covered Wage in Maine



Annual Percent Increase in the Hourly Wage of Licensed Practical Nurses in Hospitals, Other Selected Occupations, and the Annual Average Covered Wage in Maine



Annual Percent Increase in the Hourly Wage of General Staff Nurses in Hospitals, Other Selected Occupations, and the Annual Average Covered Wage in Maine



Occupation	Average Annual Wage		Average Annual Starting Wage
	Maine, 1980	Maine,1987	U.S., 1986
Mechanical Engineer	$ 23,785	$ 36,189	$ 27,864 [4]
Computer Programmer	17,324	26,306	27,000 [4]
Accountant	16,372	24,568	21,200
Office Manager	14,831	21,219	22,000 [4]
Mechanical Engineering Technician	13,657	21,508	N/A [3]
General Staff Nurse in Hospitals	**12,667** [1]	**20,862** [1]	**20,400**
Annual Average Covered Wage	11,458	17,125	20,644 [2]
Licensed Practical Nurse in Hospitals	**10,067** [1]	**15,808** [1]	**14,700**
Sales Clerk	8,133 [1]	11,690 [1]	11,180 [4]
Certified Nurse Assistant in Hospitals	**7,883** [1]	**12,043** [1]	**N/A** [3]
Food Preparation Worker, Fast Food	7,197 [1]	10,213 [1]	7,904 [4]

[1] Assuming a 40-hour week and a 52-week year.

[2] 1987 Average Covered Wage for the United States

[3] Not Available

[4] Median Wage

HOSPITAL DEMAND

There has been a dramatic substitution of nurses (RNs) for other nurses (LPNs) and non-nurses (CNAs, clerical staff, etc.) within hospitals.

"Low relative wages result in substitution of nurses for non-nurses. Nurses are versatile hospital employees. Their broad training enables them to substitute for allied nursing personnel (LPNs and aides); take on many of the responsibilities of other health-related personnel including medical social workers, occupational and physical therapists, and inhalation therapists; assume many managerial and clerical roles; and even substitute for physicians in some functions. Because of this versatility, when nurses' relative wages fall, it is more economical for hospitals to employ more nurses as opposed to other kinds of workers."[11]

Data supplied to the Commission indicates the number of full-time RNs employed by Maine hospitals increased 26% in the period 1983 to 1987 (See Bar chart on page 9). During that same period, total hospital discharges fell 11%. These raw numbers need to be reviewed in the context of the two other variables--patient acuity and the mix of staff.

Patient acuity is defined through a "case mix" index which was developed by the Maine Health Care Finance Commission. Testimony at the Commission's hearing focused on this index as one that measured change in patient need from a medical perspective, not a nursing perspective. Testimony was presented on various methods of measuring acuity changes through nursing models; but no analysis has been done across the hospital spectrum using any of those models.

Utilization of nurses in hospitals across the nation have gone from a nurse to patient ratio of 50 to 100 in 1972 to 91 to 100 in 1986, an 82% increase. Maine data shows approximately a 70 to 100 nurse to patient ratio.

The decrease in the numbers of full and part-time LPNs and full-time CNAs was more than offset by the increase in RNs and other hospital employees so that total hospital employees 1983 to 1987 increased by 22% and when adjusted for case mix, increased by 17%. National data essentially replicated the Maine experience (or vice versa) with the number and shift of employees virtually the same. (See Appendix B)

"When the costs of turnover, limited job versatility, continuing education, and supervision costs are all considered, it is more economical if nurses' salaries are relatively low to replace allied nursing personnel with nurses. There is clear evidence that this did indeed happen in the seventies. Hospitals across the nation shifted from a staffing complement of one-third nurses and two-thirds aides and LPNs, to a ratio of 50 percent registered nurses by 1980. There was a direct replacement of nurses for aides in a period characterized as one of acute shortage of nurses where the usual expectation would be for substitution in the opposite direction--more LPNs and aides, not less."[12]

Studies have also shown that currently "10% to 40% of a RN's time is routinely spent performing non-nursing functions. Additional responsibilities for clerical work, transportation services and cleaning, for example, are taking nurses away from direct patient care at the bedside. This has been exacerbated by the decreasing use of LPNs, CNAs and nursing assistants by hospitals."[13]

NURSING HOMES/HOME HEALTH CARE DEMAND

Demand data on the nursing home and home health side, while not as readily available, show similar changes. While increasing regulation, which control nursing home staff/patient ratios and staff mix, increased patient acuity and increased number of patients have raised the total number of nurses employed.

