HB
271

IOUSE COMMITTEE REPO

(7)
Date Referred to Committee: May 2, 2005 **FURTHER REFERRALS: Finance**

Date of Committee Action: 2/23/06

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 271**

HOUSE BILL NO. 271 **LIMIT OVERTIME FOR REGISTERED NURSES**

"An Act relating to limitations on overtime for registered nurses in health care facilities; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [X] CS for HB 271 **(** HES **)**
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR________ [ ] Same Title [X] New Title

[ ] attach amendments
[ ] add new referral to ____________ Committee
[ ] Letter of Intent__________ Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES (*Assigned by Chief Clerk's Office)

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS				X
HSS				X
HSS				X
CED				X

PREVIOUS FISCAL NOTES

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	Cissna	✓			
[signature]	Gardner	✓			
[signature]	Kohring			X	
Chair: [signature]	Wilson	✓			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 271
() Publish Date:

Revision Date/Time (Note if correction):

Title	Limit Overtime for Registered Nurses
Sponsor	Wilson
Requester	Health, Education & Social Services
Dept. Affected:	Commerce
RDU	Corps, Bus & Prof Licensing (117)
Component	Corps, Bus & Prof Licensing
Component No.	2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by:	Jennifer Strickler, Chief	Phone	907.465.2144
Division	Corporations, Business & Professional Licensing	Date/Time	1/24/06 9:14 AM
Approved by:	William C. Noll, Commissioner	Date	1/24/2006
Agency	Commerce, Community and Economic Development		

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271CS(HES)-DHSS-DAPH-02-27-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Alaskan Pioneer Homes

Component: Pioneers Homes

Sponsor: WILSON

Requester: HOUSE (HES)

Component No. 2671

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CS HB 271 (HES) establishes limitations on overtime for Registered Nurses (RNs) in health care facilities and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

"Overtime" (OT) means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed on by a nurse and a health care facility. Mandatory OT to address an unforeseen emergencies is not subject to the limitations or penalties under the bill.

Prepared by: Virginia Smiley, Director
Phone 465-5736
Division: Alaska Pioneer Homes
Date/Time 02/21/2006
Approved by: Karleen Jackson, Commissioner
Date 02/27/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271CS(HES)-DHSS-DBH-02-27-06
(   ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Behavioral Health

Component: Alaska Psychiatric Institute

Sponsor: WILSON

Requester: HOUSE (HES)

Component No. 311

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CS HB 271 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities. The intent of CS HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event.

The division has determined that passage of this bill will have zero fiscal impact.

Prepared by: Cristy Willer, Director
Phone 269-3410
Division: Behavioral Health
Date/Time 02/22/2006
Approved by: Karleen Jackson, Commissioner
Date 02/27/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271CS(HES)-DHSS-FMS-02-27-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Health Care Services

Component: Medicaid Services

Sponsor: WILSON

Requester: HOUSE (HES)

Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Alaska statutes (AS 47.07.070) require Medicaid hospital and nursing facility rates to be based on reasonable costs related to patient care. This proposed statute could require hospitals to hire more higher cost contract nurse staff because of the shortage of nurses in Alaska, and pay more for overtime nursing services. The additional costs would push Medicaid hospital and nursing facility rates upward. Generally speaking Medicaid pays it's share of new hospital (Approx 20-30%) and nursing facility (Approx 80-85%) costs eventually. The DHSS does not have data on how many nurses could currently be working illegal overtime under this proposed statute. There could well be an impact on Medicaid hospital and nursing facility payment rates, however the amount of such impact is indeterminate at this time. Fines and penalties are not factors considered in establishing Medicaid payment rates, so decreasing the amount of the penalty in CS HB271 (HES) does not affect the fiscal note.

Prepared by: Jack Nielson　　Phone 334-2447
Division: Commissioner's Office/Office of Rate Review　　Date/Time 02/03/2006
Approved by: Karleen Jackson, Commissioner　　Date 02/27/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

Alaska State Legislature

Representative Peggy Wilson
House District 2
Putting Alaska's Families First

SPONSOR STATEMENT

HB 271

" An Act relating to limitations on overtime for registered nurses in health care facilities and providing for an effective date."

This bill will prohibit an employer from assigning mandatory overtime and from threatening or retaliating against a nurse who refuses overtime. It will also give the nurse the latitude to make the judgment call about whether they are safe to practice (work overtime) or not. The bill assigns the administration of implementation and enforcement to the Commissioner of Department of Labor.

Mandatory overtime hours are those hours above an agreed upon, predetermined, regularly scheduled shift, which the employer makes compulsory (as opposed to voluntary). The threat of reprisals includes but is not limited to discharge, discipline, demotion or assignment to unattractive tasks or work shifts or in some cases licensure removal, retaliatory reporting, and charges of "patient abandonment".

Mandatory overtime contributes to poor quality patient care because fatigue and loss of concentration, which results from excessive overtime, increases the likelihood of errors. According to a study by the National Institute for Occupational Safety and Health (NIOSH), when staff plans to work additional shifts on a volunteer basis, they are more likely to be prepared and get plenty of rest immediately prior to working the extended shift. However, when an employer mandates overtime, this occurs with little or no prior notice. The result is high levels of fatigue and thus increased errors.

For nurses, these errors or mistakes may cause life-threatening situations for both the patient and the nurse. These situations run the gamut from back injuries for the nurse to patient medication errors to even death. The evidence is very strong that prolonged work hours and fatigue affect worker performance.

Emergency situations and Critical Access Hospitals are exempt from this bill.

Alaska State Capitol, Room 108 • Juneau, Alaska 99801
(907) 465-3759 phone • (907) 465-3175 fax

24-LS0838\C
Bullock
2/20/06

CS FOR HOUSE BILL NO. 271(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE WILSON

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on overtime for registered nurses and licensed practical**
2 **nurses in health care facilities; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:
6 LEGISLATIVE FINDINGS AND INTENT. The legislature finds that
7 (1) it is essential that registered nurses and licensed practical nurses providing
8 direct patient care be available to meet the needs of patients;
9 (2) quality patient care is jeopardized by registered nurses and licensed
10 practical nurses who work unnecessarily long hours in health care facilities;
11 (3) registered nurses and licensed practical nurses are leaving their profession
12 because of workplace stresses, long work hours, and depreciation of their essential role in the
13 delivery of quality and direct patient care;
14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the
2 persons receiving care from registered nurses and licensed practical nurses in health care
3 facilities;
4 (5) it is necessary that registered nurses and licensed practical nurses be made
5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and
6 (6) health care facilities should provide adequate and safe nurse staffing
7 without the need for or use of mandatory overtime.
8 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:
9 **Chapter 09. Overtime Limitations for Nurses.**
10 **Sec. 18.09.010. Limitations on nursing overtime.** (a) Except as provided in
11 (b) of this section, a nurse in a health care facility may not be required or coerced,
12 either directly or indirectly, to accept an assignment of overtime if, in the judgment of
13 the nurse, the overtime would jeopardize patient or employee safety.
14 (b) This section does not apply to
15 (1) a nurse on duty in overtime status because of an unforeseen
16 emergency situation that could otherwise jeopardize patient safety;
17 (2) a nurse fulfilling prescheduled on-call time;
18 (3) a nurse voluntarily working overtime;
19 (4) the first hour on overtime status when the health care facility is
20 obtaining another nurse to work in place of the nurse in overtime status.
21 (c) After working 12 or more consecutive hours, a nurse shall be allowed not
22 less than eight consecutive hours of off-duty time immediately following the end of
23 that period of duty.
24 (d) A health care facility shall provide for an anonymous process for patients
25 and nurses to make complaints related to staffing levels and patient safety.
26 (e) In this section, "unforeseen emergency situation" means an unusual,
27 unpredictable, or unforeseen situation caused by an act of terrorism, disease outbreak,
28 natural disaster, or other act of God, but does not include a situation in which a health
29 care facility has reasonable knowledge of increased patient volume or inadequate
30 staffing because of staff scheduling, vacations, medical leave, or other foreseeable
31 cause.

1 **Sec. 18.09.020. Prohibition of retaliation.** A health care facility may not
2 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
3 Board of Nursing against a nurse for exercising rights under this chapter or for the
4 good faith reporting of an alleged violation of this chapter.
5 **Sec. 18.09.030. Regulations.** The commissioner shall administer this chapter
6 and adopt regulations for implementing and enforcing this chapter. In this section,
7 "commissioner" means the commissioner of labor and workforce development.
8 **Sec. 18.09.040. Report requirements.** (a) A health care facility subject to the
9 limitations on nursing overtime in AS 18.09.010 shall establish a procedure requiring
10 each nurse to report overtime hours worked and for the nurse to designate the reported
11 hours as either voluntary or mandatory.
12 (b) The health care facility shall file a semiannual report with the section in
13 the Department of Labor and Workforce Development responsible for research and
14 analysis. The report for the six month period ending June 30 must be filed before the
15 following August 1, and the report for the six month period ending December 31 must
16 be filed before the following February 1. The report must include the number of
17 overtime hours worked, the number of overtime hours that were mandatory, the
18 number of overtime hours that were voluntary, the number of on-call hours, the
19 number of on-call hours that were mandatory, and the number of on-call hours that
20 were voluntary for nurses employed by the health care facility. The report must also
21 state the number of hours worked in each month by nurses under contract with the
22 health care facility.
23 (c) The report under this section shall be available for public inspection.
24 **Sec. 18.09.900. Definitions.** In this chapter,
25 (1) "health care facility" means a private, municipal, state, or federal
26 hospital; psychiatric hospital; independent diagnostic testing facility; residential
27 psychiatric treatment center; skilled nursing facility; kidney disease treatment center
28 (including freestanding hemodialysis units); intermediate care facility; ambulatory
29 surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by
30 the Department of Health and Social Services under AS 47.55; correctional facility
31 administered by the Department of Corrections or the Department of Health and

1 Social Services; private, municipal, state, or federal facility employing one or more
2 public health nurses; long-term care facility; or primary care outpatient facility;
3 (2) "nurse" means an individual licensed to practice registered nursing
4 or practical nursing under AS 08.68 who provides nursing services through direct
5 patient care or clinical services and includes a nurse manager when delivering in-
6 hospital patient care;
7 (3) "on-call" means a status in which a nurse must be ready to report to
8 the health care facility and may be called to work by the health care facility;
9 (4) "overtime" means the hours worked in excess of a predetermined
10 and regularly scheduled shift that is agreed upon by a nurse and a health care facility.
11 * **Sec. 3.** AS 18.09.040, enacted in sec. 2 of this Act, takes effect July 1, 2006.
12 * **Sec. 4.** Except as provided in sec. 3 of this Act, this Act takes effect January 1, 2007.

24-LS0838\Y.1
Bullock
1/21/06

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE WILSON

TO: CSHB 271(HES), Draft Version "Y"

1 Page 3, following line 26:
2 Insert a new subsection to read:
3 "(d) A health care facility shall establish a procedure requiring each nurse to
4 report overtime hours worked and for the nurse to designate the reported hours as
5 either voluntary or mandatory. For each calendar month, the health care facility shall
6 report to the division of labor standards and safety in the Department of Labor and
7 Workforce Development the name, number of overtime hours worked, and amount of
8 overtime compensation paid for each nurse. The health care facility shall determine
9 the amount of any penalty due under (c) of this section and pay the amount at the time
10 the report is filed. The report filed by the health care facility under this subsection
11 shall be available for public inspection."
12
13 Reletter the following subsection accordingly.

L

LEGAL SERVICES

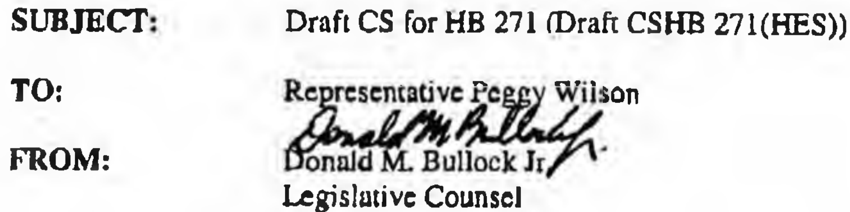
DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM September 21, 2005

SUBJECT: Draft CS for HB 271 (Draft CSHB 271(HES))



TO: Representative Peggy Wilson

FROM: Donald M. Bullock Jr.
Legislative Counsel

Enclosed with this memorandum is a draft HESS committee substitute for HB 271. This draft differs from HB 271 by rewriting the proposed sec. 18.09.030(c) on page 3 of HB 271.

HB 271 provided for civil penalties that included "[paying] a nurse required to work in violation of this chapter three times the nurse's hourly compensation for each hour worked in violation of this chapter." The proposed CSHB 271(HES) deletes the triple payment to the nurse as a civil penalty and increases each of the remaining penalties by "the amount of compensation paid to a nurse for each hour worked in violation of this chapter." This change does not affect the compensation the nurse is entitled to for working the overtime hours, but increases the amount of the penalty that must be paid to the state by the amount of compensation paid.

Also, the present draft has a January 1, 2006 effective date, which will make the bill retroactive. Do you want the effective date changed to a date after the second season, such as January 1, 2007 or earlier?

If I may be of further assistance, please advise.

DMB:med
05-449.med

Enclosure

24-LS0838\Y
Bullock
9/21/05

CS FOR HOUSE BILL NO. 271(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE WILSON

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on overtime for registered nurses in health care facilities;**
2 **and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
5 to read:
6 LEGISLATIVE FINDINGS AND INTENT. The legislature finds that
7 (1) it is essential that registered nurses providing direct patient care be
8 available to meet the needs of patients;
9 (2) quality patient care is jeopardized by registered nurses who work
10 unnecessarily long hours in health care facilities;
11 (3) registered nurses are leaving their profession because of workpl.
12 stresses, long work hours, and depreciation of their essential role in the delivery of quality and
13 direct patient care;
14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and the health and general well-being of the persons receiving care from
2 registered nurses in health care facilities;
3 (5) it is necessary that registered nurses be made aware of their rights, duties,
4 and remedies concerning hours worked and patient safety; and
5 (6) health care facilities should provide adequate and safe nursing staffing
6 without the need for or use of mandatory overtime.
7 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:
8 **Chapter 09. Overtime Limitations for Registered Nurses.**
9 **Sec. 18.09.010. Limitations on nursing overtime.** (a) Except as provided in
10 (b) of this section, a nurse in a health care facility may not be required or coerced,
11 either directly or indirectly, to accept an assignment of overtime if, in the judgment of
12 the nurse, the overtime would jeopardize patient or employee safety.
13 (b) This section does not apply to
14 (1) a nurse on duty in overtime status because of an unforeseen
15 emergency situation that could otherwise jeopardize patient safety;
16 (2) a nurse fulfilling prescheduled on-call time;
17 (3) a nurse voluntarily working overtime;
18 (4) the first hour on overtime status when the health care facility is
19 obtaining another nurse to work in place of the nurse in overtime status;
20 (5) a critical access hospital.
21 (c) After working 12 or more consecutive hours, a nurse shall be allowed not
22 less than eight consecutive hours of off-duty time immediately following the end of
23 that period of duty.
24 (d) A health care facility shall provide for an anonymous process for patients
25 and nurses to make complaints related to staffing levels and patient safety.
26 (e) In this section,
27 (1) "critical access hospital" has the meaning in 42 U.S.C.
28 1395x(mm)(1);
29 (2) "unforeseen emergency situation" means an unusual, unpredictable,
30 or unforeseen situation caused by an act of terrorism, disease outbreak, natural
31 disaster, or other act of God, but does not include a situation in which a health care

1 facility has reasonable knowledge of increased patient volume or inadequate staffing
2 because of staff scheduling, vacations, medical leave, or other foreseeable cause.
3 **Sec. 18.09.020. Prohibition of retaliation.** A health care facility may not
4 discharge, discipline, threaten, discriminate against, penalize, or file a report wi the
5 Board of Nursing against a nurse for exercising rights under this chapter or for the
6 good faith reporting of an alleged violation of this chapter.
7 **Sec. 18.09.030. Enforcement, offenses, and penalties.** (a) The commissioner
8 shall administer this chapter and adopt regulations for implementing and enforcing this
9 chapter.
10 (b) A complaint alleging a violation of this chapter must be filed with the
11 commissioner within 30 days following the date of the alleged violation. The
12 commissioner shall provide a copy of the complaint to the health care facility named
13 in the filing within three business days after receiving the complaint.
14 (c) Upon a finding by the commissioner that a health care facility has violated
15 a provision of this chapter, the following civil penalties shall apply:
16 (1) for a first violation of this chapter, the health care facility shall
17 receive a reprimand and be assessed a penalty equal to the amount of overtime
18 compensation paid to a nurse for each hour worked in violation of this chapter;
19 (2) for a second violation of this chapter within 12 months, the health
20 care facility shall receive a reprimand and be assessed a penalty equal to the amount of
21 overtime compensation paid to a nurse for each hour worked in violation of this
22 chapter plus $500;
23 (3) for a third or subsequent violation of this chapter within 12 months,
24 the health care facility shall be assessed a penalty equal to the amount of overtime
25 compensation paid to a nurse for each hour worked in violation of this chapter plus an
26 additional amount of not less than $2,500 but not more than $5,000 for each violation
27 (d) In this section, "commissioner" means the commissioner of labor and
28 workforce development.
29 **Sec. 18.09.900 Definitions.** In this chapter,
30 (1) "health care facility" means a private, municipal, state, or federal
31 hospital; psychiatric hospital; independent diagnostic testing facility; residential

1 psychiatric treatment center; skilled nursing facility; kidney disease treatment center
2 (including freestanding hemodialysis units); intermediate care facility; ambulatory
3 surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by
4 the Department of Health and Social Services under AS 47.55; correctional facility
5 administered by the Department of Corrections or the Department of Health and
6 Social Services; private, municipal, state, or federal facility employing one or more
7 public health nurses; long-term care facility; or primary care outpatient facility;
8 (2) "nurse" means an individual licensed to practice registered nursing
9 under AS 08.68 who provides nursing services through direct patient care or clinical
10 services and includes a nurse manager when delivering in-hospital patient care;
11 (3) "overtime" means the hours worked in excess of a predetermined
12 and regularly scheduled shift that is agreed upon by a nurse and a health care facility.
13 *** Sec. 3.** This Act takes effect January 1, 2006.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271-DHSS-DHCS-01-23-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Health Care Services

Component: Medicaid Services

Sponsor: WILSON

Requester: HOUSE (L&C)

Component No: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Alaska statutes (AS 47.07.070) require Medicaid hospital and nursing facility rates to be based on reasonable costs related to patient care. This proposed statute could require hospitals to hire more higher cost contract nurse staff because of the shortage of nurses in Alaska, and pay more for overtime nursing services. The additional costs would push Medicaid hospital and nursing facility rates upward. Generally speaking Medicaid pays it's share of new hospital (Approx 20-30%) and nursing facility (Approx 80-85%) costs eventually. The DHSS does not have data on how many nurses could currently be working illegal overtime under this proposed statute. There could well be an impact on Medicaid hospital and nursing facility payment rates, however the amount of such impact is indeterminate at this time.

Prepared by: Jack Nielson — Phone 334-2447
Division: Commissioner's Office/Office of Rate Review — Date/Time 01/19/2006
Approved by: Karleen Jackson, Commissioner — Date 01/23/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271-DHSS-DAPH-01-24-06
( ) Publish Date:

Revision Date/Time (Note if correction): 01-24-06
Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES
RDU: Alaskan Pioneer Homes
Component: Pioneers Homes

Sponsor: WILSON
Requester: HOUSE (L&C)
Component No. 2671

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual	134.4	134.4	134.4	134.4	134.4	134.4
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**134.4**	**134.4**	**134.4**	**134.4**	**134.4**	**134.4**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF	134.4	134.4	134.4	134.4	134.4	134.4
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**134.4**	**134.4**	**134.4**	**134.4**	**134.4**	**134.4**

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 271 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities and penalties for violations. The intent of HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a penalty payment to the RN of 3 times the normal rate of pay. "Overtime" (OT) means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed on by a nurse and a health care facility. Mandatory OT to address an unforeseen emergency is not subject to the limitations or penalties under the bill.

Prepared by: Dave Williams   Phone 465-5737
Division: Alaskan Pioneer Homes   Date/Time 01/ 8/2006
Approved by: Karleen Jackson, Commissioner   Date 01/24/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO. HB271-DHSS-DAPH 01-24-06

ANALYSIS CONTINUATION

The level of care provided to Pioneer Home residents necessitates at least one RN in each major area of each facility around the clock. More are scheduled depending on the number of floors in the facility and the level of resident health care needs. Emergent situations such as staff illness and fluctuating resident needs are addressed by requesting voluntary OT in excess of the regularly scheduled hours. Staff vacancies are also addressed with voluntary OT until management is able to fill the positions. Certified Nurse Assistants and on-call RNs are used as much as feasible to offset the use of additional RN time. Facility management find this to be more cost-effective than scheduling staffing at high levels year-round to assure no OT occurs. On occasions when there are no volunteers to work needed hours, mandatory OT is assigned. In situations where there is a vacant RN position that results in OT, RNs may be assigned OT or on-call RNs may be called in to address the staffing requirement.

The Pioneer Home system averages 463 hours of RN OT per month.* Of that amount, we estimate that 200 hours would become mandatory OT under the bill. To reduce the use of mandatory OT and minimize the penalties under the bill, the division would request ability to hire more nurses, increase use of on-call nurses and otherwise rely upon use of contracted RNs. At present, potential for an increase of RNs appears to be primarily through RN contracting agencies. Use of contracted RNs would result in an annual increase of approximately $134.4 in contractual cost for the division. That estimate is based upon an average hourly rate of $56 for 200 hours per month ($56 X 200 X 12 = $134.4) and is used in this fiscal note as the impact of the bill. If the division is not able to secure contract hours and has to pay the HB 271 treble cost penalty for all OT the added personal services cost will be $188.7. The reality of the fiscal impact is probably somewhere in between $134.4 contractual and $188.7 personal services cost depending on the available number of contracted RNs hours.

