

ALASKA LEGISLATURE COMMITTEE FILES

2007-2008

SHES

12

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION
(cont. from page 1)

SB 27 also would return the income standard for nursing home residents and HCB waiver clients to 300% of the prevailing SSI standard.

Between 2003 and 2006, the number of children in the affected income category dropped by 2,553 individuals, the number of pregnant women in the affected income category dropped by 436 individuals, and the number of persons enrolled in the 300% SSI group dropped by 106.

This fiscal analysis is based on the assumption that enrollment will rapidly recover to 2003 levels by the end of SFY 2008 and resume normal growth thereafter (about 2% per year). The proportion of enrollees that use services (participation) is expected to remain the same throughout the projection period.

For each component, the recipient count represents the number of enrolled persons using Medicaid services managed by that component during the period. It is anticipated that the number of people who lost Medicaid eligibility due to the 2003 legislation (about 3,100), will regain eligibility in 2008.

On average, an Eligibility Technician II can manage a caseload of 1,000 and with the additional caseload of approximately 3,100 cases, it will result in a need for three (3) additional Eligibility Technicians (at a cost of \$76,800, including benefits, per position) to manage the additional caseload in Field Services.

With the additional caseload, a one time cost for computers and software will be required with a cost of \$2,200 for each additional staff for a total of \$6,600. Annual costs for office space, phones and supplies are calculated at a cost of \$8,800 per additional staff for a total of \$26,400.

For the personal services allocations of this fiscal note, the fund source calculations are derived by using standard Random Moment Time Study averages.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB027-DHSS-0303-03-13-07
 Bill Version: SB 27
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Senior and Disabilities Svcs
 Component Senior/Disabilities Medicaid Svc

Revision Date/Time (Note if correction): _____
 Title RELATING TO ELIGIBILITY FOR MEDICAL ASSISTANCE

Sponsor DAVIS
 Requester SENATE (HES) Component No. 2662

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	5,130.1	5,571.3	6,050.5	6,570.8	7,135.9	7,749.8
Miscellaneous						
TOTAL OPERATING	5,130.1	5,571.3	6,050.5	6,570.8	7,135.9	7,749.8

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE	(Thousands of Dollars)					
1002 Federal Receipts	2,803.7	2,873.3	3,083.6	3,348.8	3,636.8	3,949.6
1003 GF Match	2,326.4	2,698.0	2,966.9	3,222.0	3,499.1	3,800.0
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	5,130.1	5,571.3	6,050.5	6,570.8	7,135.9	7,749.8

Estimate of any current year (FY2007) cost: _____
 Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill reverses the effect of legislation, effective September 2003, that reduced and froze the Medicaid income eligibility standard for certain children and pregnant women whose eligibility is managed through the Denali KidCare (DKC) office and froze the income standard for nursing home and home and community based (HCB) waiver recipients whose eligibility is determined under the 300% supplemental security income (SSI) eligibility criteria.

Prior to implementation of the 2003 legislation, Medicaid was available to children and pregnant women with incomes up to 200% of the prevailing Federal Poverty Guideline (FPG) for Alaska. Effective September 2003, the income standard was set in statute at what was equivalent to 175% of the FPG for 2003. This bill restores the income eligibility standard for children and pregnant women to 200% of the prevailing FPG.

(cont. on page 2)

Prepared by: Janet Clarke Phone 907-465-1630
 Division Finance and Management Services Date/Time 01/31/2007
 Approved by: Karleen Jackson, Commissioner Date 03/13/2007
 Agency Department of Health and Social Services

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

(cont. from page 1)

The state determines Medicaid eligibility for some nursing home residents and HCB waiver clients based on the maximum Supplemental Security Income (SSI) standard authorized by federal law. The 2003 legislation froze the Alaska eligibility standard to 300% of the 2003 federal standard. SB 27 would return the income standard for this eligibility group to 300% of the prevailing SSI standard.

Costs calculated for this fiscal note are based on enrollment, the total number of people qualified to use services under the affected eligibility criteria, not the number of persons that used Medicaid services and had claims paid during the period. The different Medicaid components share a common pool of enrollees, with each enrollee entitled to receive benefits through more than one component. Between 2003 and 2006, the number of children enrolled in the affected income category dropped by 2,553 individuals, the number of pregnant women enrolled in the affected income category dropped by 436 individuals, and the number of persons enrolled in the 300% SSI group dropped by 106.

This fiscal analysis is based on the assumption that enrollment will rapidly recover to 2003 levels by the end of SFY 2008 and resume normal growth thereafter (about 2% per year). The proportion of enrollees that use services (participation) is expected to remain the same throughout the projection period.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate allows for 5% medical inflation (Anchorage CPI, medical care component) and 2.24% average annual growth in the FPG and SSI standards.

Fund source calculations for each component are based on the percentages of costs reimbursed as IHS, Title XIX, Family Planning, or SCHIP in 2006 for the affected group, and the federal medical assistance percentages (FMAPs) anticipated for the year projected.

The 2008 projection was calculated as the projected cost without passage of SB27, plus the cost to reinstate the number of enrollees dropped between 2003 and 2006 (cost to reinstate was inflated by 5% per year between 2006 and 2008 so that the cost to reinstate was in 2008 dollars). The 2009-2013 projections were based on the 2008 projection after implementation of SB27, plus 8.6% annual growth. The expenditure for each division was determined based on that division's share of expenses for the affected eligibility subtypes in 2006. Senior and Disabilities Services paid 84% of the Medicaid costs for persons in the 300% SSI eligibility group in SFY 2006. They paid for less than 0.1% of the Medicaid costs for affected children and none of the costs for pregnant women.

For each component, the recipient count represents the number of enrolled persons using Medicaid services managed by that component during the period. If the number of people that lost Medicaid eligibility due to the 2003 legislation (about 3100) regain eligibility in 2008, Senior and Disabilities Services might expect to pay Medicaid expenses for an additional 38 recipients.

AFV labeling cost is estimated to be \$258,400 (\$0.38 × 680,000).

Thus, the estimated total annual non-labor cost burden associated with the Rule is \$259,000 (\$205 + \$258,400), rounded.

William Blumenthal,
General Counsel.

[FR Doc. E7-952 Filed 1-23-07; 8:45 am]

BILLING CODE 6750-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services (HHS), Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. Contact information for two frequently requested programs is given below:

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a person, call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You may also visit <http://www.hrsa.gov/hillburton/default.htm>. The Division of Facilities Compliance and Recovery notes that as set by 42

CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1-800-375-5283 or visit <http://www.uscis.gov/files/form/I-864p.pdf>.

For information about the number of people in poverty or about the Census Bureau poverty thresholds, visit the Poverty section of the Census Bureau's Web site at <http://www.census.gov/hhes/www/poverty/poverty.html> or contact the Census Bureau's Demographic Call Center Staff at (301) 763-2422 or 1-866-758-1060 (toll-free).

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690-7507—or visit <http://aspe.hhs.gov/poverty/>.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2007 notice reflect the 3.2 percent price increase between calendar years 2005 and 2006. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2007 guidelines are roughly equal to the poverty thresholds for calendar year 2006 which the Census Bureau expects to publish in final form in

August 2007.) The guideline figures shown represent annual income.

2007 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline
1	\$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570

For families with more than 8 persons, add \$3,480 for each additional person.

2007 POVERTY GUIDELINES FOR ALASKA

Persons in family	Poverty guideline
1	\$12,770
2	17,120
3	21,470
4	25,820
5	30,170
6	34,520
7	38,870
8	43,220

For families with more than 8 persons, add \$4,350 for each additional person.

2007 POVERTY GUIDELINES FOR HAWAII

Persons in family	Poverty guideline
1	\$11,750
2	15,750
3	19,750
4	23,750
5	27,750
6	31,750
7	35,750
8	39,750

For families with more than 8 persons, add \$4,000 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a

Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as "income" or "family." This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions

about how a particular program applies the poverty guidelines (e.g., Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program.

Dated: January 17, 2007.
 Michael O. Leavitt,
 Secretary of Health and Human Services.
 [FR Doc. 07-268 Filed 1-19-07; 8:45 am]
 BILLING CODE 4151-05-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): NIOSH Occupational Health and Safety Research, Program Announcement Number (PAR) 06-484

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 8 a.m.-5 p.m., February 9, 2007 (Closed).

Place: 1750 New York Avenue, NW, Washington, DC 20006.

Status: The meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92-463.

Matters To Be Discussed: The SEP meeting will include the review, discussion, and evaluation of applications received in response to "NIOSH Occupational Health and Safety Research," PAR 06-484. The applications being reviewed include information of a confidential nature, including personal information concerning individuals associated with the applications.

Contact Person for More Information:
 Horace M. Stiles, DDS, PhD, MPH,
 Designated Federal Officer, 15111 Farm Market Road, Maypearl, Texas 78064-1902, telephone 404.498.2584.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: January 18, 2007.

Elaine L. Baker,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E7-987 Filed 1-23-07; 8:45 am]

BILLING CODE 4153-10-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: 45 CFR 1304 Head Start Program Performance Standards. OMB No. 0970-0148.