Home Health staffing is controlled by patient need and most directly by dollars. The Commission received no data on increases in Home Health Agency staffing. However, due to cost restraints placed on the Home Health Care industry, some Home Health Agencies have found it difficult to offer appropriate wages and benefits to compete for nursing staff with other segments of the health care industry.

SCHOOL NURSE DEMAND

Testimony heard by the Commission at this time stated that there is no shortage of registered professional nurses available to seek school nursing positions. An increase from 195 to 325 positions state wide has been seen in the past 4 years.

School nurses further enjoy a high retention rate even with the mandated continuing education required for certification. The Commission feels that local school systems should strive to establish and maintain a pupil to nurse ratio at a level consistent with the recommendations of the National Association of School Nurses (1988 at least one nurse per 750 students). School nurses should work to educate both administrators and themselves of the breath of services a school nurse can offer. School nurses, as any other nurse, should be paid commensurate with their responsibility, expertise and longevity.

OCCUPATIONAL HEALTH NURSE DEMAND

The occupational health nurse performs many functions in the industrial setting, for example, accident prevention, industrial hygiene, first aid, emergency care, health prevention, etc. Also, they play a key role in the rehabilitation and return of injured workers back into the work place.

Statistics are generally unavailable regarding the current nurse to employee ratio. However, major insurance companies recommend 1 to 300 employees. That ratio should be maintained whenever possible. There is currently an adequate supply of industrial nurses in the State of Maine. A 9:00 a.m. to 5:00 p.m. work day and an autonomous practice at the work site are cited as possible reasons.

X. COMMISSION RECOMMENDATIONS

EDUCATION AND TRAINING

Whereas the Commission to study the status of nursing professions in Maine through its deliberations seeks to insure an adequate supply of patient care nurses,

Whereas, a key factor in providing quality health care is an adequate supply of appropriately educated health care personnel,

Whereas, this requires reasonable access to education programs in terms of scheduling, geographical access, financial and institutional considerations,

Whereas, the Commission has heard testimony and considered documented evidence establishing difficulties in the area of availability of programs, transferability of credit, cost and rigidity of program scheduling, especially at times inconvenient for currently employed personnel seeking to advance to higher levels of licensure.

Therefore be it resolved, *that institutions employing health care workers and institutions providing education need to explore flexible scheduling in terms of time and place where courses are offered, including the use of telecommunications to provide on site training.*

Be it further resolved *that loan payback programs with compatible return of service provisions and tuition and stipend grants be established and targeted to geographical areas, specialty practices, underserved practice settings, underserved professions and underserved geographic areas. The Commission recommends the establishment of the Maine Choice Fund to address these needs.*

Be it further resolved *that public and private institutions of higher education should develop programs in the health fields with a core curriculum leading to different fields of practice and integrating, in all programs, the study of health policy and management.*

Be if further resolved *that the Commission challenges institutions of higher learning to maximize transferability of credits both within degree programs and for the purpose of career ladder advancement within the nursing profession.*

Whereas, apprenticeship programs are utilized in other states as an effective training system,

Whereas, apprenticeship programs are particularly useful for those that can not afford to take the time off to get an education for a particular occupation.

Be it resolved *that the applicability of apprenticeship programs for non-licensed personnel be thoroughly researched by the Department of Labor.*

Whereas, testimony and documentation presented to the Commission indicated a need for an increased level of clinical experience for new graduate nurses. In order to promote a climate conducive to the transitional period from student nurse to staff nurse,

Whereas, testimony to this Commission demonstrates that the highest rate of turnover of new graduates is during the first year of their profession, and appears to be related to transitioning from student nurse to staff nurse.