There is a shortage of RNs nationwide that limits the ability of the division to interview and hire RNs. In this regard, the University of Alaska School of Nursing acted to increase its enrollment about two years ago. In December, the School of Nursing graduated 98 RNs who will be available to the workforce, but require about two years of experience to become independently functional and effective in reducing mandatory OT. A similar number of graduates from the school is expected in May of 2006.

The division's ability to hire RNs is hampered by the differential between state wages for RNs and non-state wages. During calendar year 2005 state wages for RNs were approximately $3.00 to $4.00 per hour less than those of the non-state hospitals in Anchorage. To address the wage differential, the Governor's budget includes funds to raise salaries of nurses by one range (or 7.5%). That change and other benefits of working for the state should reduce turnover, improve recruitment, and reduce the need for OT.

The effective date of HB 271 is January 1, 2006. For this fiscal note we assume that the effective date will be changed to July 1, 2006.

- - - -

* Source is calendar year 2004 unaudited overtime hours, Division of Personnel. premium pay for hours worked on a holiday, straight overtime, overtime pay at time and a half, swing shift overtime, and grave shift overtime.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB271-DHSS-DBH-01-23-06
( ) Publish Date:

Revision Date/Time (Note if correction): 01-23-06

Dept. Affected: Health & Social Services

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Behavioral Health

Component: Alaska Psychiatric Institute

Sponsor: WILSON

Requester: HOUSE (L&C)

Component No: 311

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual	161.3	161.3	161.3	161.3	161.3	161.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health	161.3	161.3	161.3	161.3	161.3	161.3
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if ssary)*

The intent of HB 271 is to eliminate mandatory overtime for Registered Nurses unless a grave unforeseen event drives the need for mandatory overtime. API averages 337 hours of voluntary overtime and 40 hours of mandatory overtime each month. API estimates that at least half the Registered Nurses volunteer for overtime to avoid being assigned mandatory overtime. If these nurses did not volunteer to work overtime, API estimates that 200 hours each month of mandatory overtime would be assigned. The calculation below is based upon current mandatory overtime of 40 hours per month plus the estimated 200 hou s that would be assigned. To eliminate the need for mandatory overtime, API would have to hire contractual nurses. This would result in approximately $161.3 of increased contractual cost for API annually based upon an average hourly rate of $56 for 1.5 FTE Registered Nurse locum tenens (1.5FTE x 40 = 60hs/wk x 4 = 240hr/months x 12 = 2,880hrs x $56 = $161.3).

Prepared by: Cristy Willer, Director
Phone 269-3410
Division: Behavioral Health
Date/Time 01/20/2006
Approved by: Karleen Jackson, Commissioner
Date 01/23/2006
Agency: Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 271
() Publish Date:

Revision Date/Time (Note if correction):

Title	Limit Overtime for Registered Nurses
Sponsor	Wilson
Requester	Health, Education & Social Services

Dept. Affected:	Commerce
RDU	Corps, Bus & Prof Licensing (117)
Component	Corps, Bus & Prof Licensing
Component No.	2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by:	Jennifer Strickler, Chief	Phone	907.465.2144
Division	Corporations, Business & Professional Licensing	Date/Time	1/24/06 9:14 AM
Approved by:	William C. Noll, Commissioner	Date	1/24/2006
Agency	Commerce, Community and Economic Development		

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 271
(H) Publish Date: 5/2/05

Revision Date/Time (Note if correction):
Title: Limit Overtime for Registered Nurses
Sponsor: Wilson
Requester: House Labor & Commerce

Dept. Affected: Commerce
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal: [ ]

POSITIONS

POSITIONS	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by: Jennifer Strickler, Administrative Manager — Phone (907) 465-2144
Division: Occupational Licensing — Date/Time 4/30/05 11:52 AM
Approved by: Edgar Blatchford, Commissioner — Date 4/30/2005
Agency: Commerce, Community, and Economic Development

(Revised 9/23/2004 OMB)

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: HB 271
(H) Publish Date: 5/2/05
Dept. Affected: Health & Social Services
RDU: Behavioral Health
Component: Alaska Psychiatric Institute
Component No. 311

Revision Date/Time (Note if correction):

Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

Sponsor: WILSON

Requester: HOUSE (L&C)

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual	161.3	161.3	161.3	161.3	161.3	161.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health	161.3	161.3	161.3	161.3	161.3	161.3
Other(Specify Tyoe-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**	**161.3**

Estimate of any current year (FY2005) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The intent of HB 271 is to eliminate mandatory overtime for Registered Nurses unless a grave unforeseen event drives the need for mandatory overtime. API averages 337 hours of voluntary overtime and 40 hours of mandatory overtime each month. API estimates that at least half the Registered Nurses volunteer for overtime to avoid being assigned mandatory overtime. If these nurses did not volunteer to work overtime, API estimates that 200 hours each month of mandatory overtime would be assigned. The calculation below is based upon current mandatory overtime of 40 hours per month plus the estimated 200 hours that would be assigned. To eliminate the need for mandatory overtime, API would have to hire contractual nurses. This would result in approximately $161.3 of increased contractual cost for API annually based upon an hourly rate of $50 for 1.5 FTE Registered Nurse locum tenens (1.5FTE x 40 = 60hs/wk x 4 = 240hr/months x 12 = 2,880hrs x $56 = $161.3).

Prepared by: Bill Hogan, Director
Phone 465-3166
Division: Behavioral Health
Date/Time 04/28/2005
Approved by: Joel S. Gilbertson, Commissioner
Date 04/29/2005
Agency: Department of Health and Social Services

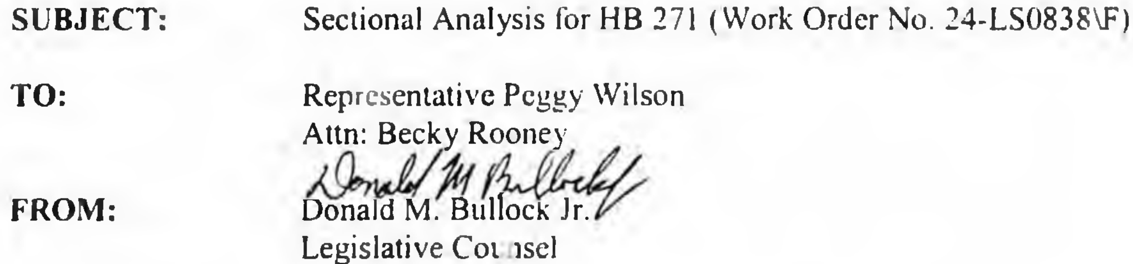
LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 30, 2005



SUBJECT: Sectional Analysis for HB 271 (Work Order No. 24-LS0838\F)

TO: Representative Peggy Wilson
Attn: Becky Rooney

FROM: Donald M. Bullock Jr.
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. States legislative findings and intent relating to limiting overtime for registered nurses for the benefit of persons receiving care from registered nurses; states that health care facilities should provide adequate and safe nurse staffing without the need for mandatory overtime.

Section 2. Adds a new chapter, AS 18.09 to AS 18 that includes the following sections:

Sec. 18.09.110. Provides that a nurse in a health care facility may not be required or coerced to accept an assignment of overtime, with certain exceptions, if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety; lists five situations in which a nurse may be required to work overtime; provides for a minimum of eight consecutive hours of off-duty time after working 12 or more consecutive hours; requires a health care facility to provide an anonymous process for nurses and staff to make complaints related to staffing levels and patient safety; adds definitions for the section.

Sec. 18.09.020. Prohibits retaliation, including filing a report with the Board of Nursing, against a nurse for exercising rights under AS 18.09.

Sec. 18.09.030. Provides for enforcement of the chapter by the commissioner of labor and workforce development; sets the time period for filing a complaint alleging a violation of the chapter; provides increasing penalties for a violation of the chapter by a health care facility that range from a reprimand for a first violation to a penalty between $2,500 and $5,000 for a third violation within a 12-month period; requires the health care facility to pay a nurse three times the nurse's hourly rate for each hour worked in violation of the chapter.

Sec. 18.09.900. Defines "health care facility," "nurse" (to mean a licensed registered nurse), and overtime.

Section 3. Makes the Act effective January 1, 2006, and will require a 2/3 vote in both houses.

If I may be of further assistance, please advise.

DMB:med
05-324.med

Carol Goss Widman
8461 Brookridge Drive
Anchorage, Alaska 99504
907-333-8797

Rep. Peggy Wilson
State Capitol
Room 108
Juneau, Alaska 99801

April 28, 2005

To Whom It May Concern:

I am writing this letter in support of House Bill 271 "an act relating to limitations on overtime for registered nurses in health care facilities; and providing for an effective date". I am a registered nurse who works for the state of Alaska and is subject to mandatory overtime. I have been mandated to work 16 hour shifts so many times I have lost count. During these times I have had to give medications to 20-30 patients. I personally would not like to have a nurse give me medications who has worked 16 hours. Numerous transcription errors, medication errors, and judgment errors are caused by this unfortunate practice used to staff hospitals. If a nurse refuses to work mandatory over time they are subject to disciplinary action.

Many states have passed bills outlawing this practice due to it being unsafe and very dangerous to patients. Nurses who work night shift 11pm – 7 am are forced to work till 3 pm -- then they are required to return to work again that night. This practice is very dangerous to patients and staff. I feel this bill is very important for the welfare of patients and citizens of the state of Alaska. Mandatory overtime is a practice that needs to be stopped.

Sincerely,

Carol Goss Widman RN

Carol Goss Widman, RN

FROM : JASON P WIDMAN FAX NO. : 907 333 8797 Apr. 28 2005 11:52PM P2

t/ 907-274-0827
f/ 907-272-0292

2207 East Tudor Rd, Suite 34
Anchorage, AK 99507-1069
www.aknurse.org
aknurse@aknurse.org

April 27, 2005

Representative Peggy Wilson
State Capitol
Room 108
Juneau, AK 99801

Dear Representative Wilson,

Let me take this opportunity to thank you on behalf of the Alaska Nurses Association and its labor program for your sponsorship of House Bill 271, "an act relating to limitations on overtime for registered nurses in health care facilities..."

I have been an RN for 26 years and have tried to work within the health care system to improve patient care. We really need to provide a safe environment for patients as well as to address the needs of the professional trying to deliver this quality care. Unfortunately, our voices as nurses often seem to go unheard. To have you, a registered nurse, in the Alaska House of Representatives, a person who both understands these issues and is able to vocalize them on our behalf, is quite a step and we are quite pleased.

As you know, hospitals and health care facilities in this country are using mandatory overtime to staff hospitals everyday. Here in Alaska, the problem is currently most acute at the Alaska Psychiatric Institute but that does not mean that with the growing nursing shortage, the problem could not become much larger affecting patient care in all of our major hospitals if it is not addressed now.

It is appropriate for the state to notify hospital administrations today that whatever staffing problems loom on the horizon, involuntary, mandatory overtime will not be tolerated as a long term solution. There is no better way than imposing mandatory overtime to drive the nurses we still have out of the profession for good.

The Alaska Nurses Association and the Providence Registered Nurses Bargaining Unit are proud to stand up for their nursing colleagues at the Alaska Psychiatric Institute and elsewhere who are being forced to work multiple additional shifts in a given week. This practice is unsafe for patients and unsafe for nurses. Ultimately, it is unsafe for our community.

Again, we want to thank you for your support and indicate our strong support for House Bill 271.

Sincerely,

Donna Phillips

Donna Phillips, RN, BSN
Member, Alaska Nurses Association Board of Directors
Chair, AaNA Labor Council
Treasurer and Membership Chair,
Providence Registered Nurses Bargaining Unit

MICHELLE MURPHY, RN
3425 Patterson Street
Anchorage, Alaska 99504
(907) 240-2980
mlmrn@acsalaska.net

April 28, 2005

Rep. Peggy Wilson
State Capitol
Room 108
Juneau, AK 99801

Dear Representative Wilson,

I am writing this letter to express my enthusiastic and sincere support for HB 271. This bill is very important because it would ensure the safety of Alaskans by banning the use of mandatory overtime as a means for hospitals and other healthcare institutions to provide nursing staff during the nursing shortage.

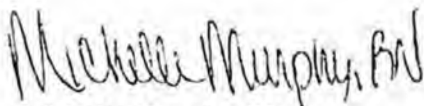
As both a full-time working RN and the Health and Safety officer for the Providence Registered Nurses union, banning mandatory overtime is a critical step for ensuring the health and safety of both the patients and the nurses caring for them. Numerous studies and statistics have shown how this practice has very adverse affects on both nurses and patients and therefore it should be banned.

Why should Alaska make this a law? Because if hospitals and other health care institutions could be trusted not to practice the unsafe use of mandatory overtime to staff their nursing shortage they would have already been doing it.

I have included an article written by Sara Markle – Elder from the United American Nurses that outlines the negative impacts on both the patients and the nurses.

Please enact this bill in Alaska and make us a leader in participating in the regulation of the dangerous use of mandatory overtime for nurses.

Sincerely,



Michelle Murphy, RN

MEMORANDUM May 3, 2005

TO: HESS Committee Members
FROM: Rep. Peggy Wilson
SUBJECT: Critical Care Hospital Definition

Critical access hospitals (CAH) are recognized by CMS for cost-based reimbursement purposes. To obtain eligibility as a CAH, the facility must be a Medicare hospital, a hospital that stopped operating on or after November 29, 1989, or a health clinic or health center that was a hospital before it was downsized.

The geographic location of the facility plays a role in its designation as a CAH as well.

The facility must be located in a rural area of a State that has established a Medicare rural flexibility program, or within a Metropolitan Statistical Area (MSA) of such a State.

The CAH must be located more than a 35-mile drive from another hospital or CAH (15 miles in mountainous terrain, or areas with only secondary roads) unless it was designated by the state to be a 'necessary provider' before January 1, 2006.

The facility must offer round-the-clock emergency care services, provide not more than 25 beds (acute and/or swing with SNF level care if the CAH has a swing bed agreement) and maintain an average length of stay of no more than 96 hours.

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Frank H. Murkowski, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3228
FAX (907) 465-3068

March 25, 2005

Representative Peggy Wilson
Alaska House of Representatives
Capitol Building Room 108
Juneau, Alaska 99801

Representative Wilson:
On March 25, 2005 your staff requested a list of critical access hospitals in Alaska. I am providing that information to you below for your reference.

Cordova Community Medical Center P.O. Box 160 Cordova, Alaska 99574 Phone: 907-424-8000	**Providence Seward Medical Ctr./Wesley Care Ctr.** P.O. Box 365 Seward, Alaska 99664 Phone: 907-224-5205
Kanakanak Hospital P.O. Box 130 Dillingham, Alaska 99576 Phone: 907-842-5201	**Sitka Community Hospital** 209 Moller Avenue Sitka, Alaska 99835 Phone: 907-747-3241
Maniilaq Health Center P.O. Box 43 Kotzebue, Alaska 99752 Phone: 907-442-3321	**Valdez Regional Health Authority** P.O. Box 550 Valdez, Alaska 99686 Phone: 907-835-2249
Petersburg Medical Center P.O. Box 589 Petersburg, Alaska 99833 Phone: 907-772-4291	**Wrangell Medical Center** P.O. Box 1081 Wrangell, Alaska 99929 Phone: 907-874-7000
Providence Kodiak Island Medical Center 1915 E. Rezanof Drive Kodiak, Alaska 99615 Phone: 907-486-3281	**Norton Sound Health Corporation** P.O. Box 966 Nome, Alaska 99762 Phone: 907-443-3311 - Website

Please let us know if you have any questions or need additional information.

Sincerely,

Robert Butteane
Project Coordinator

cc: Sherry Hill; Janet Clarke

State of Alaska Median Wage as of January 2005

Nurse I	20.51/hr (A Step)
Nurse II	26.20/hr (F Step)

Pay Systems:

Ketchikan General
One step increase for every year or 1,248 compensated hours, whichever comes later.
Maximum 2 steps per year.
20 steps total.

Central Peninsula General Hospital:
One step increase for every 1,872 hours worked.
30 steps total.

Providence Alaska Medical Center:
Unavailable

State of Alaska:
One step increase per year for the first 7 steps.
Longevity increases based on length of service after first 7 steps.
11 steps total.

Bartlett Regional Hospital:
One step every 2,080 hours worked.
12 steps total.

Overtime Paid in FY 2005 to Nurses by Facility

Organizational Unit	Number of Positions	# of EEs who worked OT	FY 05 Total Amt	FY 05 Total Hrs	Ave Hrs/ Position
Ak Psychiatric Institute	73	55	$ 205,057.41	9,585.25	131.30
Amya	1	1	$ 224.59	15.00	15.00
Amya - Challenge	2	2	$ 7,854.42	211.50	105.75
Anchorage Pioneers Home	39	33	$ 32,536.63	2,053.25	52.65
Children's Svc - Family Services Juneau	1	1	$ 275.76	6.00	6.00
Fairbanks Health Center	20	1	$ 135.90	4.00	0.20
Fairbanks Pioneers Home	19	11	$ 42,927.66	2,055.50	108.18
Juneau Pioneers Home	17	11	$ 5,053.57	383.25	22.54
Juv Just - Bethel Youth Facility	1	1	$ 990.18	16.75	16.75
Juv Just - Fairbanks Youth Facility	2	1	$ 379.90	9.00	4.50
Juv Just - Johnson Youth Center	2	2	$ 1,022.35	36.75	18.38
Juv Just - Mat Su Youth Facility	1	1	$ 2,728.80	73.75	73.75
Juv Just - Mclaughlin Youth Center	3	3	$ 6,460.18	259.75	86.58
Ketchikan Pioneers Home	12	6	$ 12,926.85	913.75	76.15
Military Youth Corps	2	1	$ 147.02	4.50	2.25
Mt Edgecumbe High School	2	1	$ 660.76	19.50	9.75
Palmer Pioneers Home	18	13	$ 11,621.94	583.00	32.67
Sitka Pioneers Home	23	15	$ 25,690.29	1,257.00	54.65
Inmate Health Care-Anchorage	54	34	$ 318,669.21	14,751.25	273.17
Inmate Health Care-Bethel	4	2	$ 35,004.85	763.50	190.88
Inmate Health Care-Eagle River	14	8	$ 55,119.93	2,532.50	180.89
Inmate Health Care-Fairbanks	10	7	$ 15,408.09	786.75	78.68
Inmate Health Care-Juneau	4	3	$ 9,524.18	326.75	81.69
Inmate Health Care-Kenai	10	5	$ 28,070.81	920.50	92.05
Inmate Health Care-Ketchikan	4	1	$ 4,920.22	122.00	30.50
Inmate Health Care-MacKenzie Pt	2	1	$ 146.94	4.00	2.00
Inmate Health Care-Nome	3	3	$ 18,079.59	317.00	105.67
Inmate Health Care-Palmer	11	6	$ 37,474.35	1,301.00	118.27
Inmate Health Care-Seward	10	10	$ 31,202.01	1,439.50	143.95
Grand Total	238	239	$ 910,314.39	40,757.25	171.25

Overtime Codes are 251(overtime), 252 (double), 254 (holiday), 260 (swing OT), 261 (grave OT)
x: Projects/Nurse OT/Nurse (only) Overtime by Org Unit
Prepared by C. Preecs, Human Resource Specialist, Division of Personnel

Nursing Employee Movement between Departments and Out of the Executive Branch in 2004

	Education			Health & Social Services			Commerce, Comm & ED			Military & VA			Corrections			Job Class Totals		
Job Class Title	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent
Assistant Chief, Public Health Nursing					1	0%											1	0%
Assistant Nursing Director					1	0%											1	0%
Chief, Public Health Nursing					1	0%											1	0%
Licensed Practical Nurse				4	21	19%							3	27	11%	7	48	15%
Nurse Consultant I				2	11	18%		1	0%							2	12	17%
Nurse Consultant II				5	16	31%										5	16	31%
Nurse I				5	10	50%					1	0%	3	4	75%	8	15	53%
Nurse II		1	0%	8	36	22%					1	0%	4	35	11%	12	73	16%
Nurse II (Psychiatric)				10	37	27%							2	7	29%	12	44	27%
Nurse III				3	20	15%					1	0%	3	9	33%	6	30	20%
Nurse III (Psychiatric)					11	0%								1	0%		12	0%
Nurse IV					2	0%											2	0%
Nurse IV (Psychiatric)				1	6	17%								1	0%	1	7	14%
Nursing Director					1	0%											1	0%
Public Health Nurse I					5	0%											5	0%
Public Health Nurse II				4	41	10%										4	41	10%
Public Health Nurse III				5	46	11%										5	46	11%
Public Health Nurse IV					8	0%											8	0%
Public Health Nurse V					5	0%											5	0%
Quality Assurance And Utilization Review Nurse														1	0%		1	0%
Departmental Totals	0	1	0%	47	279	17%	0	1	0%	0	3	0%	15	85	18%	62	369	17%

Sources: DB2 Connect to 20P Screen, Workpad Job Classification Download, AKPAY
AH: Nur[illegible]ployee Movement 2004
Prepared [illegible] Polland, Human Resource Specialist, Division of Personnel

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Print Page | Close Window

Nurses say working long hours is dangerous

OVERTIME: Workers seek to limit number of double shifts.