Description: Head Start Program Performance Standards require Head Start and Early Head Start Programs and Delegate Agencies to maintain program records. The Administration for Children and Families, Office of Head Start, is proposing to renew, without changes, the authority to require certain record keeping in all programs as provided for in 45 CFR part 1304 Head Start Program Performance Standards. These standards prescribe the services that Head Start and Early Head Start programs provide to enrolled children and their families.

Respondents: Head Start and Early Head Start grantees and delegate agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Standard	2,590	16	41.8	1,732,192
Estimated Total Annual Burden Hours:				1,732,192

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests

should be identified by the title of the information collection. E-mail address: infocollection@acf.hhs.gov.

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the Federal Register.

Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork

SB 27 Summary

	2008	2009	2010	2011	2012	2013
Enrollment						
Children	2,553	2,604	2,656	2,709	2,763	2,819
Pregnant women	436	445	454	463	472	481
Special Income	106	108	110	112	115	117
	<u>3,095</u>	<u>3,157</u>	<u>3,220</u>	<u>3,284</u>	<u>3,350</u>	<u>3,417</u>
Expenditures						
Children	\$3,905	\$4,241	\$4,605	\$5,001	\$5,431	\$5,899
Pregnant women	\$1,401	\$1,522	\$1,653	\$1,795	\$1,949	\$2,117
Special income	\$6,103	\$6,628	\$7,198	\$7,817	\$8,489	\$9,219
	<u>\$11,409</u>	<u>\$12,390</u>	<u>\$13,456</u>	<u>\$14,613</u>	<u>\$15,870</u>	<u>\$17,235</u>
Fund Source						
Federal funds	\$6,806	\$7,052	\$7,586	\$8,238	\$8,946	\$9,716
GF Match	\$4,603	\$5,339	\$5,870	\$6,375	\$6,924	\$7,519
Total Funds	<u>\$11,409</u>	<u>\$12,390</u>	<u>\$13,456</u>	<u>\$14,613</u>	<u>\$15,870</u>	<u>\$17,235</u>
% Federal	59.7%	56.9%	56.4%	56.4%	56.4%	56.4%

Notes:

Enrollment assumes a 2% average annual increase after the initial ramping up in 2008.

Expenditures assume 8.6% average annual increase after 2008.

Fund source is based on the actual 2006 federal reimbursement for each division and the anticipated FMAPs for IHS, Title XIX, SCHIP, and family planning for 2008-2013 and is adjusted for the SCHIP allocation shortfall.

The projection to restore eligibility under SB27 is higher than the 2003 projection reducing eligibility for several reasons: (1) enrollment fell quicker than predicted in the 2003 FN.

The projected FPG effect was 2.24% annually when it actually is closer to 4-5% per year;

(2) the enhanced SCHIP funding will only cover a quarter's expenditures for the children

so the GF share required to restore eligibility is larger; (3) the projected FMAP rates are

lower than what was used in the 2003 FN; and (4) costs have risen faster than anticipated.

OCS costs have been removed from this analysis. The OCS FN is for zero impact based

on projected total annual costs to OCS of from \$400 to \$600 per year (not thousands).

SB

28

**SENATE COMMITTEE REPORT
First Committee of Referral**

DATE: 1/16/07

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: 3/29/07
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 4/18/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 28

SB 28 LIMIT OVERTIME FOR REGISTERED NURSES

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

and recommends:

- be replaced with SCS or CS SB 28 (HES)
- adopt previous SCS or CS _____ (_____)
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:	
<input checked="" type="checkbox"/>	Same Title
<input type="checkbox"/>	New Title
<hr/>	
HOUSE BILL:	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	Technical Title Change
<input type="checkbox"/>	New Title w/ SCR # _____


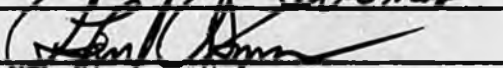
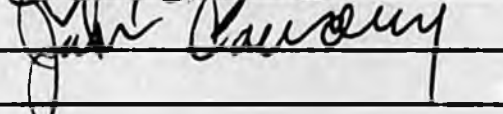
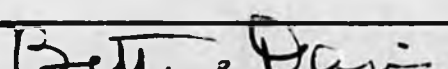
NEW FISCAL NOTE(S):

Department	Date	Fiscal	Adopt	Zero	Pass
ADM	4/2			✓	
CEO	4/4			✓	
LWF	3/30	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Adopt	Zero	Pass

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO NOT PASS	DO NOT PASS	NO REC. ALIEN	ALIAS
	Elton Thomas	✓			
	Dyson			✓	
	Cowdery				✓
CHAIR: 	B. DAVIS	✓			

25-LS0212K
Chenoweth/Wayne
3/21/07

CS FOR SENATE BILL NO. 28()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to limitations on mandatory overtime for registered nurses and**
2 **licensed practical 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 18.20 is amended by adding new sections to read:

9 **Article 4. Overtime Limitations for Nurses.**

10 **Sec. 18.20.400. Limitations on nursing overtime.** (a) Except as provided in
11 (c) of this section, a nurse in a health care facility may not be required or coerced,
12 directly or indirectly,

13 (1) to work beyond a predetermined and regularly scheduled shift that
14 is agreed to by the nurse and the health care facility;

15 (2) to work beyond 80 hours in a 14-day period; or

16 (3) to accept an assignment of overtime if, in the judgment of the
17 nurse, the overtime would jeopardize patient or employee safety.

18 (b) Except as provided by (c) of this section, after working a predetermined
19 and regularly scheduled shift that is agreed to by the nurse and the health care facility
20 as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed
21 not less than 10 consecutive hours of off-duty time immediately following the end of
22 that work.

23 (c) Subsection (a) of this section does not apply to

24 (1) a nurse voluntarily working overtime on an aircraft in use for
25 medical transport, so long as the shift worked is allowable under regulations adopted
26 by the Board of Nursing based on accreditation standards adopted by the Commission
27 on Accreditation of Medical Transport Systems;

28 (2) a nurse on duty in overtime status because of an unforeseen
29 emergency situation that could otherwise jeopardize patient safety; in this paragraph,
30 "unforeseen emergency situation" means an unusual, unpredictable, or unforeseen
31 situation caused by an act of terrorism, disease outbreak, natural disaster, or a declared

1 national, state, or local emergency, but does not include a situation in which a health
2 care facility has reasonable knowledge of increased patient volume or inadequate
3 staffing because of some other cause, if that cause is foreseeable;

4 (3) a nurse fulfilling on-call time that is agreed upon by the nurse and a
5 health care facility before it is scheduled;

6 (4) a nurse voluntarily working overtime so long as the work is
7 consistent with professional standards and safe patient care and does not exceed 14
8 consecutive hours;

9 (5) a nurse voluntarily working beyond 80 hours in a 14-day period so
10 long as the nurse does not work more than 14 consecutive hours without a 10-hour
11 break and the work is consistent with professional standards and safe patient care;

12 (6) the first hour on overtime status when the health care facility is
13 obtaining another nurse to work in place of the nurse in overtime status.

14 **Sec. 18.20.410. Prohibition of retaliation.** A health care facility may not
15 discharge, discipline, threaten, discriminate against, penalize, or file a report with the
16 Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.449
17 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.449.

18 **Sec. 18.20.420. Health care facility complaint process for overtime work**
19 **by nurses.** A health care facility shall provide for an anonymous process by which a
20 patient or a nurse may make a complaint about staffing levels and patient safety that
21 relate to overtime work by nurses and to limitations on overtime work by nurses under
22 AS 18.20.400.

23 **Sec. 18.20.430. Enforcement, offenses, and penalties.** (a) The commissioner
24 shall administer AS 18.20.400 - 18.20.449 and adopt regulations for implementing and
25 enforcing AS 18.20.400 - 18.20.449.

26 (b) A complaint alleging a violation of AS 18.20.400 - 18.20.449 must be filed
27 with the commissioner within 30 days after the date of the alleged violation. The
28 commissioner shall provide a copy of the complaint to the health care facility named
29 in the filing within three business days after receiving the complaint.

30 (c) If the commissioner finds that a health care facility has knowingly violated
31 an overtime provision of AS 18.20.400 - 18.20.449, the following civil penalties shall

1 apply:

2 (1) for a first violation of AS 18.20.400 - 18.20.449, the health care
3 facility shall receive a reprimand;

4 (2) for a second violation of AS 18.20.400 - 18.20.449 within 12
5 months, the health care facility shall receive a reprimand and shall be assessed a
6 penalty of \$500;

7 (3) for a third violation of AS 18.20.400 - 18.20.449 within 12 months,
8 the health care facility shall receive a reprimand and shall be assessed a penalty of not
9 less than \$2,500 but not more than \$5,000;

10 (4) for each violation of AS 18.20.400 - 18.20.449 after a third
11 overtime violation of AS 18.20.400 - 18.20.449 within 12 months, the health care
12 facility shall receive a public reprimand and shall be assessed a penalty of not less than
13 \$5,000 but not more than \$25,000.