Be it resolved *that a preceptorship program not less than 3 months in length be established in every acute care setting in the State of Maine for those involved in direct patient care. During this preceptorship program, the individual involved in the program should not be included in the staffing pattern for a minimum of 3 months.*

Whereas, the Health Occupations Training (HOT) project was established to address severe shortages in health care occupations by increasing the supply of health care workers through job training and loan payback,

Whereas, the Commission heard testimony concerning the funding of the program not being sufficient to service a large unmet need,

Whereas, it is difficult for health care providers who are at their revenue cap to participate in the loan forgiveness aspect of the HOT project,

Whereas, the current program is restricted to government subsidized loans and partly funded with federal job training monies and therefore partly restricted to those who meet the federal economic disadvantaged guidelines,

Be it resolved *that the Nursing Commission strongly supports the pending HOT II legislation and recommends favorable legislative action.*

Be it resolved *that the Commission presents in its legislative package several items to adjust and expand the existing HOT project to address the concerns as expressed to the Commission including the creation of a fund to provide monies to health care facilities who have been unable to participate in the HOT project because they were at their financial cap. An extension of the repeal of the project from 3 to 5 years and finally an expansion of the program to cover all health care workers instead of just registered nurses is included.*

Whereas, the nursing shortage affects both public and private employers of health care personnel,

Whereas, nurses employed by the state are not eligible to participate in the loan payback program established by the HOT project.

Be it resolved *that State agencies employing nurses make provisions in their departmental budgets to provide a loan payback program comparable to that contained in the HOT project.*

Be it further resolved *that the programs receiving block grant monies to employ nurses be allowed to include the cost of loan payback programs in their agreement with the State of Maine.*

WAGES

Whereas, the Commission believes that inadequate compensation is one of the causes of the current nurse shortage,

Whereas, nursing wages are subject to severe salary compression and are not comparable to other professions.

*"**Be it resolved** that government should reimburse at levels that are sufficient to allow efficiently organized health care delivery organizations to recruit and retain the number and mix of nurses necessary to provide adequate patient care."*[14]

Be it further resolved *that innovative compensation options should be researched and developed to offer flexibility in benefit packages assuring at a minimum health insurance coverage for employees of health care organizations and to encourage adequate numbers of nurses to work on less popular shifts and in less popular settings.*

Be it further resolved *that the proposed Research and Practice Center study innovative models and strategies for elimination of salary compression within the nursing profession.*

CAREER DEVELOPMENT

Whereas the State of Maine is in a documented nursing shortage and in need of immediate health care workers in all settings,

Whereas the development of a career ladder within the profession of nursing is a key element in recruitment and retention of nurses.

Be it resolved *that the Commission supports a well defined skill level and educational preparation for categories of patient care workers with links and articulation from one level to the next.*

PROFESSIONAL DEVELOPMENT

Whereas "both environmental and internal changes in nursing call for increased attention to career development and retention of nurses working in positions of direct patient care."[15]

Whereas, patient acuity levels have increased, and the numbers of diagnostic and treatment interventions available have increased. Indeed, the major role of hospitalization today is the need for expert nursing care.

Whereas, the current complexity of nursing makes interchangeability and easy replacement of nurses expensive and not conducive to quality care.

Whereas, in this equal rights era, women plan for and expect careers with progressive advancement rather than intermittent, disconnected jobs.

Whereas, "restructuring and sweeping changes are called for if clinical nursing as a career is to be brought in step with career opportunities in other fields."[16]

Be it resolved *that the Commission recommends that there should be development of clinical ladder systems in public and private hospitals, home health and long term care settings. The registered professional nurse should be rewarded monetarily for knowledge, education, experience and responsibility. The Commission further recommends that wage scales be established that recognize clinical ladders and provide adequate opportunities to increase earning with expanded pay ranges commensurate with advancement on a clinical ladder that is comparable to other professions. Third party payors should recognize such clinical ladders. Clinical ladder systems should be individualized to the institutions but should recognize levels of expertise, education, certification and longevity.*