By TIMOTHY INKLEBARGER
The Associated Press

(Published: June 27, 2005)

Nurses at the Alaska Psychiatric Institute in Anchorage and other state-run health care facilities in Alaska are joining a movement to limit mandatory overtime at hospitals. Nurses often work 12- to 16-hour shifts to fill holes in schedules. *(Photo by AL GRILLO / The Associated Press)*

JUNEAU -- Nurses in Alaska are joining a movement in states across the nation to limit forced overtime at hospitals, a practice they contend is dangerous both for them and their patients.

Nurses at state-run health care facilities, such as the Alaska Psychiatric Institute in Anchorage and the state's six Pioneer Homes for seniors, and at health clinics in rural areas often work 12- or 16-hour shifts to help fill holes in round-the-clock schedules.

Dianne O'Connell of the Alaska Nurses Association said nurses sometimes are called in two or three times a week to work double shifts.

They feel obligated to fill the empty shifts over fear of retribution or the possibility of losing their nursing license for abandoning their patients, O'Connell said.

API nursing director Jane Barnes said nurses who leave their posts irresponsibly without alerting other staff could be reported to the Alaska Board of Nursing.

"But we haven't had nurses do that irresponsibly," she said.

Barnes said it is unlikely that nurses would be reported or have their licenses revoked for declining a mandatory overtime shift because of fatigue. She said API takes the circumstances of each situation into account and has tried to work with nurses to accommodate their needs.

Nurses who refuse mandatory overtime shifts without good reason, though, would be subject to disciplinary action, Barnes said. She said any potential disciplinary action would be made known up front before a nurse decides whether to work the shift.

O'Connell said the mandatory overtime issue has been a problem at the Psychiatric Institute for years because the facility does not have enough nurses on staff.

"If somebody calls in sick, they don't have a pool of people to call upon," she said.

There are 8,670 licensed nurses in Alaska. According to a 2000 nationwide survey, Alaska had 782.9 registered nurses per 100,000 residents, close to the national average. But it lagged in licensed practical nurses.

The Alaska State Employees Association, which represents about 90 nurses statewide, and the

Alaska Nurses Association are pushing Alaska lawmakers to pass a bill that would prevent hospitals from requiring nurses to accept overtime hours if they believe it would jeopardize their safety or the safety of their patients. The bill, by Rep. Peggy Wilson, R-Wrangell, would not apply in emergencies.

Nurses would not be allowed to work more than 12 hours without an eight-hour break. Health care facilities that violate the law would have to pay nurses three times their regular pay for the mandatory overtime hours worked. A second offense within 12 months would result in a fine of $500, and a third violation within a year would mean a fine of $2,500 to $5,000.

J.W. Pound, a nurse who has worked at API for 14 years, said nurses at the hospital are attacked by patients on a regular basis. Many of the patients admitted to the institute are straight out of jail, Pound said.

"You have to be on your guard all the time," he said. "You have people who are pretty paranoid. A lot of them are angry and delusional."

Pound, 55, said he works the night shift when attacks are more common.

He said nurses at API often sign up for scheduled overtime shifts to get their names removed from a list of mandatory overtime shifts that can be required if other nurses are sick or unable to work.

He said some of the overtime shifts can make for 16-hour days at the hospital.

ASEA business agent Doug Carson said the assaults can become more of a safety issue for nurses after they've worked double shifts.

"If you're tired, you make yourself more vulnerable," he said.

API director and chief executive officer Ron Adler said the hospital does not compromise its workers' or patients' safety.

"There is a noted incongruence between the data and staff perceptions," Adler said.

Adler said the quality improvement program at API monitors staff safety, which he said is showing a trend of fewer employee and patient injuries.

He said mandatory overtime is a "lightning-rod issue" and the hospital is implementing a nursing management software program that will help identify peak times of the year when mandatory overtime shifts increase.

"It really gives us data and information to staff the hospital in a more precise way than we're doing," he said. "I think we can staff up with seasonal, part-time and on-call employees."

He said the hospital wants to accommodate employees and give them the time off to spend with their families.

Carson said ASEA filed a grievance against the hospital earlier this year, arguing that API cannot call nurses in on their days off. He said the grievance is pending.

Adler declined to comment on the grievance, directing questions to state labor negotiator Art Chance. Chance did not return phone calls requesting an interview.

The Legislature does not meet again until January, but Wilson, who also serves as chairman of the House Health, Education and Social Services Committee, said she plans to hold hearings sometime later this year

Wilson, who has worked as a nurse for 32 years, said she has never had to work mandatory overtime shifts but wants to give those who have a chance to discuss the issue in a public forum.

She said the issue also is a problem for nurses at state corrections facilities.

"I think what hospitals are going to have to do is start paying nurses more," she said, noting that state health care facilities pay nurses significantly less than private facilities, which makes it difficult to retain employees.

Carol Cooke, a spokeswoman for the American Nurses Association, said the move to establish laws limiting mandatory overtime is playing out in many states as well as in Congress.

She said nine states have passed laws limiting the practice and another 23 have introduced legislation.

A bill by U.S. Rep. Pete Stark, D-California, and U.S. Rep. Steven LaTourette, R-Ohio, would limit mandatory overtime to emergency situations and give the U.S. Department of Health and Human Services the authority to issue $10,000 fines to facilities that are in violation. A companion bill in the U.S. Senate has been introduced by Sen. Ted Kennedy, D-Mass.

Adler acknowledged the trend and said API is hoping to move away from mandatory overtime with its new scheduling system and seasonal and part-time employees.

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The Working Hours Of Hospital Staff Nurses And Patient Safety

Both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch.

by Ann E. Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges

ABSTRACT: The use of extended work shifts and overtime has escalated as hospitals cope with a shortage of registered nurses (RNs). Little is known, however, about the prevalence of these extended work periods and their effects on patient safety. Logbooks completed by 393 hospital staff nurses revealed that participants usually worked longer than scheduled and that approximately 40 percent of the 5,317 work shifts they logged exceeded twelve hours. The risks of making an error were significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week.

SEVERAL TRENDS IN HOSPITAL USE and staffing patterns have converged to create potentially hazardous conditions for patient safety. High patient acuity levels, coupled with rapid admission and discharge cycles and a shortage of nurses, pose serious challenges for the delivery of safe and effective nursing care for hospitalized patients.[1] While systematic national data on trends in the number of hours worked per day by nurses are lacking, anecdotal reports suggest that hospital staff nurses are working longer hours with few breaks and often little time for recovery between shifts.[2] Scheduled shifts may be eight, twelve, or even sixteen hours long and may not follow the traditional pattern of day, evening, and night shifts. Although twelve-hour shifts usually start at 7 p.m. and end at 7 a.m., some start at 3 a.m. and end at 3 p.m. Nurses working on specialized units such as

Ann Rogers (aerogers@nursing.upenn.edu) is an associate professor in the School of Nursing and in the Center for Sleep and Respiratory Neurobiology, School of Medicine, University of Pennsylvania, in Philadelphia. Wei-Ting Hwang is an assistant professor in the Department of Biostatistics and Epidemiology, Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania School of Medicine. Linda Scott is an associate professor in the Kirkhof College of Nursing, Grand Valley State University, in Grand Rapids, Michigan. Linda Aiken is the Claire M. Fagin Leadership Professor of Nursing and a professor of sociology at the University of Pennsylvania. David Dinges is a professor in the Division of Sleep and Chronobiology, Department of Psychiatry, Center for Sleep and Respiratory Neurobiology, University of Pennsylvania School of Medicine.

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surgery, dialysis, and intensive care are often required to be available to work extra hours (on call), in addition to working their regularly scheduled shifts. Twenty-four-hour shifts are becoming more common, particularly in emergency rooms and on units where nurses self-schedule.

No state or federal regulations restrict the number of hours a nurse may voluntarily work in twenty-four hours or in a seven-day period.[3] Even though state legislatures in approximately nineteen states have considered bans on mandatory overtime for nurses and other health care professionals, bills prohibiting mandatory overtime for nurses have passed only in California, Maine, New Jersey, and Oregon. No measure, either proposed or enacted, addresses how long nurses may work voluntarily.[4] The recent Institute of Medicine (IOM) report, *Keeping Patients Safe*, explicitly recommends that voluntary overtime also be limited.[5]

The well-documented hazards associated with sleep-deprived resident physicians have influenced changes in house staff rotation policies.[6] In contrast, although shift-working nurses have been the focus of numerous studies, it is not known if the long hours they work have an adverse effect on patient safety in hospitals.[7] The purpose of this paper is to examine the work patterns of hospital staff nurses and to determine if there is a relationship between hours worked and the frequency of errors.

Study Data And Methods

■ **Sample.** A cover letter explaining the study and eligibility criteria was mailed to a random nationwide sample of 4,320 members of the American Nurses Association (ANA) during the winter of 2002; 1,725 nurses expressed interest by returning their completed demographic questionnaire to the Survey Research Institute at Temple University in Philadelphia. Two logbooks covering a two-week period each, instructions for completing the logbooks, and postage-paid envelopes were mailed to 891 eligible subjects (unit-based hospital staff nurses working full time). Three hundred sixty-two subjects returned both logbooks, and thirty-one completed only one of the two logbooks, for a return rate of approximately 40 percent. The Institutional Review Board at the University of Pennsylvania approved this study, and subjects were paid $140 for their participation.

■ **Subjects.** The sample of 393 registered nurses (RNs) was predominantly female (92 percent), Caucasian (79 percent), middle-aged (mean age 44.8 ±8.8 years, range 22–66), and experienced (mean 17.2 ±10.0 years). Only 26.3 percent of the participants reported less than ten years' experience, while 41.9 percent reported twenty or more years. All participants worked full time (at least thirty-six hours per week) as hospital staff nurses. Half reported working in hospitals with more than 300 beds; only 11 percent reported working in a hospital with less than 100 beds. The majority of participants were employed at hospitals located in urban (56 percent) or suburban (19 percent) areas. The remaining participants worked in hospitals located in small towns (18 percent) or rural areas (7 percent). The characteristics of

nurses in the study sample did not differ significantly from those of nurses in the 2000 National Sample Survey of Registered Nurses (NSSRN) in terms of sex, age, marital status, and work environment (hospital size, urban/rural location, and type of hospital unit).[8] Our sample has slightly more nurses who identified their ethnicity as Asian (10.7 percent) than among participants in the NSSRN (3.8 percent).

■ **Instruments.** Spiral-bound logbooks were used to collect information about hours worked (both scheduled and actual hours), time of day worked, overtime, days off, and sleep/wake patterns. Subjects completed seventeen to forty items per day; all forty questions were completed only on days the nurses worked. Questions regarding errors and near errors were included, and space was provided for nurses to describe any errors or near errors that might have occurred during their work periods. On days off, nurses were asked to complete the first seventeen questions about their sleep/wake patterns, mood, and caffeine intake. All items in the logbook and the logbook format itself were pilot-tested before this study began.

Logbooks (both paper and electronic) have been used to collect data during field studies of pilots' cockpit alertness for more than ten years, and from various other groups of subjects including air traffic controllers, flight controllers during space shuttle missions, and emergency room physicians.[9] Data recorded about sleep patterns in these logbooks compare well with data recorded using objective measures such as wrist actigraphy or ambulatory polysomnography.[10]

Although logbooks are not often used to collect information about medical errors, there is some evidence that daily, anonymous, end-of-shift reporting of errors in a logbook is a valid approach to ascertaining the nature and prevalence of nursing errors. During a one-month study period of medication errors at a large military hospital, nurses completed formal incident reports on only 6 percent of the medication errors and 15 percent of the near errors that they reported using daily, anonymous coupons.[11] Another study found that resident physicians also were more likely to report potential injuries to patients using a confidential e-mail system with daily prompts about reporting than they were to complete traditional incident reports.[12]

■ **Analysis.** Data from demographic questionnaires and logbooks were summarized using descriptive statistics and frequency tables. The duration of scheduled and actual work hours per shift was calculated and aggregated per nurse and per week. Cutpoints for classifying shift durations were chosen as 8.5 hours and 12.5 hours because "eight-hour" and "twelve-hour" shifts are usually scheduled to allow for a half-hour handover period at the end of the shift. A work shift was classified as an overtime shift if the actual work hours were longer than the scheduled hours or if the nurse reported that the shift was "scheduled overtime."

A binary response for making an error during a worked shift was used as the primary outcome in analyses. When a nurse caught him/herself before making an error during a shift, a binary near-error variable was reported and treated as the secondary outcome. Errors and near errors were codified into categories by study

investigators, based on the descriptions provided in logbooks (for example, medication administration, procedural, transcription). The univariate associa[illegible]ns between the risk of making an error or a near error and (1) the actual duration of the shift, and (2) overtime were estimated separately using logistic regression models. The effect of overtime was also examined by stratifying shifts by their expected duration. Since multiple work shifts from the s[illegible]me nurse contributed to this analysis, procedures based on Generalized Estimating Ec[illegible]ation (GEE) were used to determine the odds ratio (OR) while accounting fo[illegible] the nonindependence between repeated measurements.[13] Significance tests were two-sided with alpha = .05. Multivariate analyses also were conducted to evaluate the adjusted associations between errors (or near errors), work hours, and overtime, while controlling for other variables including age, hospital size, and type of hospital unit. For the week-level data, logistic regression models were performed to assess if working more than forty hours or fifty hours would increase the probability of making one or more errors (or near errors) in a week.

Study Results

Data collected on 5,317 work shifts revealed that hospital staff nurses worked longer than scheduled daily, and generally worked more than forty hours per week. Half of the shifts worked exceeded ten and a half hours. Although 31 percent of the scheduled shifts were scheduled for durations greater than or equal to 12.5 hours, there were 2,057 shifts (39 percent) where nurses worked at least 12.5 consecutive hours (Exhibit 1). Fourteen percent of the respondents reported working sixteen or more consecutive hours at least once during the four-week pe-

EXHIBIT 1
Description Of Work Patterns Of Full-Time Hospital [illegible]taff Nurses, 2002

Variable	Number of shifts	Percent
Number of shifts	5,317	100.0
Scheduled shifts[a]		
Up to 8.5 hours	2,452	46.6
8.5–12.5 hours	1,183	22.5
12.5 or mo[illegible]e hours	1,623	30.9
Actual shifts[b]		
Up to 8.5 hours	771	14.5
8.5–12.5 hours	2,484	46.8
12.5 or more hours	2,057	38.7
Number of overtime shifts	4,292	81.4
Number of mandatory overtime shifts	360	6.8

SOURCE: Authors' analysis of survey results.

[a] Scheduled shift hours were missing from 59 shifts. [illegible]ean length (hours): 10.3 (standard [illegible], ±2.3); range: 1.0–22.5 hours.

[b] Actual work hours were missing from 5 shifts. Mean length (hours): 10.8 (SD, ±2.5); range: 1.2–23.7 hours.

riod. The longest shift worked was twenty-three hours, forty minutes.

Nurses reported leaving work at the end of their scheduled shift less than 20 percent of the time during the study period. Although overtime was reported at the end of all types of shifts, the proportion of shifts involving overtime was significantly higher ($p = .0001$) when eight-hour shifts (85 percent) were compared to shifts scheduled for eight to twelve hours (79 percent) and twelve hours or longer (78 percent). Overall, our participants worked, on average, fifty-five minutes longer than scheduled each day, and all participants worked beyond their scheduled work shift (overtime) at least once during the twenty-eight-day data-gathering period. Almost two-thirds of the nurses worked overtime ten or more times during that period, and a third reported working overtime each day they worked during that period. There were 360 shifts where nurses reported being mandated to work overtime and another 143 shifts where they described being "coerced" to work voluntary overtime. Even though nurses worked approximately four days per week, averaging 40.2 (±12.9) hours per week (range 8–97.2 hours per week), one-quarter worked more than fifty hours per week for two or more weeks of the four-week period.

There were 199 errors and 213 near errors reported during the data gathering period. More than half of the errors (58 percent) and near errors (56 percent) involved medication administration. Other errors included procedural errors (18 percent), charting errors (12 percent), and transcription errors (7 percent). Approximately 6 percent of the errors and 29 percent of the near errors reported lacked sufficient information for categorization. Thirty percent of the nurses reported making at least one error, and 32 percent reported at least one near error. One nurse reported eight errors, while another nurse reported nine near errors.

Our analysis showed that work duration, overtime, and number of hours worked per week had significant effects on errors. The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting of 12.5 hours or more (odds ratio = 3.29, $p = .001$) (Exhibit 2). Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled (OR = 2.06, $p = .0005$). Our data also

EXHIBIT 2
Association Of Errors Or Near Errors With Nurses' Work Duration, 2002

Work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 8.5	771	12	1.6	1.00	20	2.6	1.00
8.5–12.5	2,484	77	3.1	1.35 (.06)	94	3.8	1.44 (.18)
12.5 or more	2,057	103	5.0	3.29 (.001)	97	4.[illegible]	1.80 (.04)
Total	5,312	192	3.5		211	4.0	

SOURCE: Authors' analysis of survey results.

NOTES: Five shifts with four errors cannot be classified because of missing work durations. OR is odds ratio.

suggest that there is a trend for increasing risks when nurses work overtime after longer shifts (OR = 1.34, 1.53, and 3.26 for scheduled eight-hour, eight-to-twelve-hour, and twelve-hour shifts, respectively), with the risks being significantly elevated for overtime following a twelve-hour shift (p = .005) (Exhibit 3). Although the effects of working prolonged shifts were clearly associated with errors, there was no interaction between scheduled shift duration and overtime (p = .17). Finally, working more than forty hours per week and more than fifty hours per week significantly increased the risk of making an error (Exhibit 4). Results were somewhat similar for near errors (Exhibits 2–4).

Nurse and employment characteristics were also examined as potential confounders in the multivariate models. Our results suggest that the relationships of errors or near errors and work hours and overtime were not affected by age, hospital size, or type of hospital unit

Discussion

This study represents one of the first nationwide efforts to quantify hospital staff nurse work hours and work patterns, and to determine whether extended staff nurse work hours contribute to errors and near errors. Our findings confirm that the work schedules of hospital staff nurses are unpredictably prolonged. All nurses reported working longer than scheduled at least once, and the majority reported working longer than scheduled ten times or more in a twenty-eight-day period, as well as working more than forty hours per week. Almost one-sixth of the sample reported working sixteen or more consecutive hours at least once during the period, which suggests that double shifts (or longer) are not confined to rare emergencies. Mean daily overtime durations were slightly higher than those

EXHIBIT 3
Association Of Errors Or Near Errors With Nurses' Scheduled Work Duration And Overtime, 2002

Scheduled work duration (hours)	Number of shifts	Shifts with one or more errors: Number	Percent	OR (p value)	Shifts with one or more near errors: Number	Percent	OR (p value)
Up to 8.5							
No OT	377	8	2.1	1.00	15	4.0	1.00
OT	2,075	65	3.1	1.34 (.42)	76	3.7	0.90 (.74)
8.5–12.5							
No OT	246	6	2.4	1.00	3	1.2	1.00
OT	937	36	3.8	1.53 (.36)	42	4.5	2.32 (.08)
12.5 or more							
No OT	360	6	1.7	1.00	8	2.2	1.00
OT	1,263	70	5.5	3.26 (.005)	67	5.3	2.34 (.03)
Total	5,258	191	3.6		211	4.0	

SOURCE: Authors' analysis of survey results.
NOTES: Fifty-nine shifts with five errors and two near errors cannot be classified because of missing scheduled work durations. OR is odds ratio. OT is overtime.

EXHIBIT 4
Association Of Errors Or Near Errors With The Number Of Hours Worked Per Week By Nurses, 2002

Hours worked	Number of weeks	Weeks with one or more errors			Weeks with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
More than 40							
No	743	64	8.6	1.00	75	10.1	1.00
Yes	681	101	14.8	1.96 (<.0001)	92	13.5	1.42 (.03)
Total	1,424	165	11.6		167	11.7	
More than 50							
No	1,110	112	10.1	1.00	120	10.8	1.00
Yes	314	53	16.9	1.92 (.0001)	47	15.0	1.46 (.03)
Total	1,424	165	11.6		167	11.7	

SOURCE: Authors' analysis of survey results.
NOTE: OR is odds ratio.

reported in two small observational studies (fifty-five minutes, compared with forty-two and forty-five minutes, respectively).[14]

Although the occurrence of errors did not increase significantly until shift durations exceeded 12.5 hours per day, risks began to increase when shift durations exceeded 8.5 hours. Since errors are relatively rare, it is possible that this study lacked sufficient power to detect the effects of work hours or overtime on errors when nurses were scheduled to work shorter shifts (less than 12.5 hours). Certainly the trend toward increasing errors with longer work durations is consistent with other studies that have demonstrated that extended work periods are associated with increased accidents and neuropsychological deficits among nurses and have contributed to at least two hospitalwide epidemics of Staphylococcus aurous.[15] Investigations of these epidemics showed that nurses, who were fatigued and stressed by high patient caseloads and understaffing, made frequent mistakes and procedural errors. Despite the lack of information about accident rates involving nurses, probed performance tests reveal that nurses working twelve-hour simulated shifts make more frequent errors on grammatical reasoning tasks and medical record reviewing.[16]

There are already hints that the fatigue associated with working twelve-hour shifts is contributing to absenteeism and job dissatisfaction among RNs. Fatigue related to length of shift or the potential of overtime at end of shift, or both, was identified as the cause of approximately 12 percent of the absences reported by a random sample of Canadian hospital staff nurses. Not only did RNs report an unusually high number of sick days year (7.4 days, compared with 3.2 for other workers), but also nurses working twelve-hour shifts reported significantly higher absenteeism rates than nurses working traditional eight-hour shifts. Nurses who worked twelve-hour shifts also expressed lower levels of job satisfaction than nurses working eight-hour shifts.[17]

Inasmuch as the probability of making an error because of long work hours or

"The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety."

overtime was not altered significantly by the age or experience of the nurses, or by the type of unit or hospital size, other factors may be important. More specifically, physiological factors such as fatigue, system variables such as increased work intensity, or a combination of fatigue and increased work intensity may contribute to the errors and near errors we observed. It is also possible that heavy workloads themselves may increase the risk of making an error.