14 (d) As an employer, a health care facility violates an overtime provision of
15 AS 18.20.400 - 18.20.449 "knowingly" when the facility is either aware that its
16 conduct is of a nature prohibited by the overtime provision or aware that the
17 circumstances described in the overtime prohibition exist; however, when knowledge
18 of the existence of a particular fact is required in order to establish that the violation
19 was knowing, that knowledge exists when the facility is aware of a substantial
20 probability of its existence, unless the facility reasonably believes it does not exist.

21 (e) In this section, "commissioner" means the commissioner of labor and
22 workforce development.

23 **Sec. 18.20.440. Report requirements.** A health care facility shall file a
24 semiannual report with the section in the Department of Labor and Workforce
25 Development responsible for research and analysis. The report for the six-month
26 period ending June 30 must be filed before the following August 1, and the report for
27 the six-month period ending December 31 must be filed before the following
28 February 1. The report must include, for each nurse employed by the health care
29 facility or under contract with the health care facility, the number of overtime hours
30 worked, the number of overtime hours that were mandatory, the number of overtime
31 hours that were voluntary, the number of on-call hours, the number of on-call hours

1 that were mandatory, and the number of on-call hours that were voluntary.

2 **Sec. 18.20.449. Definitions.** In AS 18.20.400 - 18.20.449,

3 (1) "health care facility" means a private, municipal, state, or federal
4 hospital; psychiatric hospital; independent diagnostic testing facility; residential
5 psychiatric treatment center; skilled nursing facility; kidney disease treatment center
6 (including freestanding hemodialysis units); intermediate care facility; ambulatory
7 surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by
8 the Department of Health and Social Services under AS 47.55; correctional facility
9 administered by the Department of Corrections or the Department of Health and
10 Social Services; private, municipal, state, or federal facility employing one or more
11 public health nurses; long-term care facility; or primary care outpatient facility;

12 (2) "nurse" means an individual licensed to practice registered nursing
13 or practical nursing under AS 08.68 who provides nursing services through direct
14 patient care or clinical services and includes a nurse manager when delivering in-
15 hospital patient care;

16 (3) "on-call" means a status in which a nurse must be ready to report to
17 the health care facility and may be called to work by the health care facility;

18 (4) "overtime" means the hours worked in excess of a predetermined
19 and regularly scheduled shift that is agreed to by a nurse and a health care facility.

20 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 **APPLICABILITY.** The first report required to be filed under AS 18.20.440, enacted in
23 sec. 2 of this Act, shall be filed before February 1, 2008, for the period July 1, 2007, through
24 December 31, 2007.

25 * **Sec. 4.** AS 18.20.440, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect
26 July 1, 2007.

27 * **Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2008.

The Current Staffing and Emerging Nursing Shortages

POSITION

ANA urges Congress to develop appropriate responses to the current nursing shortage and the inevitable consequences of a rapidly aging and diminishing nurse workforce.

BACKGROUND

A fundamental shift has occurred in the registered nurse (RN) workforce over the last two decades. As occupational opportunities for young women have expanded, and the working conditions for nurses have deteriorated, the number of young people entering nursing has declined. The number of students entering nursing school has dropped consistently and dramatically over the last five years.

The lack of young people in nursing has resulted in a steady and dramatic increase in the average age of the U.S. nurse. Today, the average working RN is over 43 years old. The average age of working RNs is projected to continue to increase before peaking at age 45.5 in 2010. At that time, large numbers of nurses are expected to retire, and the total number of nurses in America will begin a steady decline.

At the same time, the need for nursing services is expected to continue to increase. America's demand for nursing care is expected to balloon over the next 20 years as a result of the aging of the population, advances in technology, and various economic and policy factors. The Bureau of Labor Statistics ranks nursing seventh highest in projected job growth in the United States. The demand for RNs is expected to increase by 22% by 2008.

This demand, coupled with the imminent retirement of today's aging nurse, will place severe stresses on the health care system. A recent study published in the *Journal of the American Medical Association* estimates that the overall number of nurses per capita will begin to decline in 2007, and that by 2020 the number of nurses will fall nearly 20% below requirements.

RATIONALE

RNs comprise the largest group of health care professionals in the United States, with more than 2.7 million nurses employed in health care organizations. Nurses literally underpin the health care system. The current nursing shortage (which is small in comparison to the projections for the next two decades) is creating a health care crisis in the nation's hospitals and skilled nursing facilities. Following are a few reports of the effects of this shortage:

1. In November 2000, 10% of the surgical beds at Johns Hopkins Hospital were empty as a direct result of the nursing shortage, causing delays and cancellations of surgeries.
2. Higher nursing costs are the main reason that Moody's Investor Services and Fitch are projecting continued financial hardships for the nation's nonprofit hospitals.



3. In August 2000, the Maryland Hospital Association reported that nearly 15% of the nursing jobs in that state were vacant, up 33% from January of the same year. Georgia reported a 13% vacancy rate in 1999, and expects the percentage to have increased in 2000.

4. Hospitals currently estimate that it costs between \$30,000 and \$50,000 to fill each nursing vacancy.

§

ANA believes that efforts to attract new candidates into the nursing profession will be fruitless unless problems with the current work environment are addressed. The following position papers provide ANA's positions on staffing and mechanisms to address the nursing shortage.

- Adequate nursing facility staffing
- Appropriate acute care staffing
- Nurse Education Act

Nurses' Solutions to the Nurse Staffing Shortage **UAN National Sample Survey of Staff RNs**

Core Message

The nursing shortage is the biggest problem in hospitals today. Solving the problem requires radical change. To retain experienced nurses and attract hundreds of thousands of new nurses, hospitals must provide sharply higher pay, lower patient ratios, safe working conditions and recognize nurses as professionals central to excellent patient care. Nurses must demand those changes and refuse to accept less.

The nursing shortage is the biggest problem in hospitals today.

- At least 126,000 needed to fill current vacancies, and the number increases each year.
- Estimates range as high as one million by 2010.
- 80% of nurses surveyed say there's a serious nursing shortage in their hospital. An additional 9% say there's a shortage, though not as serious.
- Three out of ten nurses surveyed say it's unlikely that will be a staff nurse in five years. Many will retire, but others, especially younger nurses, expect to leave hospitals for less stressful jobs.

Radical changes are required to solve the nursing shortage.

- **Pay – at least \$70,000 per year.** Currently hospital staff nurses average \$46,000 per year. Six out of ten nurses surveyed earned less than that amount, as did more than half (55%) with more than ten years experience.
- **Lower patient ratios and more time for patient care –** There's ample solid evidence that lower patient ratios result in better patient outcomes. Hospitals seem unaware of that. Two out of three nurses say they have less time for patient care and four of ten spend less than half their day on direct patient care.
- **Safe working conditions –** nursing is dangerous work, with risk of disease and personal injury. Responsibility for too many patients adds to the risk and stress. One third of those surveyed cited stressful working conditions as the top reason nurses leave the profession.
- **More control of patient care –** Top-down decisions on patient care issues are the norm in hospitals today. Staff nurses are rarely consulted about decisions affecting them and the patients for whom they're responsible. Nurses surveyed said being able to determine staff ratios and work loads and being consulted before decisions are made are important to them, yet those are the issues over which they have the least control.

Nurses demand a cure.

The nursing shortage can't be cured without treating the underlying causes.

Nurses have identified the solutions. Nurses are working to implement them. Our union is committed to achieving them. Now we need responsive support from America's hospitals, not Band-Aids, bromides and placebos.

Swift and sweeping change is needed to make nursing financially and professionally attractive. Without it there's little hope of retaining experienced nurses and no hope of recruiting the hundreds of thousands of new nurses needed over the next decade.

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The following is background information for CMAs:

UAN polls front-line nurses on causes and solutions for the nursing shortage.

This is a national poll exclusively of Registered Nurses on the front lines of direct patient care – the 1.3 million staff nurses who care for patients around the clock in public and private hospitals (and HMOs) all across the country.

(All staff nurses are RNs, but not all RNs are staff nurses. Of the 2.6 million licensed RNs, about 1.3 million are currently employed as hospital staff nurses.)

UAN's goal in doing the poll was to spotlight staff nurses' experience and expertise about the critical nursing shortage and how to solve it.

The U.S. Departments of Labor, Health and Human Services, various federal agencies, the American Hospital Association, the Joint Commission on Accreditation of Health Care Organizations and others have reported on the extent, causes and possible solutions for the nursing shortage. This poll reflects the experience and ideas of the nurses themselves.

Nurses' Solutions to the Nurse Staffing Shortage **UAN National Sample Survey of Staff RNs**

Key Findings and Talking Points for CMAs

The United American Nurses has conducted a national poll exclusively of hospital staff RNs on the front lines of direct patient care to spotlight their experience and expertise about the critical staffing shortage and how to solve it.

Lake Snell Perry and Associates, a leading national political and public policy research firm, designed and administered this survey which was conducted by phone using professional interviewers in November 2002. The survey reached 600 licensed hospital staff nurses who provide direct patient care.

1. Problems in today's hospitals

The nursing shortage is the top problem in hospitals today. Eight of ten nurses feel there is a serious shortage in their hospital.