NON-NURSING DUTIES

Whereas, the nursing shortage in part can be attributed to utilization of nurses in non-nursing functions which takes the nurses knowledge and skills away from the bedside,

Whereas, there has been a reduction of non-clinical staff that has effected the working conditions for nurses in the acute care settings and long term care settings,

Be it resolved *that provisions be made for adequate support staff. Be it further resolved that health care organizations should provide staffing patterns that reflect an adequate mix of clinical and non-clinical categories of patient care workers in order to place the nurse in position to provide direct care to the patient and family.*

Be it further resolved, *that continued research and development of models of practice which provide innovative modes in which nurses can effectively coordinate staff and appropriately utilize, direct and delegate to all levels of clinical and non clinical personnel for increased comprehensive care of patient and family. Further research and development is necessary to*

study comprehensive automated information systems and labor saving technologies to utilize personnel to better serve patients.

***Be it further resolved** that health care providers should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence and experience among registered nurses and other nursing personnel.*

NURSE EMPOWERMENT

Whereas, nurses possess unique professional and clinical experience concerning the design and operation of institutional based nursing services,

Whereas, the professional and clinical expertise of nurses has traditionally been undervalued and underutilized,

Whereas, this lack of professional recognition is a primary cause of frustration and alienation among nurses.

***Resolved** that all public and private health care facilities, accord direct care, non-administrative nursing personnel, a major role with nursing administrators in the development of the institution specific nursing care operative systems.*

***Be it further resolved** that the design, implementation and monitoring of such nursing care systems be decentralized to the extent practical in order to maximize the involvement of direct care personnel.*

***Be it further resolved** that nursing care should be differentiated from medical care. Nursing care should not be delegated or supervised by Medical Practitioners.*

***Be it further resolved** that all patient care has historically been called Nursing, but all patient care workers are not nurses. Therefore it is incumbent upon the Nursing Profession to define a Nurse.*

RCTs

Whereas, the American Medical Association's proposal to create a new category of patient care worker to be called a basic or advanced Registered Care Technologist (RCT) would be responsible to a physician,

Whereas, this proposal is inconsistent with the differentiation of practice resolve contained in the Commission's report.

***Be it resolved** that the Nursing Commission opposes the American Medical Association's RCT proposal.*

NURSE/PHYSICIAN RELATIONSHIP

Whereas, improved physician/nurse communication would enable the registered nurse to better coordinate and delegate the care of the patient in hospitals, home health and long care settings,

Whereas, to promote a collegial climate in which physicians and nurses collaborate in order to provide an atmosphere well suited and coordinated so as to provide the best possible care.

Be it resolved *that joint practice committees be established within public and private health care institutions with levels of representation to be determined on an institution by institution basis, and also that interdisciplinary patient care conferences be regularly held between physicians, nurses, other care givers, and family as well as patients.*

COSTING OUT OF NURSING SERVICES

Whereas, the cost of nursing care is not identified in the total cost of hospital care,

Whereas, nursing care is the largest product of any hospital, and while costs of other products are known, nursing costs remain obscure,

Whereas, it is essential that consumers in the United States understand the role that nursing plays in providing health care and therefore the cost commensurate with that,

Whereas, greater accountability is appropriate for nursing managers in regards to the delivery of nursing care,

Whereas, greater awareness within health care institutions of how to provide the most cost effective high quality care possible is important.

Be it resolved *that the Commission charges the proposed Research and Practice Center to determine the methodology and adviseability of identifying the actual costs of nursing services on individual nursing units.*

TEMPORARY NURSE AGENCIES

Whereas, the Commission heard testimony that questioned the current policies or lack thereof concerning Temporary Nurse Agencies,

Whereas, the availability, regardless of price, of temporary nurse personnel may have an impact on the willingness of the health care industry to address problems within the work place concerning in-house permanent nursing staff,

Whereas, quality assurance is non-existent in regards to Temporary Nurse Agencies.

Be it resolved *that Temporary Nurse Agencies be included in licensure requirements under the Home Health Care Act,*

Be it further resolved, *that a requirement to provide training which is comparable to the inservice and staff development training required for the organization or agency to which temporary staff are provided also be included.*

MARKETING OF NURSING

Whereas, another major component of any strategy for resolving the nurse shortage is the issue of marketing nursing and making it an attractive career option.