The use of mandatory overtime to cover staffing vacancies is a controversial and potentially dangerous practice.[18] More than one-quarter of nurse participants (28.7 percent) reported working mandatory overtime at least once during the data-gathering period, a percentage that is quite similar to that reported in two surveys of more than 47,000 nurses and in a "Quick Poll" posted on the American Association of Critical Care Nurses Web site.[19]

Mandatory overtime is generally defined as nurses' being told that they could be fired, be subjected to disciplinary proceedings, or lose their nursing license if they refused to stay beyond their regularly scheduled shift or come in to work on their day off.[20] Although not actually threatened with job loss or disciplinary proceedings, many nurses also report feeling that there will be repercussions if they refuse to work extra hours or that overtime "is voluntary but feels like it is required."[21] Perhaps that is why approximately 60 percent of the participants in the American Nurses Association Staffing Survey (N = 4,258) reported being "forced to work voluntary overtime."[22]

Our data are derived from the self-reports of a relatively small number of hospital staff nurses and may not be representative of the work schedules and clinical practices of other U.S. hospital nurses. However, the demographic characteristics of our nurse sample and our findings about hours worked are consistent with data reported by hospital staff nurses in the NSSRN, a probability-based sample.[23] In addition, the percentage of staff nurses who identified twelve-hour shifts as their usual shift pattern (60.6 percent) is quite similar to Marlene Kramer and Claudia Schmalenberg's report that almost two-thirds of the 279 staff nurses they interviewed worked twelve-hour shifts.[24]

Although our response rate was lower than that usually reported for surveys of nurses, this study required more effort than the usual survey; subjects were asked to respond to between seventeen and forty items every day for twenty-eight days.[25] Given the subject burden, it is possible that responders were more invested than nonresponders were in documenting a relationship between the hours they worked and effects on patient safety. However, the amounts of overtime reported varied, with some nurses indicating minimal overtime and others reporting extremely long shift durations or working more than fifty hours per week, or both.

Perhaps more important, the major unit of analysis for this study was the actual work shift (N = 5,317) rather than the nurse (N = 393).

The definition of *error* was not specified in the survey instrument. Nevertheless, all incidents described by participants were obvious deviations from current standards of practice. Reported medication errors clearly fell into the categories familiar to all nurses: wrong patient, wrong medication, wrong dose, wrong route (such as intravenous, oral), wrong time, and errors of omission.[26] Nurses were asked whether they made an error, not to assess whether it led to harm.

By not collecting data that could identify where participants worked, we reduced the fears usually associated with reporting errors. Studies have shown that nurses typically underreport errors because they fear repercussions, including disciplinary action by employers and regulatory agencies. As a result, only those errors considered potentially life-threatening, or approximately 5 percent of significant errors, are usually reported.[27] Errors that are considered "minor" or are intercepted before reaching the patient are almost never reported.[28] In fact, near errors are now considered nonreportable events by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[29]

The errors nurses reported in this study occurred in the context of well-documented deficiencies in nurses' practice conditions in U.S. hospitals, deficiencies that nurses have been reporting for well over a decade.[30] The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety. As advocated by the IOM report on medical errors, safer patient care is more likely to result from changes in the environment in which health care is provided than from blaming health care professionals, who may be providing the best care possible under poor circumstances.[31]

Hospital staff nurses' long hours may have adverse effects on patient care; we found that both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours. Because more than three-fourths of the shifts scheduled for twelve hours exceeded that time frame, routine use of twelve-hour shifts should be curtailed, and overtime—especially that associated with twelve-hour shifts—should be eliminated. Additional research with larger samples, inclusion of other variables such as workload and patient acuity, and more precise measurements of error is suggested.

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Press Releases

FOR IMMEDIATE RELEASE

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CONTACT:
Carol Cooke, 202-651-7027
Joan Meehan-Hurwitz, 202-651-7020
rn=realnews@ana.org
www.nursingworld.org/rnrealnews

ANA Calls for Action on Legislation to Limit Mandatory Overtime

Cites New Study that Shows Link between Patient Safety and Nurses' Work Hours

Washington, DC - The American Nurses Association (ANA) praised a new study released yesterday that shows a strong link between medical errors and the long work hours of nurses and called on Congress to take action on the Safe Nursing and Patient Care Act (H.R. 745, S. 373), which would strictly limit the use of mandatory overtime for nurses.

The study, published in the July/August issue of *Health Affairs*, found that the risk of making an error greatly increased when nurses had to work shifts that were longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours per week. It reinforced findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," which said that nurses' long working hours pose a serious threat to patient safety.

"This study is more evidence that patient safety is closely linked to nurses' working conditions," said ANA President Barbara Blakeney, MS, APRN,BC, ANP. "The growing trend of mandatory overtime for nurses is one of the greatest threats to patients' and nurses' safety. We call on Congress to protect the public by taking action to limit mandatory overtime for nurses. Doing so will help protect patients from preventable errors and retain nurses in the workforce."

To date, 10 states have taken action to limit mandatory overtime for nurses, and similar measures have been proposed in 20 other states.

The study, "The Working Hours of Hospital Staff Nurses and Patient Safety," by Ann Rogers, PhD, RN, and colleagues at the University of

Pennsylvania School of Nursing, was funded by the Agency for Health Care Research and Quality. Researchers examined logbooks kept by 393 registered nurses around the country who worked full-time in hospitals. Data collected on 5,317 work shifts revealed that in nearly 40 percent of the cases, nurses worked at least 12.5 consecutive hours. More than 25 percent of the participants in the study reported working mandatory overtime at least once during a one-month period.

According to a 2001 ANA health and safety survey, 67 percent of respondents reported working some form of mandatory or unplanned overtime every month. The ANA has long warned that mandatory overtime is dangerous for patients and nurses, and that the practice has been driving nurses away from the profession, thus exacerbating an emerging nursing shortage that is expected to worsen dramatically over the next 10 years.

"Poor working conditions are a major contributor to the nursing shortage," said Blakeney. "As this study shows, nurses are consistently working long and unpredictable hours, often caring for a large number of critically ill patients. To improve the quality of care and patient safety, we must value nurses' contributions more and make a greater investment in nursing," she said.

To counter staffing insufficiencies that are already occurring, many health care facilities across the nation have increasingly imposed mandatory overtime as a common practice.

Typically, an employer may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment, a charge that could lead to a loss of license for the nurse. At the same time, ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients, thus leading to a dilemma for many nurses.

The Safe Nursing and Patient Care Act would prohibit health care facilities from forcing exhausted nurses to work extra shifts, an unsafe practice that puts both patients and nurses at risk.

The Safe Nursing and Patient Care Act would:

- Prohibit health care facilities that receive Medicare funding from requiring a registered nurse (RN) or licensed practical nurse (LPN) to work beyond an agreed-to, predetermined, regularly scheduled shift.

  In no instance could a nurse be required to work more than 12 hours in a 24-hour period or for more than 80 hours in a two-week period - a provision that would prevent an institution from altering shift schedules in a way that would undermine the law.

- Include nondiscrimination protections for nurses who refuse overtime and for nurses who provide information and/or cooperate with investigations about the use of overtime.
- Include an exception in the case of a declared national, state or local emergency. Such an emergency would be in response to an unpredictable disaster, not in response to a staffing deficiency resulting from management practices.
- Provide for a study by the Department of Health and Human Services on the maximum number of hours that may be worked by a nurse without compromising patient safety.

# # #

The American Nurses Association is the only full-service professional organization representing 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.

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TIME AFTER TIME

Mandatory overtime in the U.S. economy

by Lonnie Golden and Helene Jorgensen

Over the last two decades, American workers have been clocking more and more hours on the job, and they now work more hours than workers in any other industrialized country. Annual work hours are 4% higher than they were in 1980, amounting to an extra 1 hour and 30 minutes at work per week, on average (ILO 1999). The cumulative rise in time on the job is even higher, of course, for families. In 1998 the typical middle-income, married-couple family worked six more weeks a year than did a similar family in 1989 (Mishel et al. 2001). Workers are also clocking more overtime hours. Almost one-third of the workforce regularly works more than the standard 40-hour week; one-fifth work more than 50 hours. Hourly manufacturing workers, the only group tracked by government statisticians, are putting in 25% more overtime than they were a decade ago.[1] In virtually every industry within the bellweather manufacturing sector, overtime had reached a record by the end of the 1990s.

The growth in overtime work, while helping to drive the healthy growth in output in the U.S., has unhealthy social costs. It is taking its toll not only on workers, but on their families, communities, and, ultimately in many cases, patients, customers, and employers. Families burdened by longer work hours are more likely to find it difficult to balance the conflicting demands of work and family. More hours spent at work mean less time with the family, less time to help a child with homework, less time for play, less time for housework, and less time for sleep. These sacrifices can translate into increased risk for accidents and injuries; greater chronic fatigue, stress, and related diseases; reduced parenting and family time; and diminished quality of goods and services – a serious public concern particularly in the health care sector. The social costs associated with the growth in work hours and persistent overtime are particularly worrisome when the long hours are involuntary.

The tenuous balance between work, family, and other non-work activities is thrown off most when overtime is mandatory (also referred to as "compulsory" or "forced"). Mandatory overtime hours are those above the standard work week (usually 40) that the employer makes compulsory with the threat of job loss or the threat of other reprisals such as demotion or assignment to unattractive tasks or work shifts. Given that overtime can have detrimental effects on workers and their families, mandatory overtime is a serious public policy concern, yet current law does not address it. The Fair Labor Standards Act of 1938 (FLSA), which regulates overtime, currently imposes no limits on overtime hours, nor does it prohibit dismissal or any other sanction for declining overtime work. Rather, the FLSA merely requires that payroll employees (who are not "exempt" from the overtime requirements of the FLSA) be paid an overtime premium of at least one-half of regular rate of pay for each hour worked over 40 during a work week.

With the rise in household work hours and overtime, there is a growing need for limits on involuntary overtime. Labor laws such as the FLSA need to be amended to protect workers against excessive work hours and mandatory overtime and to protect the public from the dangers of an overburdened, stressed workforce. Employees should have the legal right to refuse overtime after having worked a certain number of hours – without fear of job loss or other sanctions. Furthermore, an employee should be asked to work beyond some legislated upper limit only during exceptional circumstances such as a temporary health or public safety emergency. Amendment of the FLSA can preserve the right of workers to work long hours if they choose to do so, but ensure workers the right to refuse mandatory overtime.

The need for limits on mandatory overtime

In the United States, unlike in most European countries, employment is "at will," meaning that the employer can dismiss an employee for any reason or for no reason – except gender, race, age, or disability. Thus, employees who refuse to work overtime can lose their jobs or face other reprisals such as demotion or assignment to unattractive work or to less desirable shift times such as nights or weekends. Faced with the legal threat of these kinds of sanctions, many employees often work more hours than they would like and, in some cases, work an extreme number of hours well beyond the standard 40 a week.

The only disincentive to the unbridled use of overtime by employers is the FLSA requirement that payroll employees covered by the act be paid time-and-a-half for hours worked above 40 in a week. The Department of Labor estimates that about 74 million workers were covered under the FLSA overtime provision in 2000. [2] There is evidence that the required overtime pay premium for these "non-exempt" workers is effective – about 44% of "exempt" workers (i.e., most executives and supervisors, certain administrative and professional employees, and outside salespeople) work longer than 40 hours per week, compared to only about 20% of non-exempt workers. However, the share of the workforce exempted from the FLSA has been growing slightly (Hamermesh 2000) over time, despite recent court decisions reaffirming FLSA coverage over occupations such as journalists, paralegals, some computer technicians

(those positions that are not highly paid or highly skilled), and most on-call positions. Moreover, business interests continue to push Congress to broaden the exemptions to include "inside sales employees" and licensed funeral directors and embalmers. They also are lobbying to create a new classification of "knowledge workers," such as computer and network systems analysts and degreed clerical personnel, who would be exempt from the overtime regulations (see U.S. GAO 1999; Labor Policy Association 2000).

Long hours and risks to worker and public safety and health

Long hours can detrimentally affect workers, their co-workers, their families, consumers, and the public. Indeed, there is evidence that, despite the short-term benefits that make overtime attractive to employers (Easton and Rossin 1997), it may in the longer term create offsetting harm to an organization by decreasing quality, increasing mistakes (Babbar and Aspelin 1998; Hirschman 2000), and reducing productivity (Shepard and Clifton 2000). A study on the effects of overtime work on autoworkers found that overtime resulted in impaired performance in attention and executive functions. Workers also reported feeling more fatigued and depressed after working more than eight hours a day (Proctor et al. 1996). It is not surprising, then, that accident rates increase during overtime hours (Kogi 1991). For example, researchers have identified overtime as a factor contributing to safety incidents at nuclear power plants (Baker et al. 1994), confirming what researchers had previously found at manufacturing plants (Schuster 1985) and among anesthetists (Gander et al. 2000). Workers who work overtime face a greater risk of injury and illness (Aakerstedt 1994; Duchon et al. 1994, Kosa 1995; Smith 1996). For a typical example, a German study found that, after nine hours at work, the accident rate begins to rise; in the 12th hour the accident rate was twice as high as the rate for the first nine hours (Hanecke et al. 1998). Long work hours also multiply repetitive motions and exposure to harmful chemicals.

Further, frequent overtime and compressed work schedules that produce long workdays can be a major cause of the stress and chronic fatigue reported by many workers, as well as the ensuing occupational burnout or serious health conditions (Sparks et al. 1997; Spurgeon et al. 1997; Martens et al. 1999; Barnett et al. 1999; Shields 1999; Fenwick and Tausig 2001). Stress can result in increased blood pressure and cardiovascular diseases, which in some cases can have fatal consequences. The Japanese, known for long work hours, even have a word – *karoshi* – to describe death from overwork (Hayashi et al. 1996; and Sokejima and Kagamimori 1998).

In the U.S., job stress is estimated to cost industry $150 billion per year in absenteeism, health insurance premiums, diminished productivity, compensation claims, and direct medical costs (Donatelle and Hawkins 1989). Longer work hours can only contribute further to this drain. A study by Northwestern National Life (1991), which investigated employee burnout, found that seven out of 10 employees experiencing job stress said they frequently suffered health ailments. Frequent mandatory overtime was one of the leading five factors that caused increased stress. Employees who worked overtime on a regular basis were twice as likely (62% vs. 34%) to report that they found their jobs to be highly stressful.

Overtime work and the crowding-out of non-work-time activities

While hours spent at work have increased, work responsibilities at home have not decreased much.

Therefore, working families more and more find themselves squeezed for time. Overtime, and in particular forced overtime without advanced notice, is a challenge to working families. Being told at the end of the workday to stay and finish a work assignment or work a second shift can leave working parents – especially single parents – scrambling to make arrangements for child care at the last minute. Some parents can rely on other family members to care for their children at these times, but of course not all parents have this option, and therefore must depend on child care centers or babysitters to watch their children, a costly option, or perhaps even have to leave children unattended or unsupervised. Further, overtime work can interfere with after-work classes in which workers have enrolled and with community volunteering and social activities that require advance planning.

Overtime often comes at the expense of sleep: three in four people say they suffer fatigue during the day (Atkinson 1999). A poll by the National Sleep Foundation found rampant sleep deprivation, with one-third of respondents reporting less than seven hours of sleep per night and 63% getting less than the eight hours recommended for superior health, performance, and safety. In the last five years, adults who spend more time at work than sleeping has just about caught up to those who spend the reverse. Those who work sleep significantly less than those who do not, particularly those who work over 40 hours (and 38% in this poll reported working 50 hours or more per week), and they report more sleepiness during awake time and insomnia. Job-related work ranked as the activity least likely to be given up among adults who reported a lack of time (National Sleep Foundation 2001).

When workers cut back on sleep, their work performance suffers. The National Commission on Sleep Disorders estimates that companies lose up to $150 billion per year due to employee fatigue. A study conducted by the American Journal of Public Health in 1992 found that nurses in Massachusetts who work variable schedules (including mandated overtime shifts) were twice as likely to report an accident or error and two-and-one-half times as likely to report near-miss accidents (MassNurse News 2000). It concluded that these conditions were associated with "frequent lapses of attention and increased reaction time, leading to increased error rates on performance of tasks." An Australian study found that sleep deprivation has the same effects as being drunk. As the number of hours increased without sleep, the study's testers took a longer time completing a task, made more mistakes, and had problems with concentration and memorizing information. After 17-19 hours without sleep, the testers' performance and alertness suffered notably, and "performance levels were low enough to be accepted in many countries as incompatible with safe driving" (Williamson and Feyer 2000, 653-4). Sleep deprivation poses a serious safety risk for workers not only at work, but also when driving home after a long day at work. And for workers who work late into the evening, commuting by car may be the only option, since carpools and public transportation are geared to workers on daytime schedules.

Since overtime can have detrimental effects on workers and their families, no worker should be forced to work overtime. Indeed, the public health considerations associated with long work hours suggest that excessive overtime hours should be legally capped.

Levels of overtime and trends

An analysis of the number of hours usually worked by wage and salary employees shows that overtime work is widespread in most industries.[3] In the industries of agriculture, mining, manufacturing, transportation, communication, and some professional services, more than 25% of all employees reported that they worked more than 40 hours per week on a regular basis, and often considerably more. In fact, workers who clocked extra hours (both exempt and non-exempt workers) on average worked nearly 12 hours more than the standard work week of 40 hours in 2000 (see **Table 1**).

There has been a slight, gradual, yet detectable upward trend in this percentage over the last decade. According to data from establishments by the Bureau of Labor Statistics (2000), average overtime in manufacturing escalated over the 1990s, from 3.3 hours to a peak of 4.9. More than half of the 20 industries within manufacturing had increases of at least 1 hour over the 1991-98 period (Hetrick 2000). In fact, many of these industries had set records for their overtime series by early 1997. The National Study of the Changing Workforce (NSCW) survey, in its sample of almost 3,000 individuals, found that the employed put in six hours more than they are scheduled to work (Galinsky and Bond 1998).[4]

Moreover, there is evidence of substantial non-compliance with the existing FLSA rules and regulations regarding overtime hours and pay or exemptions. By misclassifying workers or evading overtime pay rules, employers presumably have employees work longer hours than if the employer followed overtime rules regarding computation of hours and exemptions. Violations are higher in certain major industries (see **Table 2**). Non-compliance appears to be highest in the construction industry, where non-exempts dominate the workforce. While the rate of compliance in services is high, there has been a dramatic decline in two of the industry's components – nursing homes and residential living facilities – in the proportion of firms that are in compliance with the FLSA.[5] The level of compliance in nursing homes dropped from 70% to 40% of surveyed firms, and is 57% in residential living facilities. The vast majority of violations (84% and 92%, respectively) were non-compliance with the industry's overtime pay rules. The most common violations in the nursing care and residential living industries are the failure of employers to pay for all the hours that an employee works and the misclassification of workers as exempt.[6]

Estimates of mandatory overtime

The last attempt to directly measure the extent of mandatory overtime with specific survey questions in a nationally representative sample was the 1977 Quality of Employment Survey (QES) of the University of Michigan. These estimates can form a baseline to estimate the current degree of mandatory overtime. The QES asked workers who worked overtime hours whether overtime was "mostly up to the worker" or "mostly up to the employer" and, separately, if they could refuse overtime without some kind of penalty. About 45% responded that overtime work was "mostly up to their employer" (vs. 44% who that said it was up to them; the rest said "both"). About 19% reported they would suffer a penalty. About one in six workers, 16%, said their overtime was both up to their employer and they would suffer a penalty if they refused it (Ehrenberg and Schumann 1984); this portion represents the most conservative estimate of the extent of mandatory overtime. In the entire QES sample, from the "merged" 1974-77 panels, 21% of men were subject to such mandatory overtime work, and 35% worked overtime voluntarily. Workers in blue-

TABLE 1
Hours worked, part-time and overtime, by industry, 2000 (employed individuals at their main jobs)

Industry	Number of workers	Average weekly hours	Percentage working part-time *(less than 35 hours)*	Percentage working more than 40 hrs/week	Percentage of workers with variable weekly hours*	Average hours worked if working more than 40	Average no. of overtime hours if working more than 40
Agriculture	1,862,667	40.3	15.0%	25.2%	15.0%	54.5	14.5
Mining	495,340	48.0	2.0	40.0	9.7	59.0	19.0
Construction	7,238,868	41.2	5.7	18.9	9.0	51.8	11.8
Manufacturing - durable	11,733,130	42.2	3.0	26.0	4.4	50.4	10.4
Manufacturing - non-durable	7,508,890	41.2	5.7	22.5	5.5	50.5	10.5
Transportation	5,729,608	41.6	10.6	25.1	10.3	53.6	13.6
Communications	1,978,388	41.9	4.7	25.3	4.0	50.8	10.8
Utilities and sanitation	1,430,693	41.3	3.1	17.3	4.1	50.8	10.8
Wholesale trade	4,838,551	42.2	6.9	30.1	5.6	51.4	11.4
Retail trade	20,595,385	35.3	30.7	15.4	8.9	51.4	11.4
Finance, Insurance, and Real Estate	7,685,257	40.4	9.6	20.8	5.1	51.1	11.1
Private households	922,179	29.7	42.7	8.7	18.3	56.7	16.7
Business and repair services	7,898,715	40.3	11.4	22.2	6.9	51.3	11.3
Personal services	2,799,577	37.3	22.2	13.2	8.7	53.6	13.6
Entertainment and recreation services	2,269,862	34.2	31.3	13.1	9.4	52.4	12.4
Hospitals	5,021,226	38.7	15.8	12.2	5.9	54.3	14.3
Medical services	5,961,670	37.0	22.5	11.5	6.2	52.0	12.0
Educational services	10,971,126	37.3	21.5	18.0	5.8	51.9	11.9
Social services	2,979,796	35.7	25.4	9.6	4.8	52.0	12.0
Other Service professions	5,334,002	40.0	15.4	27.4	6.7	52.4	12.4
Forestry and fisheries	98,284	42.6	8.4	17.6	12.0	61.8	21.8
Public administration	6,024,910	40.3	6.0	14.4	4.0	51.1	11.1
All workers							
Weighted averages across all industries	121,378,123	*39.1*	*15.4%*	*19.4%*	*6.9%*	*51.8*	*11.8*
Standard deviation among industries		*3.7*	*11.0*	*7.6*	*3.7*	*2.9*	*2.9*

* Workers with "variable hours" are those whose work week is so variable week to week that they cannot specify its usual length. A significant portion of these workers may, on average, actually work longer than a 40-hour week.