When asked about the two biggest problems facing them, nurses identify the staffing shortage and inadequate wages as top concerns.

Other problems include:

Workload issues

Nurse to patient ratios

Stress and fatigue

Lack of respect and recognition

Long hours

Support from the administration

Quality of patient care

Turnover rate and retaining nurses

Time for patient care has decreased, according two-thirds of those surveyed (67%), and nearly four in ten nurses (38%) say less than half their day is spent on direct patient care. 31% say administrative reports and documentation take more than half their day.

2. Why nurses leave the profession.

Work-related stress, patient load, and inadequate pay are the top three reasons nurses leave the profession.

Three out of ten nurses say it's unlikely they will be a hospital staff nurse in five years.

The majority of nurses surveyed feel their hospital is doing only a fair to poor job attracting and retaining nurses.

3. Solutions to the Nursing Shortage

The best solutions are:

Increased pay (82%),

Reduced nurse patient ratios (85%)

Safer working conditions (65%)

Other highly rated solutions include greater autonomy and control for staff nurses (66%), financial incentives for nursing school students (58%) and bringing RNs back to staff nursing (54%).

Less effective measures, say nurses, are signing bonuses, ad campaigns, and career guidance in school.

The least effective measures are mandatory overtime, overseas recruiting and hiring temporary nurses.

Hospitals are failing to implement the best solutions for the nursing shortage and are instead pursuing the least effective.

4. Pay is an important solution

Six out of ten nurses surveyed make less than \$46,000 per year. Pay clearly doesn't measure up to the responsibilities and demands of the job for new nurses nor for those with many years experience.

82% of all nurses surveyed say increased pay is the best solution for the nursing shortage. Two thirds say they make less money than they should for the demands of the job – a remarkably high response in view of the historical inclination among nurses to put patient care issues far ahead of compensation.

Low pay makes nursing an unattractive career choice initially, and for experienced nurses pay is no incentive to stay.

55% with more than ten years experience make less than \$46,000.

63% with six-ten years experience make less than \$46,000

77% of nurses with less than five years experience make less than \$46,000.

The extent of the salary gap is even more dramatic when long experience is taken into account. Nearly two-thirds (65%) of the nurses surveyed have more than ten years experience as a staff nurse, and more than a third (35%) have more than twenty years experience.

(\$46,782 was the average annual salary reported for all RNs in March 2000. RNs employed as hospital staff nurses earned only \$42,133.)

Pay is better in many kinds of jobs. Editors and reporters, funeral directors, tile setters, and 115 other occupations all earn more than registered nurses, according to the most recent National Compensation Survey published by the U.S. Department of Labor's Bureau of Labor Statistics.

5. Is there any good news? Some.

Mandatory overtime appears to be a less serious problem for nurses than in the past. 71% of nurses surveyed said they had some or a lot of control over refusing mandatory overtime. However, 24% – one in four – said they had only a little control in refusing overtime.

Collectively, staff nurses have a lot of experience. Over a third (35%) have worked as a staff nurse for more than 20 years and 65% have more than 10 years experience. Only 12% have 5 years or less experience. The other side of that coin is that the lower percentages of less experienced nurses reflects fewer people entering the nursing profession now and foreshadows future shortages.

An overwhelming number (86%) say they would be confident having someone close to them receive care at the hospital in which they work The fact that one of every ten (13%) said they would not is a strong reminder that patients need to choose hospitals carefully.

When asked about how good a place to work their hospital is, just over half (52%) said it was too good a place to work to leave. However, four out of ten (41%) said their hospital isn't a great place to work, but they probably would not leave and 5% said it was so bad a place to work that they definitely intend to leave.

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Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction

Linda H. Aiken, PhD,RN; Sean P. Clarke, PhD,RN; Douglas M. Sloane, PhD; Julie Sochalski, PhD,RN; Jeffrey H. Silber, MD,PhD

JAMA. 2002;288:1987-1993.

Context The worsening hospital nurse shortage and recent California legislation mandating minimum hospital patient-to-nurse ratios demand an understanding of how nurse staffing levels affect patient outcomes and nurse retention in hospital practice.

Objective To determine the association between the patient-to-nurse ratio and patient mortality, failure-to-rescue (deaths following complications) among surgical patients, and factors related to nurse retention.

Design, Setting, and Participants Cross-sectional analyses of linked data from 10 184 staff nurses surveyed, 232 342 general, orthopedic, and vascular surgery patients discharged from the hospital between April 1, 1998, and November 30, 1999, and administrative data from 168 nonfederal adult general hospitals in Pennsylvania.

Main Outcome Measures Risk-adjusted patient mortality and failure-to-rescue within 30 days of admission, and nurse-reported job dissatisfaction and job-related burnout.

Results After adjusting for patient and hospital characteristics (size, teaching status, and technology), each additional patient per nurse was associated with a 7% (odds ratio [OR], 1.07; 95% confidence interval [CI], 1.03-1.12) increase in the likelihood of dying within 30 days of admission and a 7% (OR, 1.07; 95% CI, 1.02-1.11) increase in the odds of failure-to-rescue. After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23% (OR, 1.23; 95% CI, 1.13-1.34) increase in the odds of burnout and a 15% (OR, 1.15; 95% CI, 1.07-1.25) increase in the odds of job dissatisfaction.

Conclusions In hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

Author Affiliations: Center for Health Outcomes and Policy Research, School of Nursing (Drs Aiken, Clarke, Sloane, and Sochalski), Leonard Davis Institute of Health Economics (Drs Aiken, Clarke, Sochalski, and Silber), Department of Sociology (Dr Aiken), Population Studies Center (Drs Aiken, Sloane, and Sochalski), and Departments of Pediatrics and Anesthesia, School of Medicine (Dr Silber), University of Pennsylvania, Philadelphia; and Center for Outcomes Research, Children's Hospital of Philadelphia, Philadelphia, Pa (Dr Silber).

JAMA study: High RN workloads impact mortality

Nurse researchers add more evidence to growing body of work on nurse staffing

In a new study looking at nursing care, University of Pennsylvania (Penn) researchers have determined that patients who have common surgeries in hospitals with the worst nurse staffing levels have up to a 31 percent increased chance of dying. Further, more nurses at the bedside could save thousands of patients' lives every year, report researchers in the Oct. 23-30 issue of the *Journal of the American Medical Association (JAMA)*.

The researchers found that every additional patient in a hospital nurse's average workload increased the risk of death in surgical patients by seven percent. Patients with life-threatening complications also were less likely to be rescued in hospitals where nurses' patient loads were heavier.

"Nurses reported greater job dissatisfaction and emotional exhaustion when they're responsible for more patients that they can safely care for," said Pennsylvania State Nurses Association member Linda Aiken, PhD, RN, FAAN, director of the Center for Health Outcomes and Policy Research at Penn's School of Nursing. Aiken, along with colleagues, conducted the study. "Failure to retain nurses contributes to avoidable patient deaths."

ANA President Barbara Blakeney, MS, APRN, BC, ANP, said: "This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate. It is an important contribution, but frankly, this is something that nurses have known for years. Nurses make the critical, cost-effective difference in providing safe, high quality patient care."

Specifically, the Penn nursing researchers found that:

- * If all hospitals in the nation staffed at eight patients per nurse rather than four, the risk of hospital deaths would increase by 31 percent, roughly translating to as many as 20,000 avoidable deaths in the United States annually.
- * Having too few nurses may actually cost more because of the high costs of replacing burned-out nurses and the higher cost of caring for patients with poor outcomes.
- * Adding two patients to a nurse already caring for four increases the risk of death by 14 percent.

The report, "Hospital Nurse Staff and Patient Mortality, Nurse Burnout and Job Dissatisfaction," concluded that, "When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and ... problems with low nurse retention in hospital practice."

The study, funded by the National Institute of Nursing Research of the National Institutes of Health, examined data collected from 168 hospitals, 232,342 surgical patients, and 10,184 nurses in Pennsylvania from 1998 to 1999. They examined data on relatively common, general, orthopedic surgeries and vascular surgeries, excluding cardiac operations such as coronary bypass.

ANA Article Title: Hospital Staffing and Patient Safety
Burnout and Job Dissatisfaction
ANA's history calls on hospitals to address physician for participating in address

Washington, DC - A study published today in the journal of the American Medical Association (AMA) found that registered nurses (RNs) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurse workload. The difference between four to six and four to eight patients per nurse was accompanied by a 14 percent and 11 percent increase in mortality respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when able to provide direct assessments and life-saving interventions.

"This new study is timely because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakely, MS, APRN, BC, ANP, president of the American Nurses Association (ANA). "It is an important contribution and finding that is something that nurses have known for years," she said. "Nurses make the critical care - intensive difference in providing safe, high-quality patient care," she added. Blakely pointed to ANA's own report in June 2008, "The Study of Hospital and Health Care Staffing," which was released in May 2008. The study looked at hospital and health care staffing levels in 100 hospitals and found that the number of nurses per patient was a significant predictor of patient mortality. The study also found that hospitals with higher levels of RN staffing had lower rates of hospital-acquired urinary tract infections. All five measures were associated with better patient outcomes.