Be it resolved *that the nursing profession in conjunction with the health care industry should take primary responsibility for providing immediate and sustained attention to the promotion of positive and accurate images of the profession and the work of nurses.*

EMPLOYEE ASSISTANCE PROGRAMS

Whereas, the environment within many health care institutions has become increasingly stressful,

Whereas, the use of legal and illegal drugs and/or alcohol can affect the performance of health care workers on the work site and therefore the well being of health care patients,

Whereas, unusual working hours, extraordinary personal and professional responsibilities requiring competent, coherent problem solving create the necessity for a workers assistance program to deal with substance abuse, stress management, personal problems, and burnout.

Be it resolved, *the State of Maine should encourage and promote the establishment of employee assistant programs (EAPs) to serve employees of health care institution(s) through changes and/or creation of reimbursement policies, pilot programs or direct grants.*

Be it further resolved, *that employers be encouraged to maintain employees participating in such programs and also rehire rehabilitated workers attempting to re-enter the workforce.*

NURSE PRACTITIONERS

Whereas, a nurse practitioner (NP) is a registered nurse (RN) with additional education, clinical experience and training in performing physical assessments, health histories and managing clients' health plans,

Whereas, all nurse practitioners must first be RNs, the decreasing available pool of RNs means there also will be fewer NPs,

And whereas, many health services in Maine are provided by nurse practitioners including; complete physical exams, screening for hypertension, anemia, breast cancer, and cervical cancer,

Whereas, there is a shortage of nurse practitioners in Maine,

Whereas, no education program for nurse practitioners exists in Maine.

Be it resolved *that such a program be established in northern Maine by the University of Maine system by September 1990. The University shall submit to the committee of jurisdiction of the legislature the costs and location of implementing such a program by February 1, 1990.*

Be it further resolved *that loan forgiveness programs be available for nurse practioner education.*

HEALTH CARE DIRECTORY

Whereas the Commission on Nursing has found a lack of updated quality information on individual health occupations accessible to the general public such as minimum educational requirements, licensing, and the projected need for those said occupations in Maine.

Be it resolved *that the Department of Labor be directed to compile a health care occupations manual listing all health occupations with the following information provided. The responsibility for updating annually the directory will fall under the proposed Research*

and Practice Center after the completion of the first directory.

The manual shall be completed by September 1, 1990.

1. Listing. A listing of all health care occupations;

2. Description. Brief description of each occupation;

3. Education. Minimum education requirements;

4. Training opportunities. Schools nationwide offering training in various health care occupations;

5. Salary information for each occupation;

6. Licensing and certification. Licensing and certification requirements for each occupation;

7. Cross training. Any opportunity for cross training.

8. Future needs. Projected need for next five years;

9. Refresher courses. Available refresher courses for any listed occupations;

10. Financial aid. Financial aid available for training.

Be it further resolved *that this information be updated annually and provided to all interested parties, to the legislature and to the Maine State Health Policy Advisory Council on an annual basis.*

RESEARCH AND PRACTICE CENTER

Whereas "most hospitals have allocated only relatively small amounts of money to research and development in nursing care, with long term care facilities spending even less. Furthermore, these limited resources have been spent on orienting new employees and managing high turnover. This lack of attention to clinical knowledge development and career development is a major barrier to the retention of expert nurse clinicians at the patient's bedside,"[17]

Whereas, we have studied the nursing shortage and the nursing practice issues, but many questions remain unanswered,

Whereas, availability of better information obtained through research of nursing practice models will be of importance to policy makers, health care delivery organizations and the nursing profession as a whole.

Be it resolved *that a Research and Practice Center be established to research and monitor such items as:*

A. Affects that alternative models of nursing practice have on nurse/patient ratios and staff mix.

B. Assess the impact of advances in medical technology on nurse staffing, level and mix.

C. Conduct comparative studies of predominately female professions and health

professions including nursing to further the understanding of the factors influencing career decisions.