Source: Authors' analysis of the monthly Current Population Survey of households, 2000.

TABLE 2
FLSA coverage and overtime compensation by industry, FY 1996

Industry	Employees under executive, administrative, professional	Non-exempt employees	Estimated percent exempt from overtime	Rate of employer compliance with FLSA overtime regulations
All	31,729	74,044	39.5	90%
Private	25,495	61,899	39.9	88
Agriculture	252	12	99.4	90
Mining	95	3	17.2	92
Contract construction	736	4,584	15.1	73
Manufacturing	3,230	166	19.2	91
Transportation and public utilities	1,413	2,777	55.6	83
Wholesale trade	1,580	4,069	37.2	96
Retail trade	3,049	15,445	28.6	91
Finance, insurance, and real estate	2,706	3,493	49.4	86
Services *(not including private households)*	12,434	6,154	54.4	93
Private households	0	459	50.6	96
Public sector	6,234	12,144	37.5	
Federal government	1,233	1,472	46.6	
State and local government	5,002	10,672	36.1	100
Nonclassified				
Correlation coefficient: percent exempt with percent compliance				0.133

Source: U.S. Department of Labor, Wage and Hour Division, 1998.

collar positions had a greater likelihood of facing mandatory overtime, as did workers who had medical or pension plans, while unionized workers had a lower likelihood (Idson and Robbins 1991).

More recent attempts to infer the extent of mandatory overtime are far from satisfactory. Given the long-term rise in average weekly overtime hours (at least in manufacturing), however, one might suspect that the incidence of *mandatory* overtime has risen more or less commensurately (Smith 1996). A particularly informative study by Cornell University's Institute for Workplace Studies (1999) surveyed 4,278 unionized hourly workers, concentrated mainly in the Northeast and consisting of six industries, primarily construction (craft workers), manufacturing (auto workers), and services (emergency medical technicians; mail handlers; and workers in utilities, transportation, nursing homes, and retail). In this sample, 60% worked some overtime in the previous month, with about a third of these workers putting in 11 or more hours of overtime per week. About a third of the overtime workers reported being compelled by their employer to work overtime (a proportion the authors concluded was surprisingly low). Workers employed in the transportation and emergency health services faced more employer pressure than workers in other industries.

Almost one in five workers, 18%, reported working more overtime hours than they preferred. This amounted to half the proportion satisfied with their number of overtime hours and even less than half of

the proportion actually wanting more overtime. Thus, there appears to be a maldistribution; if hours could be redistributed within all industries away from those who work overtime involuntarily and toward those who wanted more overtime (presumably to build their incomes) this would reduce the latter group by up to 40% of its current size.

Involuntarily scheduled overtime work may further worsen the negative well-being, safety, and health outcomes of overtime per se. The Institute for Workplace Studies (1999) survey found that the proportion of workers who reported high levels of work/family conflict jumped dramatically for those who put in more than 50 hours a week. In addition, respondents who faced supervisory pressure to work overtime reported negative effects. For example, 19% of all workers reported feeling depressed more than "once in a while," but among the 8% of workers who reported high levels of supervisory pressure to work overtime, the percentage jumped up to 23%. Similarly, as supervisory pressure to work overtime increased, workers reported significantly higher levels of somatic stress, higher levels of job-escape drinking, and higher absenteeism due to illness. Supervisory pressure to work overtime was also significantly associated with injuries at work. Among the 66% of workers who reported no supervisory pressure to work overtime, 9% experienced multiple injuries at work during the prior year; among workers reporting low, moderate, or some levels of supervisory pressure, the share was 14%; for workers reporting high levels of supervisory pressure to work overtime, the share was 16%. Yet, financial demands and feelings of job insecurity were cited more frequently than employer pressure as the ultimate motivator of extra work time.

It is important to keep in mind that employees who are not subject to mandatory overtime may still end up working more overtime hours than they would prefer. Many workers have overtime scheduled by their employer, and "choose" overtime because their base wage or salary is insufficient to support their family; some may feel that their chances for a promotion or pay increase improve if they put in extra hours.

Sources of mandatory overtime

The need for mandatory overtime is in part an outcome of the prolonged economic expansion of the 1990s. Low unemployment rates led to labor shortages in certain industries such as health care and telecommunications and in occupations such as nursing. Rather than raising wages to attract new employees, employers opted to have their current workforce work more hours – even if it meant paying an overtime premium. In addition, adjusting hours to the seasonality of demand may be more common, tending to intensify the use of mandatory overtime. Half of all surveyed accounting firms, particularly the larger ones, used mandatory staff overtime for this purpose (Pfau, Quint, and Huttlinger 1997). Further, employers appear to be less willing to invest in training of new employees, and instead prefer to have their current workforce put in more hours; this has been the case in the high tech industry. Overtime continues to be appealing, despite its apparent longer-term harms and risks, because employers can enjoy non-wage cost savings (Cutler and Madrian 1998), while employees gain greater access to higher wage rates (Bell 2000; Hecker 1998) and more flexible daily work schedules (Golden 2000, 2001).

Mandatory overtime in health care: accident risks and compromising of quality

Overtime work is widespread among nurses, medical residents, and doctors, and this pattern of work can lead to situations that jeopardize the health of patients. Understaffing of nurses at hospitals means that nurses sometimes are forced to work a second shift after their first shift ends. High patient load and fatigue from long hours can result in inadequate compliance with procedures and less monitoring of patients. As a result, overtime can compromise patients' health or safety. Medical residents cited fatigue as a cause for their serious mistakes in four out of 10 cases (Boodman 2001), and two studies linked infection outbreaks at hospitals to overtime work (Arnow et al. 1982; and Russell et al. 1983). Indeed, the California Nurses Association reports that more nurses are refusing to work in hospitals with unsafe conditions, in which they include being forced to work unplanned overtime. The American Nurses Association (ANA), in a national survey of 7,300 of its members, found, disturbingly, that 56% of nurses believe that the time they have available for care for each patient has decreased, and 75% feel that the quality of patient care at their own facility has decreased in the last two years. The cited inadequate staffing as the chief reason.

Mandatory overtime in health professions generally is likely high, although no reliable data regarding its extent are available. In the Institute for Workplace Studies (1999) report, health sector workers averaged a little over three hours of overtime per week – not particularly high. In a survey on mandatory overtime, the journal *Nursing2000* reported that 36% said they never worked mandatory overtime. One quarter of the respondents worked mandatory overtime once or twice a month, while another quarter worked it once or twice a week. However, about 14% worked additional mandatory hours every day (*Nursing2000*). Respondents to a poll (2,125 total) administered by the American Association of Critical Care Nurses in May-June 2000 found that 43% of their members' hospitals have a mandatory overtime policy. The same poll found that responding members attributed mandatory overtime mainly (three-quarters of the reasons designated) to both routine short-staffing policies and a nursing shortage. Perhaps it is no coincidence that nurse's aides were second only to truck drivers in the total number of cases of disabling injuries and illness. And not surprisingly, the ANA delegates voted almost unanimously to declare that refusing overtime does not constitute patient abandonment, from which nurses are legally prohibited.

Mandatory overtime provisions in collective bargaining agreements

Generally, union workers are better protected from mandatory overtime than are nonunion workers, since union contracts can specify upper limits on overtime, establish a scheme to make overtime more orderly or voluntary, or establish a system of compensatory leave. In 1977, over one in five union members had collective bargaining agreements that restricted mandatory overtime, according to the QES. But as many unions have lost membership, in particular those in manufacturing and communication industries, workers' bargaining power to obtain such contract provisions may have diminished.[7] Unions may find it increasingly difficult to both oppose mandatory overtime measures in workplaces and negotiate better premiums for overtime work. In addition, unions whose members have experienced declining wage rates are under pressure to preserve overtime work as a way to allow members to prop up their earnings.

In recent years, several unions have successfully negotiated contract language that places limits on mandatory overtime or requires steps to make such arrangements more voluntary in nature.[8] For example, in the health services sector, Tenet Health Care and St. Vincent's Hospital in Worcester, Mass., signed an agreement with 600 nurses that allowed the hospital to mandate overtime but for no more than for a four-hour period twice every three months. (The hospital has the right to assign up to two hours of mandatory overtime, and the nurse can work an additional two hours if she felt capable of doing so safely.) Tenet management had initially demanded that the nurses agree to work mandatory 16-hour shifts with one hour's advance notice.[9] Limits to forced overtime have been implemented in telecommunications and other industries as well. The Communications Workers of America (CWA) strike at Verizon in 2000 resulted in reduced mandatory overtime limits, in some instances cutting them in half, from 15 to 7.5 hours a week; the company is also now required to give at least 2.5 hours notice if overtime work is required, and it must give consideration to those employees requesting to be excused from overtime.[10] Northwest Airlines permits employees to refuse overtime if they provide reasons such as child care responsibilities that cannot be altered on short notice. The American Postal Workers Union and the National Association of Letter Carriers agreed with the U.S. Postal Service to restrict excessive mandatory overtime. The agreement protects those members who sign up on a list of "overtime desired" but want to work only limited overtime, plus those members who are not on the overtime list at all.[11] In the manufacturing sector, the United Steelworkers of America negotiated a cap on mandatory overtime at FMC, a Baltimore, Md. pesticide plant. Newspaper Guild Local 35 (covering Washington-Baltimore) and the Bureau of National Affairs negotiated a voluntary overtime arrangement in which members can be excused from working compulsory overtime unless no other appropriate employee is available.

Policy solutions: legislated mandatory overtime limits, bans, and other remedies

Legislative initiatives at both the federal and state levels would regulate mandatory overtime. Bills have been introduced in the 107th U.S. Congress that would limit the amount of forced overtime that nurses and other licensed health care providers could work. The Safe Nursing and Patient Care Act of 2001 was introduced in the Senate (S-1686) and House (HR 3238). It aims to amend the Social Security Act by limiting the number of mandatory overtime hours a nurse may be required to work among providers of services to which payments are made under the Medicare program Under the Registered Nurses and Patients Protection Act (H.R. 1289, also referred to as the Lantos-McGovern Bill, and a very similar bill with different sponsors, H.R. 1902), licensed health care professionals could not be required to work more than eight hours in a day or 80 hours within a two-week period, unless a written agreement between the employer and the employee specifies otherwise. Nurses associations across the country have endorsed such bills, arguing that it would reduce overtime and improve both patient safety and quality of care. While the latter bill refers only to registered nurses, it would cover all other licensed health care workers in the country (except medical doctors). To date, House leaders have taken no action on it.

These federal proposals as well as a number of similar state initiatives have been important first

State Public Health Employee Worker Shortage Report:

A Civil Service Recruitment and Retention Crisis

The Council of State Governments
Preparing states for tomorrow, today . . .

ASTHO
Association of State and Territorial Health Officials

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For additional information contact:
publications@astho.org

Association of State and
Territorial Health Officials
1275 K Street, N.W.
Suite 800
Washington, D.C. 20005-4006
Phone (202) 371-9090
Fax (202) 371-9797
www.ASTHO.org
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Table of Contents

Section I
Executive Summary 2

Section II
Introduction 3

Section III
Public Health Workforce Shortages 4

Trends Impacting the Public Health Workforce 4

Public Health Shortage Profiles by Profession 7

Section IV
Keys to Success: State Plans to Address Public Health Workforce Issues 10

Section V
Conclusion 13

Section VI
References 14

Table of Charts

Figure 1
Agencies Affected By Worker Shortage 3

Figure 2
Average Age of Public Health Workers 4

Figure 3
Annual Growth Rate of the U.S. Labor Force 5

Figure 4
Percent of State Public Health Employees Eligible for Retirement 5

Figure 5
Position Vacancy Rates in the State Public Health Agencies 6

Figure 6
Turnover Rates for State Public Health Personnel 6

Figure 7
Composition of Total Public Health Workforce 7

Figure 8
State Public Health Occupational Classes Most Affected 8

Figure 9
State Public Health Personnel Recruitment and Retention Plans 11

Figure 10
Keys To Solving Public Health Workforce Challenges 12

Executive Summary

The most difficult challenge state and local public health agencies face in developing the capacity to respond to terrorist events, emerging infectious diseases, and other public health threats and emergencies is assuring a qualified workforce is available to carry out these functions. If current workforce demographic trends are left unchecked, they will have an adverse affect on the capacity of state health agencies to carry out their mission; including responsibilities that have continued to expand since the events of September 11, 2001, and the ensuing anthrax attacks.

In October 2002 the Council of State Governments (CSG) and the National Association of State Personnel Executives (NASPE) conducted a workforce survey of all state agencies. The resulting report, "State Employee Worker Shortages: The Impending Crisis," noted that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006, and that health agencies would be the hardest hit.

The findings from the CSG/NASPE workforce survey appeared to confirm the anecdotal evidence and other information that was emerging about the pending crisis in the state public health workforce. The combination of that evidence and the CSG/NASPE findings were so compelling that ASTHO concluded a broader inquiry and analysis of state public health workforce trends were warranted. Consequently, in November and December of 2003, ASTHO surveyed its members, the senior health officials of the 57 states and territories (and the District of Columbia), on a wide spectrum of workforce trends and indicators. ASTHO received responses from 37 states. This report contains the results of the survey.

The following are key findings from the ASTHO/CSG survey:

- A rapidly aging workforce whose average age is 46.6 years
- Public health retirement rates as high as 45 percent over the next five years
- Current vacancy rates of up to 20 percent in some states
- Public health employment turnover rates of 14 percent in some parts of the country

These findings illustrate a growing public health employee shortage in a majority of the states that has been further exacerbated by severe state budget cuts during 2002 and 2003–the deepest cuts in 60 years[1] –which have had profound effects on the ability of public health agencies to fill vacant positions.

More than 50 percent of the states cite the lack of qualified personnel or individuals willing to relocate as major barriers to preparedness.[2] Approximately 42 percent of the current epidemiologists in state health agencies lack formal academic training in epidemiology.[3] Only public health nurses, an occupational group that averages more than 30 years of service,[4] are more affected by workforce shortages than epidemiologists.

State health agencies are supporting and, in some cases, implementing a variety of strategies to head off the workforce crisis. States reported that increased access to advanced education, competitive pay and benefits, and flexible work schedules and telecommuting opportunities are the three most important incentives in attracting and retaining an adequate public health workforce.

Introduction

The Council of State Governments (CSG) and the National Association of State Personnel Executives (NASPE) conducted a survey in October 2002 that predicted state public health departments would be the state agencies most likely to experience the government workforce shortage. The survey data captured in the report, "State Employee Worker Shortages: The Impending Crisis", indicated that 85 percent of the state agencies responding named the health field as the most affected by personnel shortages.[5]

The Association of State and Territorial Health Officials (ASTHO), in conjunction with CSG and NASPE, conducted the National Survey on State Public Health Employee Worker Shortage in December 2003. This report reflects the survey findings provided by the State Health Officials and serves as a companion to the NASPE/CSG report. The new survey findings provide a better understanding of current public health workforce challenges and state health agencies' strategies for addressing the workforce crisis.

The last major review of the national public health workforce was conducted in 2000 by the Bureau of Health Professions in the Department of Health and Human Services Health Resources and Services Administration.[6] The Bureau's report, "Public Health Work Force Enumeration 2000," illustrated the differences in responsibilities among state public health agencies, the variation in ways agencies enumerate their employees, the large variety of professional disciplines employed, and the complexity of making cross-agency comparisons. This report stated that the ratio of state public health workers to population had dropped from 219 per 100,000 in 1980 to 158 per 100,000 in 2000. This landmark report did not examine the issues of recruitment and retention.

In the five years since the enumeration study state public health has entered a new era with new responsibilities. Public health has been subject to significant new pressures and challenges. The events of 9/11 and the anthrax attacks brought the role and responsibility of the public health workforce in emergency response efforts to the fore in public understanding and to the attention of colleagues in emergency management and other first response agencies. This was followed by severe state budget cuts during 2002 and 2003-the deepest in 60 years. Public health agencies did not escape the cuts.

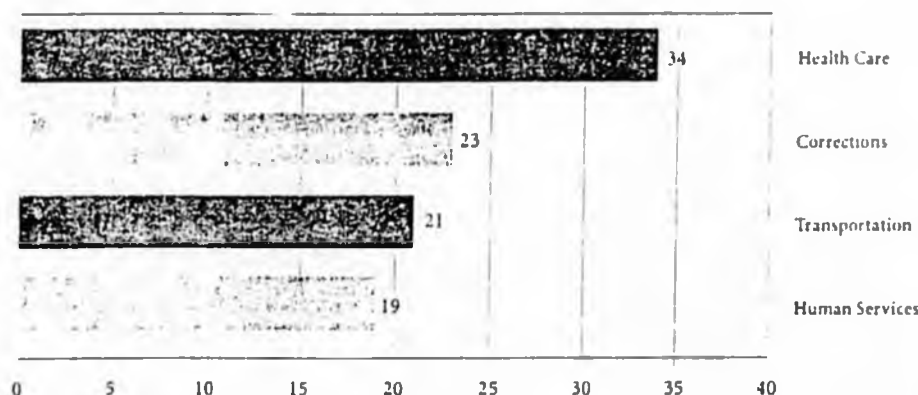


Figure 1

Agencies Affected by Worker Shortage

Chart represents the number of states that listed each agency as one "most likely to be most affected by a worker shortage."

Source: CSG/NASPE Survey.

Public Health Workforce Shortages

Trends Impacting the Public Health Workforce

Four trends emerged from the survey of ASTHO members which confirm the findings in the earlier report, "State Employee Worker Shortages: The Impending Crisis":

1 A rapidly aging public health workforce and shrinking labor pool

2 A high percentage of the public health workforce is eligible for retirement eligibility.

3 Chronic shortages in professional areas such as public health nursing, epidemiology, laboratory science and environmental health.

4 High turnover rates in states.

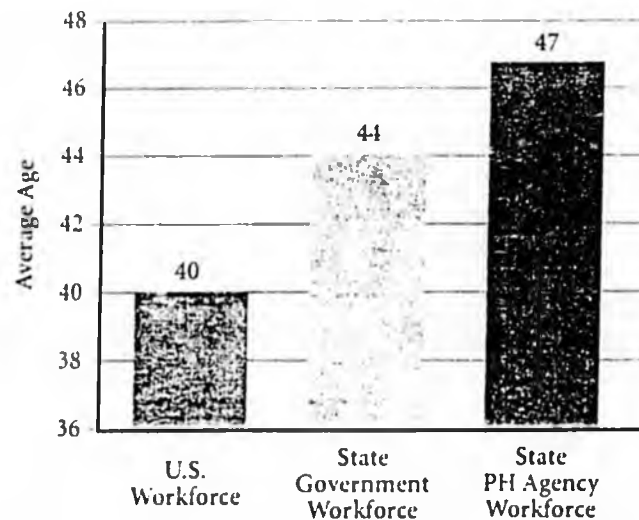
One: A Rapidly Aging Workforce

The average age of state public health employees is 46.6, according to the ASTHO/CSG survey. Since the largest portion of the U.S. working population is starting to move into retirement age, this trend toward an aging workforce creates new challenges for filling vacant positions in public health. By comparison, the "State Employee Worker Shortages: The Impending Crisis" report revealed the average age of all state agency employees to be 44 years, the center of the baby boom generation's age range and the age of the U.S. workforce.[7] According to the Social Security Administration, the average age of the American workforce is 40, or 15 percent younger than the state public health workforce.[8]

Figure 2

Average Age of Public Health Workers, by Region

Source: ASTHO/CSG Survey, CSG/NASPE Survey, Social Security Administration



The population of the United States is undergoing significant change. The nation is experiencing a significant bulge in the eligibility for retirement. The older population (65 and over) numbered 35.6 million in 2002, an increase of 3.3 million or 10.2 percent since 1992. However, the number of Americans aged 45-64, increased by 38 percent during this period.[9] Figure 3 shows the falling growth rate of the U.S. workforce. The baby boomer generation is aging and the succeeding generation of workers is significantly smaller.[10]

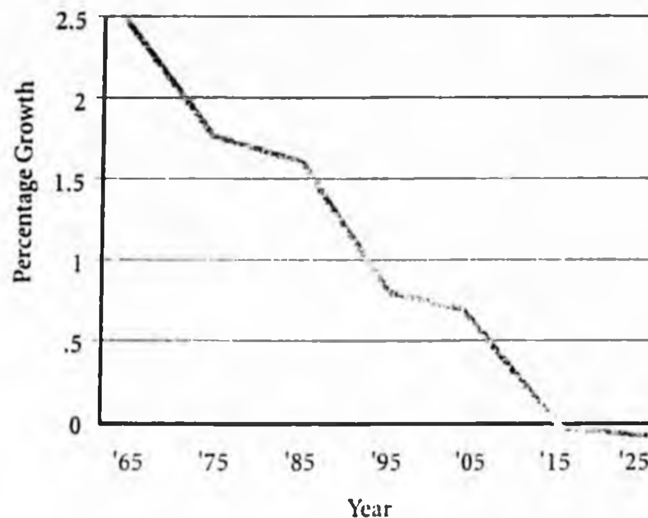


Figure 3

Annual Growth Rate of the U.S. Labor Force

Source: Social Security Administration

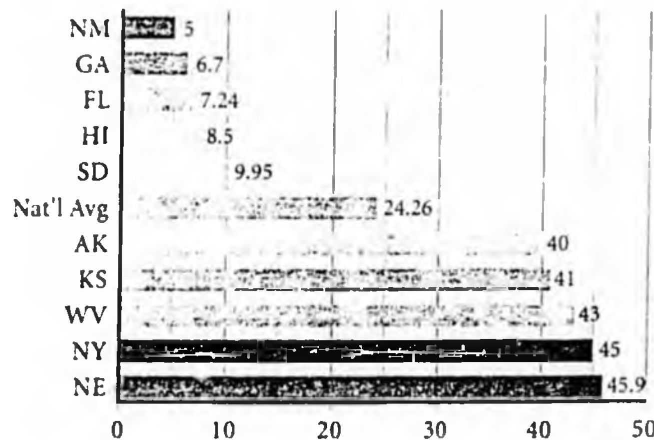


Figure 4

Percent of State Public Health Employees Eligible for Retirement

Source: ASTHO/CSG Survey

Note: The five states with the highest and lowest percentages each are shown.