Today's ANA article also reported that patient load had a direct impact on nurse mortality rates. Adding one patient per nurse to a hospital's staffing level increased nurse deaths by 51 percent and job dissatisfaction by 15 percent. The data indicates that more than 40 percent of nurses who reported high burnout and job dissatisfaction intended to leave their job within the next year.

"Appropriate staffing is the number one concern of nurses today," Blakely said. "Nurses already face great stress and challenges on the job. They want care for greater numbers of patients that ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of timely interventions."

Blakely emphasized that nurses are distressed because of a lack of control over their work environment which prevents them from achieving high-quality nursing care. In addition to the

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ANA Press Release October 23, 2002

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JAMA Article Links Hospital Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize Principles for Nurse Staffing to address problem

Washington, DC -- A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurse (RN) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurses's workload. The difference between four to six and four to eight patients-per-nurse was accompanied by a 14 percent and 31 percent increase in mortality respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when able to make direct assessments and life-saving interventions.

"This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakeney, MS, APRN, BC, ANP, president of the American Nurses Association (ANA). "It is an important contribution, but, frankly, this is something that nurses have known for years," she said. "Nurses make the critical, cost-effective difference in providing safe, high-quality patient care," she added. Blakeney pointed to ANA's own report, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting*, which was released in May 2000. The study looked at hospital and Medicare data in nine states in five categories of adverse outcomes: length of hospital stay, hospital-acquired pneumonia, postoperative infection, bed sores and hospital-acquired urinary tract infections. All five measures were markedly lower with higher levels of RN involvement in patient care. Two other studies published this year, one in the *New England Journal of Medicine* and one by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), also found direct links between nurse staffing levels and better patient outcomes.

Today's JAMA article also reported that patient load had a direct impact on nurse retention rates. Adding one patient-per-nurse to a hospital's staffing level increased nurse burnout by 23 percent and job dissatisfaction by 15 percent. The data indicate that more than 40 percent of nurses who reported high burnout and job dissatisfaction intended to leave their job within the next year.

"Inappropriate staffing is the number one concern of nurses today," Blakeney said. "Nurses already face great stress and challenges on the job. They must care for greater numbers of patients than ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of suitable interventions."

Blakeney emphasized that nurses are dissatisfied because of a lack of control over their work environment which prevents them from delivering high-quality nursing care. In addition to the

right number and mix of direct-care staff for hands-on care, other resources are necessary to support RNs' ability to deliver the best possible care. ANA has developed and strongly encourages the use of its Principles for Nurse Staffing, which include: nurse control over the practice environment; effective and efficient support services; readily available and current patient information; sufficient orientation and mentoring for new staff and new nursing graduates; education in the use of new technology; and sufficient time for collaboration, planning, coordination and delivery of care that meets both patient and family needs. Research has shown that hospitals which incorporate much of the philosophy embedded in the Principles for Nurse Staffing into their organizational culture and practice have higher rates of satisfaction and retention among nursing staff, and better outcomes for patients.

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistleblower protections for nurses, mandate collection of workforce and nursing-sensitive quality data, establish patient staffing systems and provide funding for nursing education.

In addition, hospitals that utilize nursing "best practices" can apply for designation as "Magnet" facilities a recognition made by the American Nurses Credentialing Center, a subsidiary of ANA. Hospitals that have achieved "Magnet" status have higher retention rates for nurses and improved patient outcomes.

Many of the issues touched on in the JAMA study have been addressed in Nursing's Agenda for the Future (www.NursingWorld.org/naf). The plan, which was released in April, is the result of an in-depth strategic planning process that involved leaders from more than 60 national nursing organizations. It reflects the brain trust of nursing and includes strategies to address basic issues, such as recruitment, as well as more complex issues, such as the economic value of nursing.

The authors of the new JAMA study said that improving nurse staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse (\$42,000 to \$64,000) are correct.

"Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," by Linda H. Aiken, et. al, appears in the October 23/30, 2002 issue of JAMA. The study, funded by the National Institute of Nursing Research of the National Institutes of Health, looked at 232,342 patients between the ages of 20 and 85 who underwent general surgical, orthopaedic, or vascular procedures in 168 Pennsylvania hospitals from April 1, 1998, to Nov. 30, 1999.

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ANA is the only full-service professional organization representing the nation's 2.7 million Registered Nurses through its 54 constituent associations. 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.

CORE ISSUE: Nursing Shortage

In 2003, ANA continued spearheading work surrounding "Nursing's Agenda for the Future" (NAF), the strategic plan developed by national nursing organizations to address the interrelated factors that have created a growing shortage of nurses. Since NAF's inception in 2001, nursing organizations have submitted more than 200 proposals to move the plan forward. Among the activities enacted in 2003 are "Handle with Care" (see "Health and Safety"), a proactive, multifaceted campaign launched by ANA to promote safe patient handling and prevent musculoskeletal disorders among nurses. Also, NAF's steering committee determined that substantiating the economic value of nursing was the "quantum leap" effort best able to move NAF forward. In 2003, a request for proposals to perform the research necessary to quantify the economic value of nursing was developed, and by the year's end, a series



Political influence used to address shortage

ANA was ranked in the top 10 percent of groups with influence in health care according to a study published in the Capitol Hill newspaper, *The Hill*, in fall 2003. ANA's clout was evident earlier in the year when it successfully urged for the formation of the House Nursing Caucus, which ended the year with 75 members. After a year in which 85 percent of its endorsed candidates were elected, ANA-PAC continued its successes by raising more than \$334,621.64 in 2003, including a record-breaking \$73,180 in contributions at the ANA House of Delegates in June. In late 2003, the PAC unveiled its "Give \$20.04 for 2004" campaign and aims to fund as many nurse-friendly candidates for office in 2004 as possible.

Members of the ANA-PAC Board in 2003 included Greer Glazer, PhD, RN, CNP, FAAN, chair; Mary Foley, MS, RN, vice chair; JoAnne Penn, MA, RN, BC; Patricia Holloman, BSN, RN, CNOR; Mary Behrens, RN, MSN, FNP-C; Linda Gobis, JD, RN, FNP; Alexia Green, PhD, RN, FAAN; Susan King, MS, RN; Rose Marie Martin, BSN, RN, OCN; Erin Murphy, BSN, RN; and Betty Smith-Campbell, PhD, RN, ARNP.

of research proposals was under consideration with the expectation that some, if not all, of the research may be completed by late 2004 or early 2005. So far, 10 CMAs have contributed financially toward completion of this quantum leap project in amounts ranging from \$200 to \$5,000. Other ongoing strategic planning continued among ANA and the other NAF organizations in 2003, and ANA provided a detailed progress report on NAF activities in the fall. ANA's philanthropic arm, the American Nurses Foundation, worked to initiate fundraising activities for the "Invest in Nursing Capital Campaign," which aims to raise \$25 million and will ultimately fund the activities and initiatives of NAF.

Believing that one path to addressing the nursing shortage is funding for nursing education, the ANA fought hard to increase appropriations for nursing education for fiscal year (FY) 2003. As a result, in February, Congress funded nurse education programs, including the "Nurse Education Act" and the "Nurse Reinvestment Act," at \$113.5 million, an increase of 25 percent over the previous fiscal year. At the same time, the administration submitted its FY 2004 budget, which contained only \$98.3 million in funding for nurse education programs. ANA immediately began educating members of Congress about the continuing need to invest in nursing and worked closely with Senators Barbara Mikulski (D-MD) and Susan Collins (R-ME) to garner support for its request for \$175 million in funding. ANA also spearheaded an effort to rally other provider groups to support this increase and delivered a letter to House and Senate appropriators in May signed by ANA and nine other health care groups. In December, ANA

achieved victory when the House voted on an omnibus budget package for FY 2004, including \$143 million for nurse education, \$30 million more than the prior year and a 60 percent increase over FY 2002. The Senate passed the package in early January 2004.

In addition, as a result of ANA's collaborative efforts through its "Nationwide State Legislative Agenda," several states succeeded in securing funding for nurse education. These included Arkansas, Arizona, California, Colorado, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, Nevada, Oregon, Rhode Island, South Dakota, Texas, Virginia, West Virginia and Wyoming.