D. Examine the direct and indirect effects of various payment strategies on the number mix and compensation levels of nursing personnel in all health care settings.

E. Assess the effects of salary and benefit packages on nurse supplies and demand as well as recruitment and retention.

F. Strategies for eliminating salary compression.

G. All others issues concerning recruitment and retention of health care professions included but not limited to the image of nursing.

H. Assess the value of apprenticeship programs.

I. Develop a methodology for determining the advantages and disadvantages of costing out of nursing services.

Be it further resolved *that a Research and Practice Center shall be attached to a campus of the University of Maine system as recommended by the Chancellor and approved by the Legislature. It is further resolved that the research center will research such areas as identified in cooperation with health care providers and the education community. To the extent possible, research will involve personnel and programs at health care facilities rather than solely at the research center. (Be it further resolved that $500,000 will be appropriated for the initial staffing, housing and funding of research areas to be studied. None of those funds will be expended until the Chancellor's budget for such purpose is approved by the Legislature.)*

Be it further resolved *that the Research and Practice Center will include an advisory board which should include representatives from all interested parties.*

STATE HEALTH PLAN

Whereas the state plays a major role in purchasing health care services and allocating resources,

Whereas the field of health care and the needs of citizens are always changing,

Whereas health care institutions and educational institutions need to plan for the anticipated changes.

Be it resolved *that the Department of Human Services shall develop a comprehensive State Health Plan and update it annually. This health care plan shall be a coordinated approach to the health care needs of the State of Maine utilizing internal and external data provided by agencies, associations and all interested parties. This information should then be reported to the Legislature through the committee of jurisdiction and disseminated to the public at large so that all other interested parties can plan accordingly.*

Be it further resolved, *that the Commission believes strongly that the State of Maine's long range strategy and corresponding policies should be focused on incrementally moving towards a comprehensive public health system.*

XIII. CONCLUSION

It was the intent of this Commission not to legislate or mandate most of the recommendations but to encourage and promote such changes to the health care industry. The Commission believes that the Maine State Health Policy Advisory Council and the newly established Research and Practice Center should spearhead a sustained effort devised to: monitor the nurse labor market, collect improved data and conduct further research on the demand for nurses as well as the supply and follow through on the implementation of the recommendations outlined in this report.

Health care in Maine, as in the rest of the nation, is undergoing dramatic change due to social, economic, and demographic evolutions that have already occurred and also those that are anticipated. These changes effect the way health care is structured, paid for and delivered.

Nurses will play a critical role in determining the success we will have as a state or as a nation in dealing with the major challenges we face in the coming years. We must take positive action <u>now</u> as policy makers, administrators, consumers, and citizens to guarantee that quality health care is available for those that come after us....without quality, well educated, competent and contented nurses, that goal is laudible but unattainable.

Appendix (A)