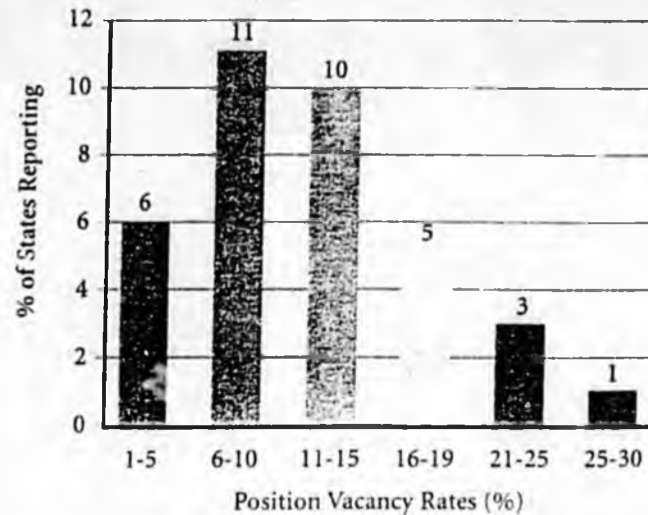
Two: High Percentage of Workers Eligible for Retirement

The "State Employee Worker Shortages: The Impending Crisis" reported that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006. The rates for state public health agencies according to the ASTHO/CSG survey are as high as 45 percent (Figure 4). On average, about 24 percent of the public health workforce is eligible for retirement compared to 21 percent reported for all state employees in October 2002.[11]

Figure 5

Position Vacancy Rates in the State Public Health Agencies

Source: ASTHO/CSG Survey



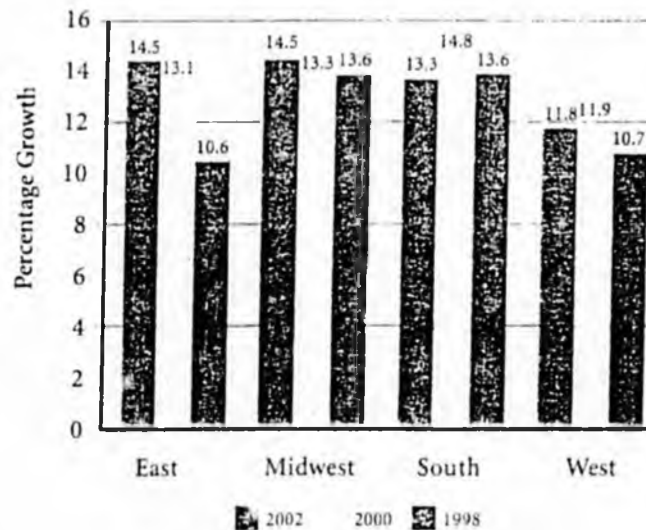
Three: Chronic Shortages in Professional Areas

Four states from the survey show vacancy rates for public health positions of 20 percent or higher. Seventeen out of 35 states reported vacancy rates in the 11-20 percent range. Fourteen states reported that the percentage of state health agency vacancies did not change or had declined in the last five years. The ASTHO/ CSG report shows that around 11 percent of state jobs across all state agencies are vacant.[12]

Figure 6

Turnover Rates for State Public Health Personnel, by Region and Year

Source: ASTHO/CSG Survey



Four: High Turnover Rates

In addition, states must contend with an annual employee turnover rate that averaged 14 percent for the 28 states responding to this question. The high turnover represents a potentially huge loss of institutional knowledge, leadership, and experience for state health agencies. Although in most states the turnover rate for public health is comparable to the turnover rate for all state government agency employees, hiring freezes and shortages will make it hard for state public health agencies to fill vacant positions.[13] The earlier CSG survey documented that 27 states had enforced some type of mandatory hiring freeze.[14]

Public Health Shortage Profiles by Profession

As highlighted in Figure 7, public health professionals such as nurses, laboratory scientists, environmental workers, physicians, nutritionists, educators, and social workers comprise 45 percent of the current public health workforce. The rest of the workforce consists of health officials and administrators (3.5 percent), technicians (9.4 percent), administrative support personnel (12 percent), paraprofessionals (3.5 percent), and other technical and administrative categories.[15]

State and local health agencies are reporting the most significant worker shortages in the areas of nursing, environmental health, epidemiology, and laboratory science.[16] Figure 8 of the ASTHO/CSG survey reflects that the state health agency workforce shortage issue is most noticeable among public health nurses. Thirty out of 37 reporting states identified public health nursing as the field that is and will continue to be the most affected by the personnel shortage. Furthermore, the survey documented considerable shortages for three other public health disciplines including epidemiologists (15 states), laboratory workers (11 states) and environmental health specialists (11 states).

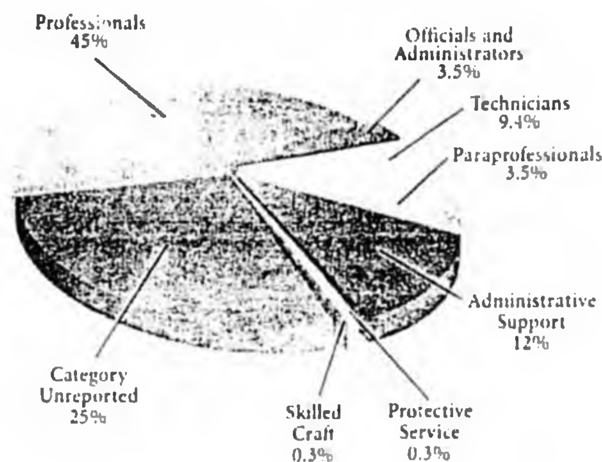


Figure 7

Composition of Total Public Health Workforce

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professionals, National Center for Health Workforce Information and Analysis, The Public Health Work Force: Enumeration 2000, Dec. 2000.

Public Health Nursing

Thirty out of 37 reporting states indicated that nursing is the occupational class most affected by the workforce shortage. shortages are twice that of the next leading class, epidemiologists (Figure 8)

The leaders of state public health nursing average more than 30 years service and are very close to retirement. In one state nearly 40 percent of the public health nursing workforce is eligible for retirement today.[17]

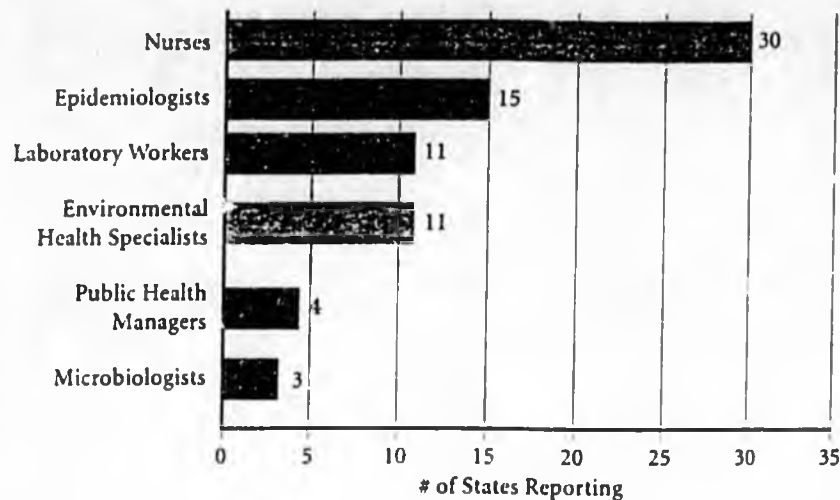
Public health nurses comprise 11 percent of the total public health workforce and 25 percent of all public health professionals.[18] The ASTHO/CSG survey shows the 37 reporting states have a total of 14,733 nurses working for public health agencies. The number of public health nurses varies by state: one state reported six nurses on staff, while another reported having 2,591.

The roles and responsibilities of the public health nurse can also vary by state. They might include, for example, instructing individuals on preventive care, nutrition, and childcare and arranging for immunizations, blood pressure screening, and/or working with community leaders to promote health education.[19]

Figure 8

State Public Health Occupational Classes Most Affected by Worker Shortage

Source: ASTHO/CSG Survey



Health providers across the nation, public and private, are reporting serious deficiencies in the supply of nurses in all health care settings. According to national projections, by the year 2010 there will be a need for one million additional registered nurses in all health fields.[20] The nursing shortage in the private sector adds to the challenge for the public health sector, which must compete for a limited pool of applicants.

Part of the public health nurse recruitment challenge is that young people are increasingly reluctant to enter public health nursing, primarily because of low salaries in the field.[21] Unfortunately, fiscal conditions in many states do not permit the salary increases necessary to allow state health agencies to effectively compete for limited talent.

Women in the past have traditionally filled the vast amount of nursing positions due to limited career paths. However, today's women have greatly expanded career opportunities to choose from when selecting a career leaving behind significant recruiting gaps.

Epidemiology

Epidemiology provides the fundamental public health functions of monitoring health status, diagnosing and investigating health hazards and events, and evaluating the effectiveness of health services.

According to the ASTHO/CSG survey, at least 15 of the 37 reporting states have a shortage of epidemiologists (Figure 8). The U.S. General Accounting Office reports that barriers to recruiting and retaining epidemiologists in the public health field include noncompetitive salaries and a general shortage of professionals.[22] Approximately 42 percent of the current epidemiology workforce in state health departments lacks formal academic training in epidemiology.

The shortage of epidemiologists may be partly explained by the high level of education required for this profession in relation to public salaries: 28.6 percent of epidemiologists have doctoral level training, 40 percent have master's level training, 18.4 percent have bachelor level training and 13 percent have various other types of educational qualifications.[23]

Laboratory Scientists and Technicians

Public health laboratories are often the first line of defense in protecting the American people against diseases and other health threats. Public health laboratories provide diagnostic testing, disease surveillance, applied research, and training. The laboratory workers in state public health constitute 3.1 percent of the total public health workforce.[24]

While several states participating in the ASTHO/CSG survey noted the shortage of laboratory workers, other surveys have also found shortages of laboratory personnel. A report by the Association of Public Health Laboratories that includes data as of December 2002, reveals a severe shortage of qualified laboratory personnel in the states.[25] Thirteen states reported no doctoral-level molecular scientist on staff, and 23 states reported only one. Most states agreed that at least two doctoral-level molecular scientists were needed on staff to ensure emergency readiness.

A shortage of information technology specialists can seriously imperil the ability of states to meet the national goal of timely and effective communication of laboratory results during an emergency.[26] Sixteen states reported no dedicated, full-time information technology specialist to manage laboratory information systems and 18 states reported only one person serving in this capacity.

The primary barrier to hiring adequate laboratory staff is the lack of trained personnel willing to serve in the public sector. In recognition of this, Congress took steps in 2003 to help meet the need of more public health laboratory staff by appropriating $146 million to improve laboratory capacities. However, even though the supplemental funding provides for hiring of a skilled laboratory workforce, the needed workforce simply does not exist. Of 22 states that have not met the August 2003 deadline for preparedness benchmarks from the grant money, 17 cited the difficulty in recruiting new staff as a major problem.[27]

The Association of Public Health Laboratories cautions that policy-makers might erroneously assume that because all of the funds have not been spent, states don't need the money. In fact, intractable vacancy rates and the physical unavailability of professionals willing to work in the public sector are the core of the problem.[28]

Environmental Health Professionals

The term environmental health professional covers a broad array of services in the public health field. For the past 150 years environmental health services have focused on food, water and sanitation. The emergence of new threats – such as cryptosporidium, hantavirus, West Nile virus, SARS, and bio/agro-terrorism – shows the need for a strong environmental public health system and workforce.

Eleven of the 37 reporting states in the ASTHO/CSG survey identified a shortage of environmental health professions. There are slightly more than 20,000 environmental health professionals and technicians in the United States.[29] They comprise about 4.5 percent of the total public health workforce.[30]

Current challenges for recruiting and retaining existing environmental health workers include low pay scales at the state level, minimal advancement opportunities, and competition with the private sector. State environmental programs often serve as a training ground for people to learn needed skills and then move into the private sector at higher salaries.

Keys to Success: State Plans to Address Public Health Workforce Issues

Measuring the extent of the current workforce deficit, projecting future staffing needs, and developing effective strategies to meet these needs present new challenges to State Health Officials. Given current budget constraints at the state level, states are experimenting with new approaches in recruitment and retention. Some of these strategies have been implemented, while others are still in the planning stage.

Workforce Recruitment and Retention

States are considering various strategies to ensure adequate staffing of public health agencies, including:

- Increasing pay and benefits
- Offering flexible work schedules and telecommuting opportunities
- Providing professional training
- Training future public health leaders
- Marketing public health careers at high schools and on college campuses
- Partnering with educational institutions
- Using information technology and the Internet for recruitment

The ASTHO/CSG survey identified six trends that are developing in the approaches to workforce recruitment and retention among the states. These are shown in Figure 9. The CSG/NASPE Survey reported that 34 states are establishing new recruitment and retention strategies and 75 percent of states have developed long-term plans to address the personnel crisis.

Outreach Campaigns

Seven of the 37 reporting states are implementing recruiting strategies that promote public health careers at high schools and higher education institutions. For example, outreach campaigns aimed at universities and colleges, schools of public health and health services, and historically minority colleges. State health agencies are also redefining public service by developing public health career promotion campaigns that showcase state public health agency positions as interesting careers where giving back to the community, detecting new and emerging threats, and keeping America healthy are just part of the job.

All 37 states that participated in the survey have proposed various approaches to alleviating public health worker shortages. For example, some states are developing mid-life career change programs to attract professionals leaving other career paths. Other states are developing reports on the current conditions affecting the workforce to aid policymakers in determining future planning.

Information Technology

Five states reported using information technology and the Internet to expand their outreach and optimize their outreach campaigns. Some states are using the Internet to advertise public health vacancies, taking advantage of commercial partnerships offered by web-based job search engines for augmenting recruitment capabilities and shortening the hiring process. States are also developing clearinghouses for current in-depth information on health careers.

Professional Training

Recognizing the value of institutional knowledge, state health agencies are devising innovative strategies to retain current employees. Fourteen of the 37 reporting states are considering incentives designed to advance the competencies of their public workforce, such as scholarship and loan repayment programs, work-study arrangements, professional training, and distance learning opportunities. Emphasis on the value and attainment of proper qualifications through higher education and continuing education is essential if the public health workforce is to keep up with the escalating demands of new scientific technologies and methodologies.[31]

Eleven of the 37 reporting state public health agencies are considering partnering with various professional educational institutions to design public health programs and curricula. By educating all health professionals about public health skills, states can develop basic public health curriculum units that can be adopted into any baccalaureate or graduate health professional program. This increases the pool of partners for public health organizations that reach out for collaboration in future retention, training, and mentorship.

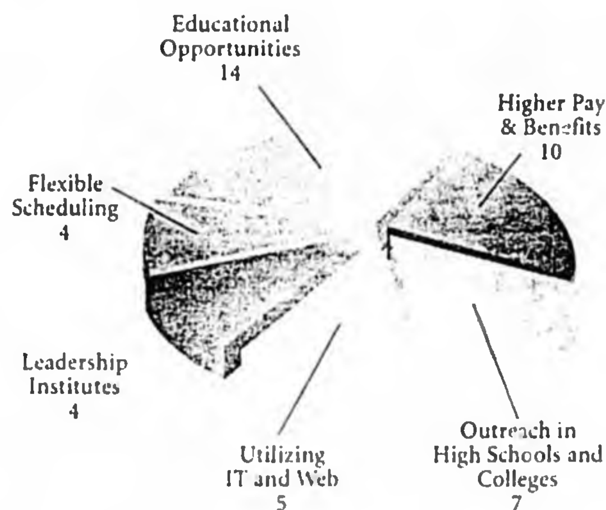


Figure 9

State Public Health Personnel Recruitment and Retention Plans

Source: ASTHO/CSG Survey

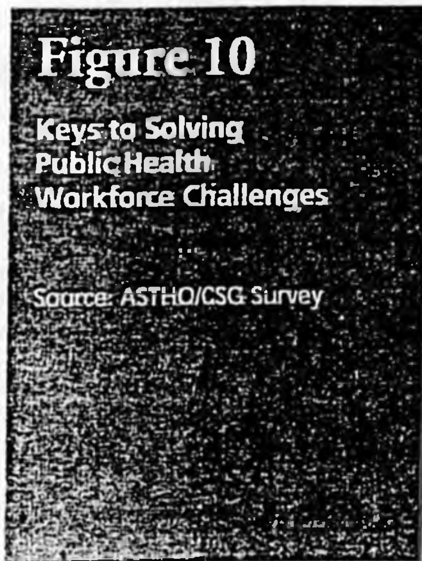
Higher Pay and Benefits and Flexibility

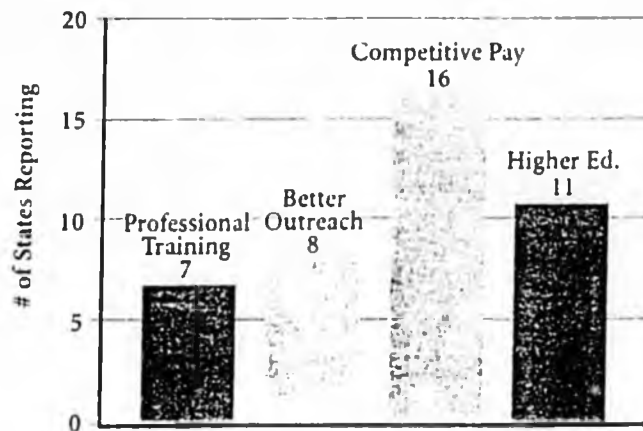
States are concerned that considerably lower salaries in governmental public health positions make it difficult to compete with the private sector for employees. Sixteen states are considering offering pay and benefits that are in line with the private sector as a potential solution to public health worker shortages (Figure 10). The ASTHO/CSG report documents that 45 states have faced serious budget difficulties during the past two years that will make it difficult for them to address the state workforce shortage.[32] Despite funding cuts, the ASTHO/CSG survey demonstrates some states are finding vehicles to increase pay to retain employees when the market shrinks for particular high-need occupational categories.

Four of the 37 reporting states are offering telecommuting and other flexible scheduling opportunities to their public health employees. States found flexible schedules improve organizational resilience, promote skills retention for those who might want to move out of state but continue to work on a full-time or part-time basis, lower absenteeism, and reduce the desire to "job hop".

One way to retain the expertise and experience of the aging workforce is to rehire retired employees. Of 36 states that responded to this question in the survey, all but four states reported that they actively seek to rehire retired employees. Of the 33 states responding that are permitted to rehire, 16 provide retirement benefits to the rehired employees. Some states are offering part-time employment to attract public health system retirees.

Tapping the retired worker talent pool offers a significant opportunity to avoid the loss of institutional knowledge and retain highly-skilled employee. It also allows more time for succession planning activities. Currently, Americans age 50 and older make up 28 percent of the population, with 50.6 million people between ages 50 and 70. As the baby-boomers mature, it's predicted that there will be as many Americans of retirement age as there are 20-25 year olds.[33]





Enhancing Leadership Capacity

Four of the 37 reporting states are focused on enhancing the leadership capacity of their public health managers through leadership training institutes. Public health agencies partner with state educational institutions to help future health leaders acquire and develop necessary leadership skills.

Conclusion

An adequate supply of competent public health professionals is a vital component of the governmental public health infrastructure. A number of factors are having an adverse affect on the ability of state public health to ensure that there are sufficient numbers of these individuals to fill current and rapidly growing vacancies. Chief among these are that the current workforce is rapidly aging and nearing retirement while there are few students and young professionals who are interested in careers at public health agencies. The combination has resulted in a critical narrowing of the public health workforce pipeline in a majority of the states. If left unchecked, time will exacerbate the crisis.

The ASTHO/CSG survey shows that the greatest worker shortages are in the areas of public health nursing, epidemiology, laboratory science, and environmental health, all of which require advanced specialized training and education. These professionals detect emerging diseases; educate the public about actions to take to prevent exposure, protect the food supply, and help develop public health policy to prevent the spread of disease. A long-term aggressive plan must be implemented to educate, recruit, and retain competent public health professionals.