Other Initiatives

- ANA continued to promote the Magnet™ Recognition Program as a tool for addressing the nursing shortage, because it encourages the development of and rewards hospital environments that retain nurses. ANA applauded the Institute of Medicine for highlighting the Magnet™ Program in its report on the link between the work environment and patient safety (see "Nurse Staffing"). At the end of 2003, close to 90 acute care hospitals have earned Magnet recognition.
- ANA fought efforts by non-nursing organizations to address the nursing shortage by calling for nurse immigration standards to be scaled back. Specifically, the ANA opposed the "Rural and Urban Health Care Act," introduced in the House in March, which would greatly expand the current H-1C temporary nurse visa and in the process, would remove many of the important safeguards that had originally been built into this visa program, including those that protect foreign nurses from exploitation by their sponsoring employers. ANA also expressed concerns about the ethical implications of the legislation, which could result in aggressive recruiting in developing nations. ANA alerted members of Congress to its concerns about the bill and called on Congress to address the problems behind the U.S. nursing shortage, particularly the health care industry's failure to maintain a work environment conducive to safe, quality nursing practice and the retention of experienced nurses.
- The nursing shortage is one of many nursing issues that continued to drive ANA's international activities in 2003. ANA continues to serve as the U.S. representative to the International Council of Nurses, which dealt with such issues as the nursing shortage, vulnerable and victimized populations and SARS in 2003. ANA President Barbara Blakeney also was appointed to the U.S. delegation attending the annual World Health Assembly in Geneva, Switzerland, in May and was appointed to serve on the Labor Advisory Committee for Trade Negotiations and Trade Policy.
- ANA continued its nurse recruitment efforts as part of the "Nurses for a Healthier Tomorrow" (www.nursesource.org) coalition, which developed a new campaign focused on nursing faculty recruitment in 2003. The theme for the campaign is: "Nursing education ... pass it on" to illustrate that through teaching, nurse educators are "passing on" the nursing education they've received as well as the practical experience they have gained in clinical work. In addition to print ads, posters and Web content will be developed to support the campaign.

ANA President Barbara Blakeney told a House subcommittee in October that the nursing shortage will affect the ability of VA facilities to meet veterans' health care needs. UAN Vice President Ann Converso, RN, (right) who sits on the ANA Board of Directors, also testified.



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Nurse-Staffing Levels and the Quality of Care in Hospitals

Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., Soeren Mattke, M.D., M.P.H., Maureen Stewart, B.A., and Katya Zelevinsky

ABSTRACT

Background It is uncertain whether lower levels of staffing by nurses at hospitals are associated with an increased risk that patients will have complications or die.

Methods We used administrative data from 1997 for 799 hospitals in 11 states (covering 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients) to examine the relation between the amount of care provided by nurses at the hospital and patients' outcomes. We conducted regression analyses in which we controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each hospital's patients, and other variables.

Results The mean number of hours of nursing care per patient-day was 11.4, of which 7.8 hours were provided by registered nurses, 1.2 hours by licensed practical nurses, and 2.4 hours by nurses' aides. Among medical patients, a higher proportion of hours of care per day provided by registered nurses and a greater absolute number of hours of care per day provided by registered nurses were associated with a shorter length of stay ($P=0.01$ and $P<0.001$, respectively) and lower rates of both urinary tract infections ($P<0.001$ and $P=0.003$, respectively) and upper gastrointestinal bleeding ($P=0.03$ and $P=0.007$, respectively). A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia ($P=0.001$), shock or cardiac arrest ($P=0.007$), and "failure to rescue," which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis ($P=0.05$). Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections ($P=0.04$), and a greater number of hours of care per day provided by registered nurses was associated with lower rates of "failure to rescue" ($P=0.008$). We found no associations between increased levels of staffing by registered nurses and the rate of in-hospital death or between increased staffing by licensed practical nurses or nurses' aides and the rate of adverse outcomes.

Conclusions A higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care for hospitalized patients.

Source Information

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (J.N., S.M., M.S., K.Z.); the Vanderbilt University School of Nursing, Nashville (P.B.); and Abt Associates, Cambridge, Mass. (S.M.).

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JAMA study: High RN workloads impact mortality

Nurse researchers add more evidence to growing body of work on nurse staffing

In a new study looking at nursing care, University of Pennsylvania (Penn) researchers have determined that patients who have common surgeries in hospitals with the worst nurse staffing levels have up to a 31 percent increased chance of dying. Further, more nurses at the bedside could save thousands of patients' lives every year, report researchers in the Oct. 23-30 issue of the *Journal of the American Medical Association (JAMA)*.

The researchers found that every additional patient in a hospital nurse's average workload increased the risk of death in surgical patients by seven percent. Patients with life-threatening complications also were less likely to be rescued in hospitals where nurses' patient loads were heavier.

"Nurses reported greater job dissatisfaction and emotional exhaustion when they're responsible for more patients that they can safely care for," said Pennsylvania State Nurses Association member Linda Aiken, PhD, RN, FAAN, director of the Center for Health Outcomes and Policy Research at Penn's School of Nursing. Aiken, along with colleagues, conducted the study. "Failure to retain nurses contributes to avoidable patient deaths."

ANA President Barbara Blakeney, MS, APRN, BC, ANP, said: "This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate. It is an important contribution, but frankly, this is something that nurses have known for years. Nurses make the critical, cost-effective difference in providing safe, high quality patient care."

Specifically, the Penn nursing researchers found that:

- * If all hospitals in the nation staffed at eight patients per nurse rather than four, the risk of hospital deaths would increase by 31 percent, roughly translating to as many as 20,000 avoidable deaths in the United States annually.
- * Having too few nurses may actually cost more because of the high costs of replacing burned-out nurses and the higher cost of caring for patients with poor outcomes.
- * Adding two patients to a nurse already caring for four increases the risk of death by 14 percent.

The report, "Hospital Nurse Staff and Patient Mortality, Nurse Burnout and Job Dissatisfaction," concluded that, "When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and ... problems with low nurse retention in hospital practice."

The study, funded by the National Institute of Nursing Research of the National Institutes of Health, examined data collected from 168 hospitals, 232,342 surgical patients, and 10,184 nurses in Pennsylvania from 1998 to 1999. They examined data on relatively common, general, orthopedic surgeries and vascular surgeries, excluding cardiac operations such as coronary bypass.

ANA's Blakeney calls on hospitals to utilize Psychopics for Nurse Staffing to address problem

Washington, DC - A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurses (RNs) staffing levels have a significant effect on preventing hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurse's workload. The difference between four to six and four to eight patients-per-nurse was accompanied by a 14 percent and 31 percent increase in mortality, respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when they make direct assessments and life-saving interventions.

"This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakeney, MS, APRN, BC, ANP, President of the American Nurses Association (ANA). "It is an important contribution, but frankly, this is a recurring problem that nurses have known for years," she said. "Nurses make the critical, cost-effective difference in providing safe, high-quality patient care," she added. Blakeney pointed to ANA's own report, Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting, which was released in May 2000. The study looked at hospital and Medicare data in nine states in five categories of advanced care: acute care, length of hospital stay, hospital-acquired pneumonia, postoperative infection, falls and hospital-acquired urinary tract infections. All five measures were negatively affected with higher levels of RN involvement in patient care. Two other studies published this year in the New England Journal of Medicine and one by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) also found that higher nurse staffing levels and better patient outcomes.

Today's JAMA article also reported that patient mortality had a direct impact on nurse retention rates. Adding one patient per nurse to a hospital's staffing level increased nurse turnover by 25 percent and job dissatisfaction by 15 percent. The data indicates that more than 40 percent of nurses who reported high turnover and job dissatisfaction intended to leave their job within the next year.

"Appropriate staffing is the number one concern of nurses today," Blakeney said. "Nurses already face great stress and challenges on the job. They must care for greater numbers of patients than ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of suitable interventions."

Blakeney emphasized that nurses are disheartened because of a lack of control over their work environment which prevents them from delivering high-quality nursing care. In addition to the

ANA Press Release October 23, 2002

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JAMA Article Links Hospital Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize Principles for Nurse Staffing to address problem

Washington, DC -- A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurse (RN) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurses's workload. The difference between four to six and four to eight patients-per-nurse was accompanied by a 14 percent and 31 percent increase in mortality respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when able to make direct assessments and life-saving interventions.

"This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakeney, MS, APRN, BC, ANP, president of the American Nurses Association (ANA). "It is an important contribution, but, frankly, this is something that nurses have known for years," she said. "Nurses make the critical, cost-effective difference in providing safe, high-quality patient care," she added. Blakeney pointed to ANA's own report, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting*, which was released in May 2000. The study looked at hospital and Medicare data in nine states in five categories of adverse outcomes: length of hospital stay, hospital-acquired pneumonia, postoperative infection, bed sores and hospital-acquired urinary tract infections. All five measures were markedly lower with higher levels of RN involvement in patient care. Two other studies published this year, one in the *New England Journal of Medicine* and one by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), also found direct links between nurse staffing levels and better patient outcomes.

Today's JAMA article also reported that patient load had a direct impact on nurse retention rates. Adding one patient-per-nurse to a hospital's staffing level increased nurse burnout by 23 percent and job dissatisfaction by 15 percent. The data indicate that more than 40 percent of nurses who reported high burnout and job dissatisfaction intended to leave their job within the next year.

"Inappropriate staffing is the number one concern of nurses today," Blakeney said. "Nurses already face great stress and challenges on the job. They must care for greater numbers of patients than ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of suitable interventions."