METHODOLOGY

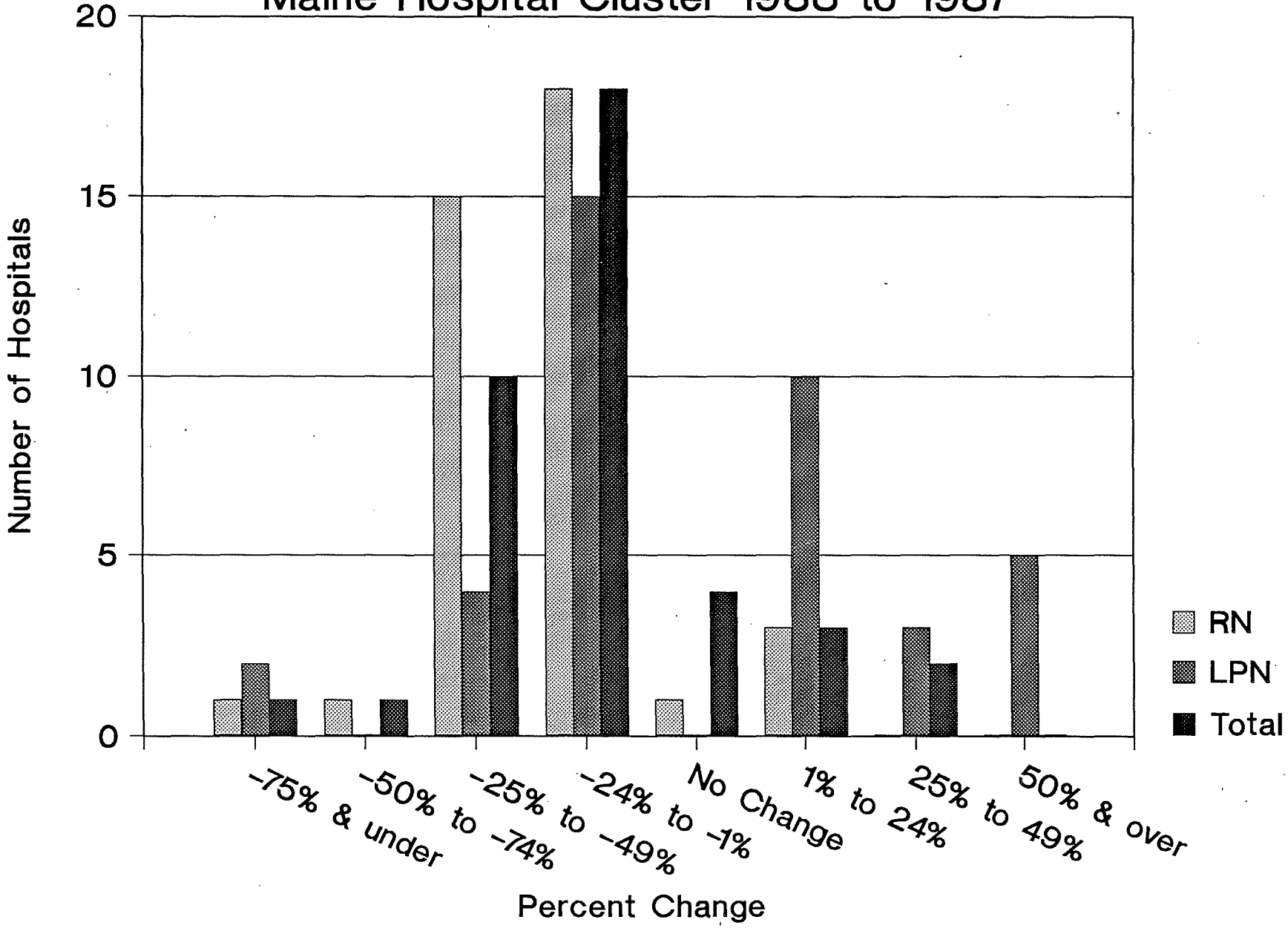
The information presented in the "Occupational Employment of Selected Nurse Occupations" section is derived from programs conducted by the Maine Department of Labor, Bureau of Employment Security, Division of Economic Analysis and Research. Occupational data is collected annually from a sample of employers in the state through the federal-state cooperative Occupational Employment Statistics (OES) program. This program produces current employment by occupation, for each detailed industry surveyed. When all industries have been surveyed, the data in aggregated into industry-occupation matrices covering all sectors of the economy, and annualized to a base year, currently 1984. A national change factor matrix, which consists of the percent changes each occupation is expected to exhibit in its distribution within each industry during the projection period, is then applied to base year matrix, producing of projected year matrix.

Projections of employment by detailed industry in the state are made using several projection techniques including linear regression models, employment share projections models, and shift and share projection models. All mechanical calculations are thoroughly analyzed by persons knowledgeable of labor market conditions, and suitably modified as necessary.

When the industry employment projections have been finalized, the projected industry-occupation matrix is then applied to them, thus producing occupational employment projections.

The demand for occupational employment can be divided into two distinct components - industry growth demand and replacement demand. Industry growth produces demands for new jobs, as the employment of a company is expanded. Replacement demand is created by the need to replace those workers who die, retire, or leave the work force for other reasons such as disabilities or family responsibilities.