States are implementing various strategies to improve worker recruitment and retention, such as reaching out to school-aged children to spark interest in the public health profession, using information technology to recruit new public health workers, providing incentives to improve skills, increasing the pay and benefits of the existing public health workforce, and rehiring retired public health employees. The underlying current of tight state budgets, however, affects all of these efforts.

Aside from offering competitive salaries, long-term solutions will require innovative programs for on-the-job training and expensive advanced degree education. Many states said outreach campaigns to new partners, institutes of higher learning, school aged children, and legislatures are critical to building the public health workforce pool. Many states also indicated that scholarship and loan repayment programs could help public health to recruit the best and the brightest America has to offer.

There are a variety of reasons for the public health workforce shortage. The survey provides examples of the practices states are implementing to alleviate the shortages and how the entire public health system must plan for long-term solutions. Both the problems and the solutions are multi-dimensional and will require a well-coordinated effort on the part of the public health agencies, legislatures, institutes of higher learning, and the federal government to help improve the outlook for the future workforce and guarantee the security and health of the American people.

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13. Ibid., p 3

14. Ibid , p 4

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Alaska Employment Projections in Healthcare

Occupation	Employment Year 2002	Employment Projected 2012	Percent Change	Comments
Licensed Practical & Licensed Vocational Nurses	521	609	16.9	Employment of LPNs is expected to grow about as fast as the average for all occupations through 2012 in response to the long-term care needs of an increasing elderly population and the general growth of healthcare. Replacement needs will be a major source of job openings, as many workers leave the occupation permanently.
Registered Nurses (registered nurse, hospital nurse, office nurse, nursing care facility nurse, home healthcare nurse, public healthcare nurse, occupational health nurse, head nurse, nurse supervisor, clincal nurse, nurse anesthetists, and nurse mid-wives)	5,004	6,670	33	Job opportunities for RNs are expected to be very good. Employment of registered nurses is expected to grow faster than the average for all occupations through 2012, and because the occupation is very large, many new jobs will result. In fact, more new jobs are expected be created for RNs than for any other occupation. Thousands of job openings also will result from the need to replace experienced nurses who leave the occupation, especially as the median age of the registered nurse population continues to rise.
Nursing Aides, Orderlies & Attendants	1704	2148	26	Excellent job opportunities are expected for this occupation, as rapid employment growth and high replacement needs produce a large number of job openings. Employment of personal and home care aides is projected to grow much faster than the average for all occupations through the year 2012. The number of elderly people, an age group characterized by mounting health problems and requiring some assistance, is projected to rise substantially. In addition to the elderly, however, patients in other age groups will increasingly rely on home care, a trend that reflects several developments, including efforts to contain costs by moving patients out of hospitals and nursing care facilities as quickly as possible, the realization that treatment can be more effective in familiar rather than clinical surroundings, and the development and improvement of medical technologies for in-home treatment.
Dental Hygienist	438	619	41.3	Employment of dental hygienists is expected to grow much faster than the average for all occupations through 2012, in response to increasing demand for dental care and the greater utilization of hygienists to perform services previously performed by dentists. Job prospects are expected to remain excellent. In fact, dental hygienists is expected to be one of the fastest growing occupations through the year 2012. Population growth and greater retention of natural teeth will stimulate demand for dental hygienists. Older dentists, who have been less likely to employ dental hygienists, are leaving the occupation and will be replaced by recent graduates, who are more likely to employ one or even two hygienists. In addition, as dentists' workloads increase, they are expected to hire more hygienists to perform preventive dental care, such as cleaning, so that they may devote their own time to more profitable procedures.
Dental Assistant	703	980	39.4	Job prospects for dental assistants should be excellent. Employment is expected to grow much faster than the average for all occupations through the year 2012. In fact, dental assistants is expected to be one of the fastest growing occupations through the year 2012. In addition to job openings due to employment growth, numerous job openings will arise out of the need to replace assistants who transfer to other occupations, retire, or leave the labor force for other reasons. Many opportunities are for entry-level positions offering on-the-job training.

Source: Alaska Occ Forecast 2012, SOA, Occupational Outlook Handbook, BLS
X Reports-Ad Hoc/Ad Hoc Reports 2005/Healthcare Projects Alaska-DOP-050824.xls
Prepared by: JRusso/Aanrud, HRS, DOP

Alaska Employment Projections in Healthcare

Occupation	Employment Year 2002	Employment Projected 2012	Percent Change	Comments
Medical Records and Health Information Technician	357	549	53.8	Job prospects should be very good. Employment of medical records and health information technicians is expected to grow much faster than the average for all occupations through 2012, due to rapid growth in the number of medical tests, treatments, and procedures that will be increasingly scrutinized by third-party payers, regulators, courts, and consumers. Although employment growth in hospitals will not keep pace with growth in other healthcare industries, many new jobs will nevertheless be created. The fastest employment growth and a majority of the new jobs are expected in offices of physicians, due to increasing demand for detailed records, especially in large group practices. Rapid growth also is expected in nursing care facilities, home healthcare services, and outpatient care centers. Additional job openings will result from the need to replace technicians who retire or leave the occupation permanently.
Physical Therapist Assistant	51	72	41.2	Employment of physical therapist assistants and aides is expected to grow much faster than the average through the year 2012. The impact of proposed Federal legislation imposing limits on reimbursement for therapy services may adversely affect the short-term job outlook for physical therapist assistants and aides. However, over the long run, demand for physical therapist assistants and aides will continue to rise, in accordance with growth in the number of individuals with disabilities or limited function. The growing elderly population is particularly vulnerable to chronic and debilitating conditions that require therapeutic services. These patients often need additional assistance in their treatment, making the roles of assistants and aides vital. The large baby-boom generation is entering the prime age for heart attacks and strokes, further increasing the demand for cardiac and physical rehabilitation. In addit n, future medical developments should permit an increased percentage of trauma victims to survive, creating added demand for therapy services.
Pharmacy Technicians	359	571	59.1	Good job opportunities are expected for full-time and part-time work, especially for technicians with formal training or previous experience. Job openings for pharmacy technicians will result from the expansion of retail pharmacies and other employment settings, and from the need to replace workers who transfer to other occupations or leave the labor force. Employment of pharmacy technicians is expected to grow faster than the average for all occupations through 2012 due to the increased pharmaceutical needs of a larger and older population, and to the greater use of medication. The increased number of middle-aged and elderly people—who, on average, use more prescription drugs than do younger people—will spur demand for technicians in all practice settings. With advances in science, more medications are becoming available to treat more conditions.

Source: Alaska Occ Forecast 2012, SOA, Occupational Outlook Handbook, BLS
X Reports-Ad Hoc/Ad Hoc Reports 2005/Healthcare Projects Alaska-DOP-050824.xls
Prepared by: JRusso lAanrud, HRS, DOP

Alaska Employment Projections in Healthcare

Occupation	Employment Year 2002	Employment Projected 2012	Percent Change	Comments
Physician Assistant	185	251	35.7	Employment of PAs is expected to grow much faster than the average for all occupations through the year 2012, due to anticipated expansion of the health services industry and an emphasis on cost containment, resulting in increasing utilization of PAs by physicians and healthcare institutions. Physicians and institutions are expected to employ more PAs to provide primary care and to assist with medical and surgical procedures because PAs are cost-effective and productive members of the healthcare team. Physician assistants can relieve physicians of routine duties and procedures. Telemedicine—using technology to facilitate interactive consultations between physicians and physician assistants—also will expand the use of physician assistants. Job opportunities for PAs should be good, particularly in rural and inner city clinics, because those settings have difficulty attracting physicians.
Speech-Language Pathologists and Audiologist	190	199	4.7	Employment of speech-language pathologists and audiologists is expected to grow faster than the average for all occupations through the year 2012. Members of the baby boom generation are now entering middle age, when the possibility of neurological disorders and associated speech, language, swallowing, and hearing impairments increases. Medical advances are also improving the survival rate of premature infants and trauma and stroke victims, who then need assessment and possible treatment. Many States now require that all newborns be screened for hearing loss and receive appropriate early intervention services. Many States now require that all newborns be screened for hearing loss and receive appropriate early intervention services.

Source: Alaska Occ. Forecast 2012, SOA; Occupational Outlook Handbook, BLS
X:Reports-Ad Hoc/Ad Hoc Reports 2005/Healthcare Projects Alaska-DOP-050824.xls
Prepared by: JRusso /Aanrud, HRS, DOP

OCT 0 5 2005

STATE OF ALASKA

FRANK H. MURKOWSKI, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

P.O. BOX 11^^00
JUNEAU, ALASKA 99811-0200
PHONE: (907) 465-2200
FAX: (907) 465-2135

September 30, 2005

Save
Becky

The Honorable Peggy Wilson
Alaska House of Representatives
PO Box 109
Wrangell, AK 99929

Dear Representative Wilson:

You have asked me to advise your committee regarding the collective bargaining implications of proposed legislation concerning mandatory overtime for nurses and other health care employees. First, Registered Nurses must be distinguished from other unlicensed or lesser-licensed employees. Registered Nurses are classified as professionals for purposes of the federal Fair Labor Standards Act (FLSA), to which the State, other public employers, and private sector employers are subject. Under the FLSA, Registered Nurses and other professionals are exempt from overtime so long as they are paid a salary. In those instances where Registered Nurses are compensated for overtime, it is a creature of a labor agreement or employer policy. The State pays overtime to some levels of the Registered Nurse classification by agreement with the general government and supervisory bargaining units. Lower levels of health care employees, e.g., Certified Nurses Aides and Psychiatric Nursing Assistants, are overtime eligible under the FLSA.

The Alaska Public Employment Relations Act (AS 23.40.070 – 260, PERA) requires public employers to bargain over "wages, hours, and terms and conditions of employment" (AS 23.40.250(1)). Clearly, overtime eligibility criteria and thresholds are matters concerning hours of work and thus are mandatory subjects of bargaining. A mandatory subject is a matter about which the parties must bargain if either party makes a proposal and over which either party may persist to impasse. Nurses and other health care employees are Class One employees within the meaning of AS 23.40.200 *et seq.* and may not strike. If the parties reach impasse on a subject such as overtime, the dispute is submitted to arbitration under AS 23.40.200 (a)(1). The arbitrator's award is subject to legislative approval under AS 23.40.215 and 250(4). If approved by the Legislature, the State is bound by the arbitrator's decision.

It is not uncommon for state employee unions to propose contractual restrictions on or prohibitions of mandatory overtime. Similarly, it is not uncommon for the State of Alaska to fight to retain the ability to assign an employee to lawful work. It remains our department's position that recruitment and retention of nurses should be addressed in a more comprehensive

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and longer term solution as detailed in our recent testimony before the House Health, Education, and Social Services Committee.

If you have any questions regarding this correspondence, please contact me.

Sincerely,

Michael Tibbles
Deputy Commissioner

cc: The Honorable Paul Seaton
Alaska House of Representatives

Katie Shows

From: michael tibbles [michael_tibbles@admin.state.ak.us]
Sent: Tuesday, September 27, 2005 11:23 AM
To: Katie Shows
Subject: Re: question from HESS meeting

Katie,

I have talked to several of our directors here at DOA and staff at H&SS. I have only been able to come up with one example where a department has actually fined another. This would be in the case of OSHA (DOL - Division of Labor Standards and Safety) violations. However, in the context you have requested, it does not make a lot of sense. The Department of Labor could find the Department of Health and Social Services. The Department of Health and Social Services would not have budgeted money to pay the fine and therefore would request funds from the Legislature only to deposit the money back into the General Fund.

I also wanted to pass along to you that we are preparing a short letter to address one of the questions Rep. Seaton raised at the hearing. We will outline what items are subject to bargaining under state law and as interpreted by the court system. Please let me know if you have any additional questions.

Mike Tibbles

Katie Shows said the following on 9/23/2005 9:59 AM:

> Mr. Tibbles,
>
> Rep. Seaton had a question for you after this morning's HESS committee meeting.
>
> On page 3, lines 23-28 of the CSHB 271 (version 24-LS083/Y) it outlines the provisions of the fine and that the Commissioner of Labor assess on the health care facilities, which are under the authority of the Department of Health and Social Services. Is it common practice for one commissioner to assess a variable fine against a facility controlled by a different department?
>
> Thanks,
>
> Katie Shows
> Legislative Aide
> Rep. Paul Seaton
> 1.907.465.2921

Fax to Peggy Wilson
from Paul Seaton

Testimony to House HESS Committee on CSHB 271(HES), Draft "Y"
Limitations on Overtime for Registered Nurses in Health Care Facilities
BY: Rod Betit, President/CEO Alaska Hospital & Nursing Home Association
January 24, 2006

ASHNHA Alaska State Hospital and Nursing Home Association

Madame Chair, members of the Committee I appreciate the opportunity to speak to CSHB 271 on behalf of my membership.

This bill as drafted would apply to the following ASHNHA members:

HOSPITALS

- Alaska Regional Hospital — Anchorage
- Bartlett Regional Hospital — Juneau
- Central Peninsula Hospital — Soldotna
- Fairbanks Memorial Hospital — Fairbanks
- Ketchikan General Hospital — Ketchikan
- Mat-Su Regional Medical Center — Palmer/Wasilla
- Providence Alaska Medical Center — Anchorage
- South Peninsula Hospital — Homer
- Alaska Psychiatric Institute — Anchorage
- North Star Behavioral Health — Anchorage

NURSING HOMES

- Denali Center — Fairbanks
- Heritage Place — Soldotna
- Ketchikan General — Ketchikan
- Mary Conrad Center — Anchorage
- Providence Extended Care Center — Anchorage
- South Peninsula — Homer
- Wildflower Court — Juneau
- Alaska Pioneer Homes — Anchorage, Fairbanks, Juneau, Sitka, Ketchikan, Palmer

My membership has deep respect for the sponsor's commitment for improving health care delivery in the State, and for her concern about the fair treatment of health care professionals in these institutions.

We support the sponsor's goal to avoid excessive use of mandatory overtime as this can lead to reduced quality of patient care if exhausted health care workers have worked too many hours without a break.

Testimony to House HESS Committee on CSHB 271(HES), Draft "Y"
Limitations on Overtime for Registered Nurses in Health Care Facilities
BY: Rod Betit, President/CEO Alaska Hospital & Nursing Home Association
January 24, 2006

ASHNHA members try to limit the use of mandatory overtime to situations that are unforeseen and would leave patients with inadequate supervision, inadequate assistance with personal care needs, or inadequate medical management. When these unexpected staffing situations arise facility management may have to keep nursing staff into the next shift. Facility management has to balance the impact on nursing staff against the patients' needs. Failure to meet the patients' needs expose the facility to serious licensing action if they do not insure that all patients' needs are adequately met.

The problem being addressed by CSHB 271 is when nursing staff are frequently required to work into the next shift, particularly during certain periods of the year. This obviously raises some concerns about quality of patient care and fairness to nursing staff.

In testimony given on this bill last year, and during the interim, there was general agreement that non-State facilities have used mandatory overtime infrequently and that this bill is not aimed at correcting problems in those facilities. I have not come by one complaint against a non-State facility for excessive use of overtime, mandatory or otherwise.

It is my understanding that this bill is attempting to address on-going mandatory overtime problems in state facilities, most frequently cited is API. API's use of mandatory overtime varies throughout the year. The heaviest periods of use are during the winter months when patient census predictably increases.

It is important to look at the reasons for use of mandatory overtime by API when determining whether CSHB 271 provides a reasonable remedy that would fix the underlying problems. We understand the reasons to be:

1. Inadequate number of filled nursing positions to provide patient care due to hiring difficulties caused by non-competitive salaries and the stress of the job leading to higher turnover than in general acute care facilities.
2. A State and community expectation for API to take all patients who need hospitalization regardless of staffing available at the time. The business of caring for patients who are a "risk to themselves or others" is not something that can be turned away or passed to other providers as this is a very intense, complex population that API is best able to serve.
3. Inadequate provision in state employee contracts to allow API to request a market survey to validate salary disparities with the private health care market, and permission to increase salaries to be competitive throughout the year without legislative review.

4. Inadequate funding in API's operating budget to actually pay higher salaries to hire staff as soon as they deem a problem developing without budget authority from the Legislature which generally cannot come in time to head off a serious problem.

During the interim the sponsor worked diligently to craft an alternative solution to this problem in hopes that CSHB 271 would become unnecessary. We participated earnestly in trying to help find that solution but it proved elusive. We believe that the sponsor has brought CSHB 271 back up in hopes of keeping the discussion alive and fleshing out a better answer.

We understand the sponsor's decision to do that but have real problems with this bill. In my membership's view CSHB 271 does not address the underlying reasons listed above for the State facility problems. CSHN 271 provides punishment for excessive use of mandatory overtime but does not put any measures in place to break the cycle at State facilities.

In addition, CSHB 271 throws a net around the entire health care system with a system of reporting and monitoring that is not supported by my membership given the lack of evidence of any problem with use of mandatory nurse overtime in non-State facilities.

So, we would like to offer an alternative set of recommendations to consider that we believe would address the underlying problems. We believe the following actions would place API and other State facility management in a position to more effectively staff their facilities according to changing patient census throughout the year, and reduce the dependence on mandatory overtime.

1. Immediately authorize State managers to offer higher salary levels as validated by market surveys so they can hire additional nurses soon. We understand the Legislature and the Administration will need to figure out how to handle the budget impact, but we believe this step is necessary to make the State hiring system responsive to the market conditions it is facing.
2. Consider providing API funding for an ongoing nurse preceptor program that will help newly hired nurses gain advanced skills to provide care in an inpatient psychiatric setting. A preceptor program is an excellent way to close the gap between hiring nurses with little or no experience and moving them to a proficient level. Through the efforts of the University of Alaska, ASHNHA members, the Alaska Nurses Association and others the University of Alaska nursing program is now graduating 200 new nurses a year rather than 100. With competitive pay, mentorship, preceptor training and

periodic respite from intense nursing demands in an inpatient psychiatric setting, API will have more success attracting and keeping the nursing staff they need.

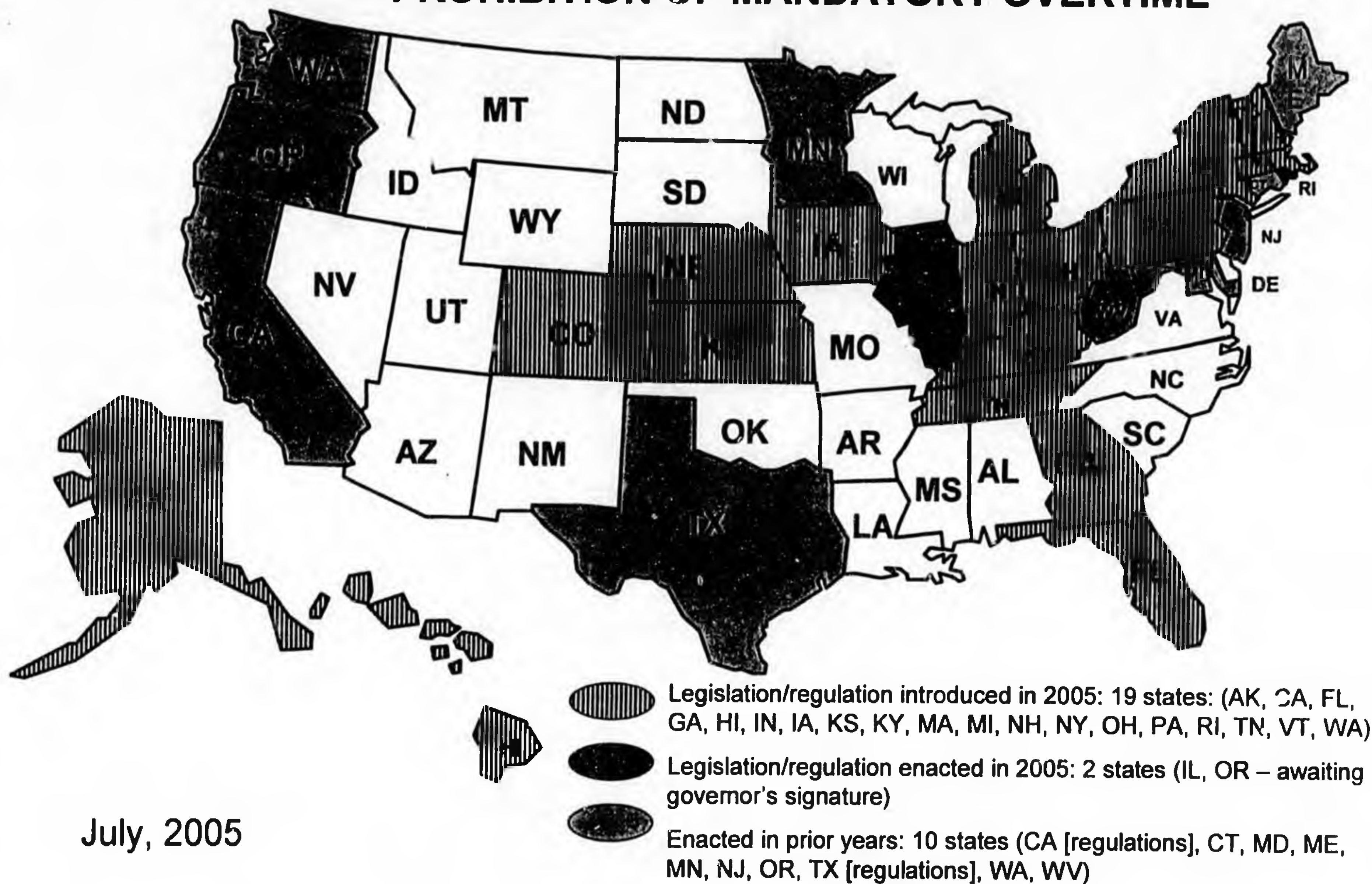
3. Help API solve the problem of coming up with a pool of temporary nurses that can be hired during staffing crises to fill gaps. This is a specialized area of nursing that most temporary staffing agencies do not address. Even under the best of circumstances there will be need for temporary staffing to cover changes in census and unexpected loss of staff.
4. Consider establishing a separate bargaining unit for essential health care related staff separate from other employees to allow special procedures to be developed that will address these problems in the future. Ongoing market survey of nursing salaries should be a routine part of this program.
5. Create a work group to find other solutions to this problem.