Blakeney emphasized that nurses are dissatisfied because of a lack of control over their work environment which prevents them from delivering high-quality nursing care. In addition to the

right number and mix of direct-care staff for hands-on care, other resources are necessary to support RNs' ability to deliver the best possible care. ANA has developed and strongly encourages the use of its Principles for Nurse Staffing, which include: nurse control over the practice environment; effective and efficient support services; readily available and current patient information; sufficient orientation and mentoring for new staff and new nursing graduates; education in the use of new technology; and sufficient time for collaboration, planning, coordination and delivery of care that meets both patient and family needs. Research has shown that hospitals which incorporate much of the philosophy embedded in the Principles for Nurse Staffing into their organizational culture and practice have higher rates of satisfaction and retention among nursing staff, and better outcomes for patients.

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistleblower protections for nurses, mandate collection of workforce and nursing-sensitive quality data, establish patient staffing systems and provide funding for nursing education.

In addition, hospitals that utilize nursing "best practices" can apply for designation as "Magnet" facilities a recognition made by the American Nurses Credentialing Center, a subsidiary of ANA. Hospitals that have achieved "Magnet" status have higher retention rates for nurses and improved patient outcomes.

Many of the issues touched on in the JAMA study have been addressed in Nursing's Agenda for the Future (www.NursingWorld.org/naf). The plan, which was released in April, is the result of an in-depth strategic planning process that involved leaders from more than 60 national nursing organizations. It reflects the brain trust of nursing and includes strategies to address basic issues, such as recruitment, as well as more complex issues, such as the economic value of nursing.

The authors of the new JAMA study said that improving nurse staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse (\$42,000 to \$64,000) are correct.

"Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," by Linda H. Aiken, et. al, appears in the October 23/30, 2002 issue of JAMA. The study, funded by the National Institute of Nursing Research of the National Institutes of Health, looked at 232,342 patients between the ages of 20 and 85 who underwent general surgical, orthopaedic, or vascular procedures in 168 Pennsylvania hospitals from April 1, 1998, to Nov. 30, 1999.

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ANA is the only full-service professional organization representing the nation's 2.7 million Registered Nurses through its 54 constituent associations. 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.

SETTING THE STANDARD FOR
**SAFE AND EFFECTIVE
PATIENT CARE**

IN NEW JERSEY



Health Professionals
and Allied Employees



HPAE/AF/ALU CIO

From: Charlie Franz [ccf@sphosp.com]
Sent: Tuesday, April 03, 2007 5:05 PM
To: Sen. Bettye Davis
Cc: Sen. Fred Dyson; Sen. Joe Thomas; Sen. John Cowdery;
Sen. Kim Elton
Subject: Senate Bill 28: Nurse Mandatory Overtime

Dear Senator Davis & Committee Members:

I am writing as the CEO of South Peninsula Hospital to express my strong opposition to the provisions of Senate Bill 28. South Peninsula Hospital 22-bed community hospital with a 25-bed co-located nursing home. Our hospital has a negotiated labor agreement with Teamsters Local 940 that covers all members of the hospital's staff except managers and confidential employees. Our negotiated agreement details all aspects of our relationship with our nursing staff including the use of mandatory overtime.

The Union agreed to the inclusion of a provision for mandatory overtime in our labor agreement because as our partners in providing health care our staff recognizes that occasionally situations arise where mandatory overtime may be required to provide safe patient care. When such a need arises, there are provisions for how the overtime is assigned, paid and the maximum duration of the overtime. We use contract nursing staff in a few departments to augment the regular employees and it is a very rare occasion when we actually use mandatory overtime.

South Peninsula Hospital has worked diligently with other members of Alaska State Hospital & Nursing Home Association to reduce the nursing shortage in Alaska. We have contributed substantial resources over the last several years to help support an expanded nursing program at the University of Alaska. This program has doubled its annual out put of nurses.

The proponents of SB-28 have not presented evidence that hospitals or nursing homes are imposing any amount of unreasonable mandatory overtime on nursing staff. SB-28 is not needed; limits the ability of hospitals to negotiate labor contracts to manage the workforce and respond to the varying demands of patient care; imposes onerous and unnecessary financial penalties on hospitals that are already struggling to survive financially; and introduces legislation where good management practices are all that is needed.

Please vote against this unnecessary piece of legislation.

Charles Franz

Charles C. Franz, MSW, FACHE
Chief Executive Officer
South Peninsula Hospital
CCF@SPHOSP.com

From: Moe Chaudry [MChaudry@sitkahospital.org]
Sent: Tuesday, April 03, 2007 3:58 PM
To: Sen. Bettye Davis; Sen. Fred Dyson; Sen. Joe Thomas; Sen. John Cowdery; Sen. Kim Elton
Subject: SB 28 - Nurse Mandatory Overtime Bill

TRANSMITTED VIA ELECTRONIC MAIL

April 3, 2007

**Senator Bettye Davis, – Chair
Senate HES Committee**

**Senator John Cowdery
Senator Fred Dyson
Senator Kim Elton
Senator Joe Thomas**

Re: Senate Bill 28: Nurse Mandatory Overtime

Dear Senator Davis & Committee Members:

I am writing this letter as the CEO of Sitka Community Hospital, in opposing the imposition of mandatory overtime on nursing staff under Senate Bill 28. Sitka Community Hospital is 12-bed critical access hospital with a 15-bed co-located nursing home. Our hospital, along with other hospitals in Alaska, do not use mandatory overtime as a tool to address nursing shortages or nursing gaps

When nursing shortages exist, we purchases temporary nursing services to supplement staff nursing hours rather than imposing mandatory overtime. This practice has avoided the need to rely on mandatory overtime to fill gaps in nursing staff schedules. SB-28 legislation is not needed and would place Sitka Community Hospital in an unfair position when negotiating work hour agreements with our nursing staff.

Sitka Community Hospital, aiong with other members of Alaska State Hospital & Nursing Home Association have worked hard to reduce the nursing shortage problem in Alaska by contributing substantial funding over the last four years to help support an expanded nursing program at the University of Alaska. This program is now graduating 200 nurses annually c ompared to 100 nurses before the program's expansion.

In my humble opinion, proponents of SB-28 have not presented any evidence that hospitals/nursing homes are imposing mandatory overtime on nursing staff. I believe SB-28 is an unneeded legislation. I urge you not to move this bill forward from this Committee.

Sincerely,

4/4/2007

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB028-DOA-DOP-4-2-07
 Bill Version: SB028
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Administration
 Title Limit Overtime for Registered Nurses RDU Central Administrative Services
 Component Personnel
 Sponsor Senator Davis
 Requester (S) Health, Education & Social Services Component No. 56

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type--Do not abbreviate)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB 28 would place limits on hours worked per day, hours worked per week, and mandatory overtime hours worked by registered nurses and licensed practical nurses.

This bill will have no fiscal impact on the Division of Personnel.

Prepared by: Dianne Kiesel
 Division: Division of Personnel & Labor Relations
 Approved by: Kevin Brooks, Deputy Commissioner
 Agency: Department of Administration

Phone: 465-4429
 Date/Time: 4/2/07 7:00pm
 Date: 4/2/07 7:30pm



Banner Health

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April 2, 2007

Senator Joe Thomas
State Capitol
Juneau, AK 99801

RE: SB28

Senator Thomas:

Thank you for representing the Interior in the Senate. We appreciate your leadership and commitment and look forward to working with you in the years to come. I may not be able to testify in person so I am sending my comments to you in writing. Although I can see that the intent of this legislation is to protect nurses and patients, and I appreciate the attention of our Senators to these important healthcare issues, I must respectfully testify against SB28 as unnecessary legislation. I would like to raise several points herein for your consideration.

I believe that any real concerns that SB28 attempts to address are covered adequately by other laws, regulations, and professional standards. There are already appropriate protections in place for both healthcare workers and for patient safety, including OSHA, Fair Labor Standards Act, and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

JCAHO standards require that hospitals monitor staffing effectiveness. Fairbanks Memorial Hospital does so by tracking staff overtime and other staffing measures in relation to any clinical errors and other patient safety measures. We practice evidence based medicine in the nursing profession, which means we endeavor to use proven "best practices" from around the nation in our care and our staffing models.

Also, I think there are details in the proposed legislation which make it unfavorable to nurses working in an acute care environment. Our organization has flexible scheduling options to include numerous shift choices for full time and part time nurses. Many nurses prefer to work 12 hour shifts with the typical schedule being 7:00a - 7:30p for example. A full time nurse would typically work 3 of these shifts in a week. They prefer to have their days scheduled back to back (i.e.: Mon, Tues, Wed) allowing them to group their days off together. The proposed language requiring 12 hours between shifts would significantly limit this possibility and be a disservice to nurses.



Banner Health

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We have policies and practices in place to address the situations we believe this legislation targets. Our hospital does not have mandatory overtime, except for true emergencies as described in the proposed legislation.

Lastly, we believe that these issues should not be legislated but left to the hospitals and nurses to address through Shared Decision Making processes or good faith bargaining. This has proved successful in our facility as we share a common vision of a safe environment for the patient and appropriate work-life balance for the professional nurse.

Again, we respect your efforts to further these admirable objectives but respectfully recommend that this SB28 is not necessary or desired.

Sincerely,

Jim L. Lynch
Director of Human Resources
Fairbanks Memorial Hospital
907-458-5575

cc: Senator Bettye Davis



Appendix

A Summary of Recent Research Supporting the Need for Staffing Ratios and Workload Limitations in Healthcare.
AFT Healthcare, March 2003

Effect of nurse staffing on mortality rates and other patient outcomes.