Percent Change in the Number of Case Mix Adjusted Discharges per RN, LPN, and Total Nursing Full-Time Equivalents by Maine Hospital Cluster 1983 to 1987



Appendix C

CURRENT LAW REGULATING THE PRACTICE OF NURSING

Maine State Board of Nursing

Enacted by Chapter 303, Public Laws 1959; Amended 1961 ... 1985.
Extracted from Professions and Occupations, Title 32, Revised Statutes 1964, Chapter 31.

Sec. 1, 32 MRSA A 2102, sub., S 2, as last amended by PL 1985.

2. Professional Nursing. The practice of "professional nursing" means the performance, by a registered professional nurse, for compensation of professional services defined as follows:

A. Diagnosis and treatment of human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being and execution of the medical regimen as prescribed by a licensed physician or dentist or otherwise legally authorized person acting under the delegated authority of a physician or dentist:

(1) "Diagnosis" in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. This diagnostic privilege is distinct from medical diagnosis;

(2) "Human responses" means those signs, symptoms and processes which denote the individual's health needs or reaction to an actual or potential health problem; and

(3) "Treatment" means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen;

B. Medical diagnosis or prescription of therapeutic or corrective measures when those services are delegated by a licensed physician to a registered nurse who has completed the necessary additional educational program required for the proper performance of those services and whose credentials must be approved by the board.

The board may adopt, pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, rules defining the appropriate scope of practice for nurses practicing under this paragraph. The rules shall also define the appropriate relationship with the physician. In adopting the rules, the Board shall invite comments from the Board of Registration in Medicine;

C. Delegation of selected nursing services to licensed practical nurses when the services use standardized protocols and procedures leading to predictable outcomes in the observation and care of the ill, injured and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medication and treatments prescribed by any person authorized by state law to prescribe. The board shall issue such rules concerning delegation as it deems necessary to ensure quality health care to the patient;

D. Delegation of selected nursing services to assistants to nurses who have completed or are currently enrolled in a course sponsored by a state-approved facility or a facility licensed by the Department of Human Services. This course shall include a curriculum approved by the State Board of Nursing. The board shall issue such rules concerning delegation as it deems necessary to ensure quality of health care to the patient;

E. Supervision and teaching of nursing personnel;

F. Administration of medications and treatment as prescribed by a legally authorized person. Nothing in this section may be construed as limiting the administration of medication by licensed or unlicensed personnel as provided in other laws; and

G. Teaching activities of daily living to care providers designated by the patient and family.

XIII. FOOTNOTES

1 Bloom, David, "Women and Work," *American Demographics*, Vol. 8, No. 9, Sept. 1986, pg. 25.

2 Ibid.

3 Ibid.

4 Moccia, Patricia. "At the Faultline: Social Activism and Caring," *Nursing Outlook* Vo. 36 #1 (Jan 1988).

5 Suzanne Gordon. "The Crisis in Caring," *Boston Globe Magazine* (July 10, 1988).

6 Cole, B. Sizing, M. "Nursing Managers' Salaries Vary Little," *Modern Healthcare #17*, pg. 48, (Dec. 4, 1987).

7 Benner, Pat. "Novice to Expert," pg. 199, (1984).

8 "The Nursing Shortage: Strategies of Solutions," *American Nursing Association*, (Sept. 1988).

9 Cole, B. Sizing, M. "Nursing Managers' Salaries Vary Little," *Modern Healthcare #17*, pg. 48, (Dec. 4, 1987).

10 "The Nursing Shortage: Strategies of Solutions," *American Nursing Association*, (Sept. 1988).

11 Cole, B. Sizing, M. "Nursing Managers' Salaries Vary Little," *Modern Healthcare #17*, pg. 48, (Dec. 4, 1987).

12 Aiken, Linda H. "The Nurse Labor Market," *The Journal of Nursing Administration*, (Jan.1984).

13 "The Nursing Shortage: Strategies of Solutions," *American Nursing Association*, (Sept. 1988).

14 *HHS Secretary's Report on Nursing*, Recommendation #6, (Dec. 1988).

15 Benner, Pat. "Novice to Expert," pg. 174, (1984).

16 Ibid. pg. 199

17 Ibid., pg. 200.