ASHNHA believes there are solutions to the problems that State facilities are facing. We appreciate the work the sponsor has done to bring attention to this problem and to look for solutions. We think the solutions outlined above have merit but more importantly recommend a work group be convened to support the sponsor's efforts to figure out how to place State facilities on a more solid footing so they do not have to resort to excessive mandatory overtime for lack of other options.

Thank you for the opportunity to comment on this bill and I would be happy to respond to any questions the committee might have.

The American Nurses Association's Nationwide State Legislative Agenda

PROHIBITION OF MANDATORY OVERTIME



July, 2005

Background: Mandatory Overtime

Mandatory overtime is a difficult problem for RNs and health care facilities. Because of inadequate RN staffing, employers have used mandatory overtime to staff facilities often as a cost savings factor. Nurses are concerned about the health effects of long term overtime and the quality of care being provided. Research indicates that risks of making an error were significantly increased when work shifts were longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week.[1]

As part of the American Nurses Association's (ANA) Nationwide State Legislative Agenda on the nurse staffing crisis, State Nurses Associations support the enactment of mandatory overtime legislation in state legislatures and regulatory agencies. ANA is also pursuing the enactment of federal legislation to prohibit mandatory overtime. The Safe Nursing and Patient Care Act of 2005 (HR 791/S 351) www.anapoliticalpower.org has been introduced in the House and Senate and would prohibit the requirement that a nurse work more than 12 hours in a 24 hour period and 80 hours in a consecutive 14 day period, except under certain circumstances.

In 2005, legislation to prohibit mandatory overtime was introduced in the following 19 states: **AK, CA, FL, GA, HI, IN, IA, KS, KY, MA, MI, NH, NY, OH, PA, RI, TN, VT and WA.** The Illinois Nurses Association was instrumental in the passage of legislation in **IL** that allows hospitals to mandate a nurse to work overtime only in unforeseen emergent circumstances. Even if they must do so, no nurse may work more than 4 hours beyond her/his regularly scheduled work shift. A nurse may not be punished for refusing to work overtime, and if a nurse works 12 hours there must be an 8 hour rest period before working again. This bill awaits the governor's signature. The Oregon Nurses Association was successful in amending **OR** mandatory overtime law (enacted in 2001) by prohibiting a hospital from requiring a nurse to work more than 48 hours in a week or more than 12 consecutive hours in a 24-hour period. There are a few specific exceptions to the limits on mandatory overtime. Nothing in the bill prevents voluntary overtime. This bill also awaits the governor's signature.

In 2004, **WV** enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. The commissioner of labor is charged with the enforcement of the law and shall administer a penalty for any violations. **CT** enacted legislation prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances such as participating in a surgical procedure until the procedure is completed, public health emergency etc. Legislation was also introduced in **FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT,** and **WA.**

In 2003, three states, **LA, NV** and **WV**, enacted legislation requiring the establishment of study committees to further explore the issue. 22 other states introduced prohibition of mandatory overtime legislation/regulation designed to set maximum hours of work per day/week with protected right of refusal for work time requested in excess of predetermined maximums.

In 2002, the following states enacted prohibition of mandatory overtime legislation: **MD** law states that an employer may not require a nurse to work more than the regularly scheduled hours according the predetermined work schedule. There are some exceptions including an emergency

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[1] Rogers A, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* 2004;23(4):202-12

situation that could not be reasonably anticipated and if a nurse has critical skills and expertise that are required for the work. **MN** law prohibits action against a nurse who refuses mandatory overtime because it would jeopardize patient safety. **NJ** enacted legislation prevents a health care facility from requiring an employee to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, not to exceed 40 hours per week. **TX** regulations require hospitals to develop policy and procedures for mandatory overtime. **WA**'s new language states that acceptance of mandatory overtime by a nurse is strictly voluntary and refusal is not grounds for adverse actions against the nurse.

Legislation enacted in 2001 in **ME** would prevent a nurse from being disciplined for refusing to work more than 12 consecutive hours except in certain circumstances and must be given 10 consecutive hours off following overtime. **OR** enacted legislation prevents a nurse from being required to work more than 2 hours beyond a regularly scheduled shift or 16 hours in a 24 hour time period. Regulations adopted in **CA** prior to 2001 prevent an employee scheduled to work a 12 hour shift from working more than 12 hours in a 24 hour period except in a health care emergency.

...ing Matters

***Nursing Matters** fact sheets provide quick reference information and international perspectives from the nursing profession on current health ε social issues.*

Nurses and Overtime*

Nurses are increasingly working overtime. Nurses' overtime (mandatory** or vol has been used as a measure to reduce the impact of the critical shortage of nur and/or the downsizing of nursing departments in both private and public health f However, the increasing amount of overtime threatens nurses' ability to provide individualised care for patients.

While in many countries federal regulations define the maximum hours that can worked in sectors having a direct impact on public safety (e.g. aviation, transpoı nurses and other health care workers are rarely protected. A few examples hav selected to provide an overview of existing situations.

** Overtime is time worked in addition to the normal or regular contracted hours.*
*** Mandatory overtime is obligatory, compulsory or imposed by the employer leaving no the employee.*

Examples

1. ***USA – mandatory overtime***

   Promoted by hospital management as a way to staff effectively during an emergency, mandatory overtime has become instead a means to cover routine personnel shortages.

   In a large number of hospitals nurses report the existence of a documente policy that imposes mandatory overtime. Overtime may be from 4 to 16 hc (or more) and nurses are included in a duty roster to perform the overtime after their regular shift. Depending on the state where the nurses are employed, they may be paid extra money (not always) but do not get any time off.

   In January 2001 the "Registered Nurse and Protection Act" was introduce the US Congress. It aims to limit the number of hours that licensed health workers, including registered nurses (RNs), would be obliged to work. The will amend the Fair Labour Standards Act to bar mandatory overtime beyc hours in a workday or 80 hours in any 14-day work period. Exceptions are

accepted in cases of natural disasters or in the event of a state of emerge declared by the authorities. A licensed health care employee may howeve voluntarily work beyond 8 hours in any given workday.

2. ***Australia***

Australian nurses report a significant increase in their workload over the p five years. A recent report shows an increasing amount of regularly worke overtime. On 23 June 2000, Australian Nursing Federation (ANF) ACT Bra members voted unanimously to outlaw the working of 16 and 18-hour shifl and ban recall shifts when individual nurses considered them to be unsafe

3. ***Europe***

Nurses within the EU are protected by law from being forced to do overtir but it is still common practice in almost all countries that nurses do work overtime. To date, the directive that exists has not been implemented in al European countries. According to the Working Time Regulations, work tir must not average more than 48 hours per week over a standard averaginç period of 17 weeks. It is possible however to extend this period to 26 weel a year if agreement is reached by employers and employees. Daily and weekly rest entitlements are also specified in the regulations:

⇒ *Daily rest:* Employees are entitled to a rest period of not less than 11 consecutive hours in each period of 24 hours during which the employee works for the employer.

⇒ *Weekly rest period:* Employees are entitled to an uninterrupted rest period of not less than 24 hours in each 7-day period. This is in addi to the daily rest period.

⇒ *Breaks:* Employees are entitled to a rest break when daily working ti exceeds 6 hours.

United Kingdom:

A national survey of registered nurses commissioned by the Royal Collegı Nursing (RCN) and carried out by the Institute for Employment Studies (IE in 1999 showed that 59% of the respondents report that they work an aveı of 6.6 of excess hours per week. In 1998, the average was 5.8 hours/weel Twenty-eight percent of the nurses report undertaking paid work in additio their main job. They work an average of 6.6 hours a week in these additioı jobs. The increased income is the main reason given for taking on this secondary employment.

4. ***Japan***

A 1997 survey by the Japanese Nursing Association showed that 4,636 nursing personnel reported working an average of 12 hours 36 minutes of overtime each month. More than 70% of hospital employees were requireı work rotating night shifts (Japanese Nursing Association News, 1998).

It is common practice that individuals in certain positions (e .ıanagement) wo overtime without specific compensation or benefits. Most often however this ove not mandatory and the risk to public safety is not present. Perceptions about the of hours constituting long hours vary according to the type of work. However soı employees work 100 hours per week or more. British employees are reported tc some of the longest hours in Europe.

Rationale for working long hours:

The main reasons for working long hours are:

- Work pressure – arising from heavier workloads, increasing demand, few
  and tighter budgets.
- Work organisation – in some cases lack of prioritisation or individual ineffi
  can increase the workload.
- Long hours culture – generated by the example of managers working lonc
  peer pressure, job insecurity, individuals feel their presence at work is crit
  the realisation of the organisation's mission.
- A strong commitment amongst individuals towards their work, colleagues,
  customers or clients.
- A need to increase take-home pay.

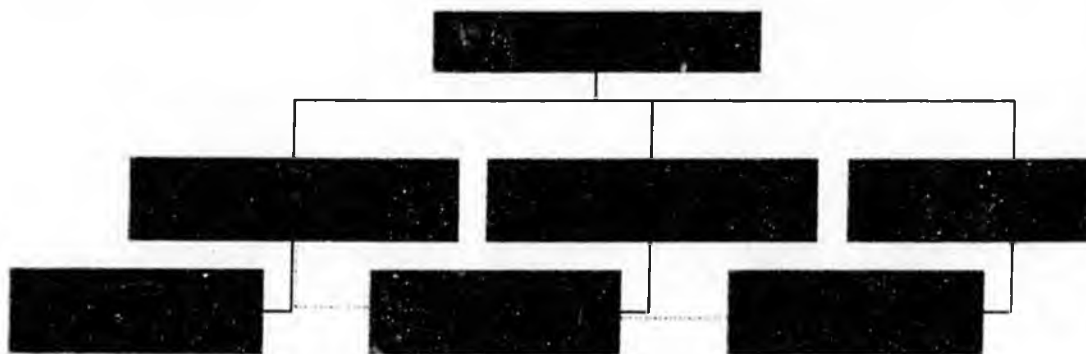
Some, if not all, of these reasons are relevant to nurses.

Effect on health

When no limits are set on overtime work and no guidelines exist for the rest peri following extended hours of work, the burden of these physical and mental dem have a negative affect on patients as well as nurses. Extensive overtime (volunt mandatory) may put patients and nurses at risk.

Nurses

A limited number of studies demonstrate the relationship between extended shi than eight hours) and fatigue as well as increased safety risks. The negative consequences are not limited to physical health, e.g. fatigue, headache, sleeple Disruptions and stressed dynamics within the social and family life are also repc



Patients

Extensive overtime puts patients at risk, due to:

- Nurses being less alert to changes in patients' condition.
- Nurses having slower reactions.
- Medication errors – adverse drug events (ADEs).
- Errors in clinical judgement.
- Increase in nosocomial infections.
- Increase in decubiti.

All the above potential consequences are likely to lead to deterioration in the qu care provided.

What Nurses can do

- A professional nurse is the best judge of her own capability. If she cannot safe care in a given situation, she must inform her supervisor.
- Research on the subject of extended overtime and related health issues a influence on medical errors should be undertaken so that more comprehe data is available.
- The public should be informed about the working conditions in health care – not to frighten them but to alert them about the act situation and gen support for constructive change.
- National nurses' associations should work together with other health profe organisations to ensure appropriate regulation of overtime.
- National nurses' association should provide the ethical framework for nurs overtime practices, especially in cases where nurses reject an assignmen physical exhaustion or mental stress.

For further information please contact ICN at icn@icn.ch

Fact sheet/Nurses and Overtime

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"The work of bedside nursing has become increasingly demanding, from physical tasks such as securing and transporting patients in wheel chairs, to caring for sicker and more obese patients, and even enduring abusive behavior from patients, family members, and staff, including physicians. Marked reductions in hospital length of stays have also made it more difficult for nurses to get to know patient needs. These and other factors have decreased the average nurse retirement age to the mid-50's. Many initiatives to address the nursing shortage are focusing on making it safer and less stressful for nurses to stay at the bedside as they age."

An excerpt from *Charting Nursing's Future*, a publication of the Robert Wood Johnson Foundation, November 2005.

KIDS TOGETHER, Inc.

People First Language

Examples to Use and to Share

by Kathy Snow

Labels Not to Use...	People First Language...
the handicapped or the disabled	people ***with*** disabilities
the mentally retarded or he's retarded	people ***with*** mental retardation or he has a cognitive impairment
my son is autistic	my son ***has*** autism
she's a Down's; she's mongoloid	she ***has*** Down syndrome
birth defect	***has*** a congenital disability
epileptic	a person ***with*** epilepsy
wheelchair bound or confined to a wheelchair	***uses*** a wheelchair or a mobility chair or is a wheelchair user
she is developmentally delayed	she ***has*** a developmental delay
he's crippled; lame	he ***has*** a physical disability he has a mobility impairment
she's a dwarf (or midget)	she ***of*** short stature
is learning disabled or LD	***has*** a learning disability
afflicted with, suffers from, victim of	person who ***has*** ...
she's emotionally disturbed; she's crazy	she ***has*** an emotional disability

normal and/or healthy kids	typical kids or kids without a disability
quadriplegic, paraplegic, etc.	he ***has*** quadriplegia, paraplegia, etc.
she's in Special Ed	she ***receives*** Special Ed services
handicapped parking, bathrooms, etc	***accessible*** parking, bathrooms etc.
she has problem with...	she has a need for...

See Also:

Pennsylvania's Executive Order
"All Commonwealth agencies, boards or commissions under the Govenor's jurisdiction shall use 'People First' language..."

Return to previous page

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Madam Chair and members of the committee,

My name is Cathy Feaster. I am a nurse practitioner and nursing supervisor in the Community Health Services Division of the Municipality of Anchorage Department of Health and Human Services. I'm here to testify on behalf of House Bill 271.

This bill recently came to our attention at the department, and although we support the spirit and intent of this bill, we have some concerns regarding possible unintended consequences.

It appears the bill will have no negative consequences in regards to the majority of our nurse driven programs and services. However, we have one program, the Sexual Assault Response Team clinic known as SART which by its nature creates special circumstances.

SART is a team comprised of a police detective, a forensic nurse, and a STAR advocate Team members ~~all of whom~~ are on call 24 hours a day, 7 days a week. Upon receiving a call the team joins as a unit to interview, medically examine and support the sexual assault client. The SART clinic has many challenges. We would hate to see legislation jeopardize this critical service.

We would like this bill to move forward in this committee and offer to work with the sponsor in looking closely at the implications and language to ensure there are no unintended consequences that might negatively impact the viability and important mission of the Sexual Assault Response Team.

Thank you Madam Chair and members of the committee.

Cathy Feaster, MSN, ANP
RHC Program Manager
Dept. of Health & Human Services
907.343.4789
907.249.7648 fax
feasterec@muni.org

ASHNHA Position on Draft Committee Substitute for CSHB 271 Version 'P'

Prepared by: Rod Betit, President/CEO

February 28, 2006

The Alaska State Hospital and Nursing Home Association (ASHNHA) wishes to express its appreciation for the sponsor's efforts to reach consensus on CSHB 271 Version 'P'. The meetings held in the intervening weeks have been very helpful and constructive. While the measure now contains a very useful reporting requirement that ASHNHA members support, there remains one major provision of this legislation which ASHNHA members cannot support.

First, I would like to draw your attention to a survey ASHNHA conducted of its membership regarding the use of "mandatory overtime" as defined locally between management and nursing. As the attached survey conducted by ASHNHA shows, facilities are not using mandatory overtime to fill the nursing gaps that exist around the State (see attached Survey results). Further, to ASHNHA's knowledge there has been no evidence presented to the contrary by other parties. Therefore, ASHNHA's membership cannot support measures that reduce management's ability to fairly and openly negotiate employment practices with their nursing staff.

Specifically, ASHNHA's concern is around Sec. 18.09.010 of the bill which provides that a nurse will be the sole determiner of whether overtime is appropriate. In effect the bill removes management from this decision process. This is simply not reasonable personnel policy to adopt by state law. Currently, overtime parameters are negotiated between management and representatives of nursing staff in each community. Different standards exist in different communities, acceptable to both management and nursing representatives, based on a host of factors. This language would interfere with the local ability to arrive at these employer/employee relationships.

On the other hand, ASHNHA supports the intent of Sec. 18.09.040 of the bill. We believe this is the heart of this legislation. This section would require periodic reporting of nurse overtime utilization, as well as use of temporary nursing services by each facility. We agree with the sponsor that there is a valid public health concern to monitor in the years ahead. By collecting this level of information from health facilities the Legislature will be able to determine whether steps being taken to address the nursing shortage are having any impact, and if not, what other measures should be implemented to address the problem.

Again ASHNHA's membership appreciates the sponsor's willingness to work on the provisions of this bill. Unfortunately, although a number of important amendments have been made, there still remains a major provision of this bill which ASHNHA members cannot support. Thank you for this opportunity to testify today.

ASHNHA Represents the Following Alaska Health Care Providers

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

ASHNHA 2004 and 2005 NURSE OVERTIME SURVEY RESULTS - VERSION 'D' (February 13, 2006)

Facility		Nurses in Union?	Shortage Better or Worse?	Length of Shift (Hrs)	Nurse Vacancy Rates		Mandatory OT Usage- Total Hrs		On-call Policy				# of OT grievances filed
					2004	2005	2004	2005	Require	# times /month			
Alaska Regional Hospital	No	Yes	Worse	8,10,12	4 to 6%	4 to 6%	NONE	NONE	Certain Units	varies	[illegible]	68000 hrs	NONE
Alaska Native Medical Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Alaska Pioneer Homes (All Six Facilities)	No	Yes	Worse	7.5	unknown	unknown	unknown	unknown	No	NONE	NONE	NONE	unknown
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	20%	30%	unknown	46 hrs.	No	NONE	NONE	NONE	unknown
Bartlett Regional Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Bassett Army Community Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Central Peninsula General Hospital	No	Yes	Worse	12	14%	11%	NONE	NONE	Certain Units	7-8 X	3744 hrs	5616 hrs	NONE
Cordova Community Medical Center	[illegible]	No	No Chg.	12	10%	20%	NONE	NONE	Certain Units	varies	1872 hrs	3744 hrs	NONE
Denali Center Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Fairbanks Memorial Hospital	No	No	No Chg.	8, 10, 12	7%	7%	NONE	NONE	Certain Units	varies	[illegible]	12175 hrs	NONE
Heritage Place Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Kanakanak General Hospital	Yes	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Ketchikan General Hospital	No	Yes	Better	12	12%	8%	NONE	NONE	Certain Units	10 X	10000 hrs	10000 hrs	NONE
Maniilaq Health Center	Yes	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Mary Conrad Center Nursing Home	No	No	Worse	8, 10, 12	15%	5.55%	NONE	NONE	No	NONE	NONE	NONE	NONE
Mat-Su Regional Medical Center	No	No	No Chg.	8 & 12	10%	12%	unknown	unknown	Certain Units	7 X	1400 hrs	[illegible]	NONE
Mt. Edgecumbe SEARHC Hospital	No	No	Worse	8, 10, 12	15%	15%	NONE	NONE	Certain Units	8 X	4200 hrs	[illegible]	NONE
North Star Behavioral Health System	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Norton Sound Regional Hospital	Yes	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Petersburg Medical Center	Yes	No	Worse	8 & 10	5%	5%	unknown	NONE	Yes	4 X	NONE	NONE	NONE
Providence Alaska Medical Center	No	Yes	Worse	8, 10, 12	4.36%	4.76%	NONE	NONE	Certain Units	NA	NONE	NONE	NONE
Providence Extended Care Center	No	No	Worse	8, 10, 12	20.83%	20.75%	NONE	NONE	No	NONE	NONE	NONE	NONE
Providence Kodiak Island Medical Center	[illegible]	Yes	No Chg.	12	10%	10%	NONE	NONE	Certain Units	NA	unknown	4000 hrs	NONE
Providence Seward Medical & Care Center	[illegible]	No	No Chg.	8 & 12	unknown	5%	NONE	NONE	Yes	3 X	NONE	NONE	NONE
Providence Valdez Medical Center	Yes	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Sitka Community Hospital	Yes	No	No Chg.	12	20%	20%	NONE	NONE	Certain Units	varies	5847 hrs	4738 hrs	NONE
South Peninsula Hospital	No	Yes	No Chg.	8,10,12	6%	3%	NONE	NONE	Certain Units	15 X	144 hrs	1056 hrs	NONE
USAF 3rd Medical Group–Elmendorf	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Wildflower Court Nursing Home	No	No	No Chg.	8 & 12	0%	0%	NONE	NONE	No	NONE	1040 hrs	80 hrs	NONE
Wrangell Medical Center	Yes	No	No Chg.	8 & 12	0%	0%	unknown	NONE	Yes	55 hrs	NONE	NONE	NONE
Yukon Kuskokwim Delta Regional Hospital	No	No	Better	8 & 10	40%	28%	NONE	NONE	Certain Units	NONE	34000 hrs	28208 hrs	NONE
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											104391 hrs	128817 hrs	$24.17