- After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7% increase in the likelihood of patients dying within 30 days of admission and a 7% increase in failure to rescue. (Aiken, Linda et. al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," *Journal of the American Medical Association*, Vol. 288, No. 16, October 23/30, 2002, pps. 1987-1993.)
- A study of medication errors in two hospitals over a 6-month period found that nurses were responsible for intercepting 86 percent of all medication errors made by physicians, pharmacists and others involved in providing medications for patients before the error reached the patient. (Leape, L. et. al, "Systems analysis of adverse drug events." *Journal of the American Medical Association* 274 (1): 35-43)
- Nurse staffing is a predictor of risk-adjusted mortality. In studying 2190 hospitals, it was found that 10.7% of the variance in patient mortality was explained by nurse staffing ratios. ("A Matter of Life and Death," *Modern Healthcare, Special Supplement*, September 30, 2002, pps. 16-20.)
- Nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors. (Joint Commission for the Accreditation of Healthcare Organizations, 2002.)
- Study found a ten percent increase in the proportion of RNs as a percentage of total hospital staff was associated with five fewer patient deaths for every 1000 discharged patients. (Tourangeau, Ann E., et. al., *Nursing-Related Determinants of 30-day Mortality for Hospitalized Patients*, *Canadian Journal of Nursing Research*, 2002, vol. 33., No. 4, 71-88.)
- Seventy percent of radiology techs, seventy-nine percent of respiratory therapists and seventy-one percent of certified nurse assistants say that the quality of patient care is suffering because of increased workloads or poor staffing in their professions. (National Survey. Peter D. Hart Research Associates, April 2002)
- In a study of data from eleven states, higher nurse staffing levels were related to lower instances of urinary track infections, pneumonia, upper gastrointestinal bleeding and shock in medical patients and lower rates of "failure to rescue" in major surgery patients. (Needleman, J.; Buerhaus, P.; Mattke, S; Stewart, S.; and Zelevins' ; *K. Nurse Staffing and Patient Outcomes in Hospitals. U.S. Department of Health and Human Services: February 2001.*)
- Higher nurse:patient ratios were strongly associated with lower mortality rates in dedicated AIDS units. Patient satisfaction was strongly associated with organizational control of care by bedside nurses. (Aiken, L.H.; Sloane. D.G.,;Lake E.T.; Sochalski, J.; and Weber A.L. *Organization and outcomes of inpatient AIDS care. Medical Care*, 37(3): 760-772, 1999.)
- More nursing hours and higher skill mix are related to lower rate of pressure ulcers, pneumonia and urinary tract infections. (Lichtig, L.K.; Knauf, R.A.; and Milholland, K. *Some impacts of nursing on acute care hospital outcomes. J of Nursing Admin*, 29(2): 25-33, 1999.)

- **Mortality rates decrease as staffing levels per occupied bed increase for registered nurses, medical residents, registered pharmacists, medical technologists and total hospital personnel. (Bond, C.A., et al. Health care professional staffing, hospital characteristics and hospital mortality rates. Pharmacotherapy, 19(2), 1999.)**
- **The higher the percentage of RNs, the more satisfied patients were with nursing care, pain management, education and overall care. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)**
- **An ICU nurse:patient ratio of less than 1:2 during evenings was associated with increased length of stay in the hospital. An ICU nurse:patient ratio of less than 1:2 during the day was associated with increased number of days in the ICU. (Pronovost, P.J. et.al. Organizational characteristics of intensive care units related to outcomes of abdominal aortic surgery. Journal of the American Medical Association, 281(14), 1999.)**
- **The more FTE RNs per adjusted patient day, the smaller the incidence of urinary tract infections and pneumonia after major surgery. A significant relationship was also found between FTE RNs and thrombosis and pulmonary compromise after major surgery. (Kovner, C. and Gergen, P.J. Nurse staffing levels and adverse events following surgery in U.S. hospitals. Image: J of Nursing Scholarship, 30(4), 1998)**
- **The higher the RN skill mix (up to 87.5% RNs) the lower the incidence of adverse occurrences (medical errors, patient falls, skin breakdown, patient and family complaints, respiratory and urinary tract infections, and deaths.) (Blegen M.A.; Goode, C.J.; and Reed, L. Nurse staffing and patient outcomes. Nursing Research, 47(1): 4350, 1998. Also: Blegen M.A. and Vaughn, T. A multisite study of nurse staffing and patient occurrences. Nursing Economics, 16(4): 96, 1998.)**
- **In a study of data from three states (NY, CA and MA), researchers found that as RN staffing increased, the number of patients suffering from pressure ulcers decreased. A higher proportion of RNs was also significantly associated with lower length of stay. (American Nurses Association. Implementing Nursing's Report Card: A Study of RN Staffing, Length of Stay and Patient Outcomes. Washington, DC: American Nurses Publishing. 1997)**
- **Increasing patient census and decreasing nursing hours per patient day are strongly correlated with increased nosocomial infection rates. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-8, 1997.)**
- **Hospitals with higher RN:patient ratios and a higher percentage of RNs had lower than predicted patient mortality rates. (Aiken, L.; Smith H.; and Lake, E.T. Lower Medicare mortality among a set of hospitals known for good nursing care. Medical Care, 32(8): 771-787, 1994.)**
- **Hospitals with a higher proportion of RNs had lower severity-adjusted mortality rates. (Krakauer H.; Bailey R.C.; Skellan, K.J.; Steward J.D.; Harts A.J.; Kuhn, E.M.; and Rimm, A.A. Evaluation of the HCFA model for the analysis of mortality following hospitalization. Health Serv Res, 27(3): 317-35, 1992.)**
- **The percentage of RNs per adjusted admissions was a significant predictor of lower mortality. (Manheim, Larry M. et. al. Regional Variations in Medicare Hospital Mortality. Inquiry 29:55-66, Spring, 1992)**

Patients on units where staffing fell below computed requirements had higher incidences of clinical complications (infections, gastrointestinal, neurologic) (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998. Also: Behner, K.G.; Fogg, L.; Frankenbach, J. and Roberston, S. Nursing resource management: Analyzing the relationship between costs and quality in staffing decisions. Health Care Management Review, 15 (4): 63-71, 1990.)

- Hospitals with a higher percentage of RNs and hospitals with a higher staffing level (measured by nurse-to-patient ratio), had lower adjusted mortality rates. (Hartz, A.J.; Krakauer, H.; Kuhn, E.M.; Young, M.; Jacobsen, S.J.; Gay, G.; Muenz, L.; Katzoff, M.; Bailey, R.C.; and Rimm, A.A. Hospital characteristics and mortality rates. New England Journal of Medicine, (321): 1720-25, 1989.)
- Hospitals with better-than-predicted death rates demonstrated respect for nursing judgment wherein it was a routine policy for the unit charge nurse to cancel major elective surgery if nursing staff was inadequate. (Knaus, W. et. al., An Evaluation of Outcome from Intensive Care Units in Major Medical Centers., Canadian Critical Care Nursing Journal, June/July, 1987.)

Working conditions affect patient care.

- ICU mortality rates were highest when the ICU staff was "overworked" as defined by the level of occupancy in the ICU and the average number of nurses per occupied bed. The mortality rate was significantly lower in patients who were treated during times of moderate workload. (Tarnow-Mordi, W.O.; Hau, C.; Warden, A.; and Shearer, A.J. Hospital mortality in relation to staff workload: A 4-year study in an adult intensive care unit. The Lancet, 356(9225): 185, 2000.)
- Higher rates of patient falls occurred when nurses reported more stress and more absenteeism. (Dugan, J.; Lauer, E.; Bouquot, Z.; Dutro, B.K.; Smith, M.; and Widmeyer G. Stressful nurses: The effect on patient outcomes. J Nurs Care Quality, 10(3): 46-58, 1996.)
- The less satisfied nurses were with the time they had to do their work, the more likely a patient was to develop a nosocomial infection. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)
- Admission during a period with a lower regular nurse-to-patient ratio and a higher pool nurse to patient ratio was associated with increased risk for bloodstream infection. (Robert, J.; Fridkin, S.K.; Blumberg, H.M.; Anderson, B.; White, N.; Ray, S.F.; Chan J.; and Jarvis, W.R. The influence of the composition of the nursing staff on primary bloodstream infection rates in a surgical intensive care units. Infection Control and Hospital Epidemiology, (21): 12-17, 2000.)

Improving patient outcomes by staffing correctly leads to lower costs.

- Statistical model shows that when nursing units are understaffed the additional costs associated with patients who develop complications are greater than the labor savings due to understaffing. (Behner, K.G.; Fogg, L.F.; Fournier, L.C.; Frankenbach, J.T.; and Robertson, S.B. Nursing resource management: Analyzing the relationship between between costs and quality in staffing Decisions. Health Care Manag Rev, 15(4): 63-71, 1990.)
- While immediate personnel costs are less with short staffing, long term costs were higher because patients with complications often stay longer in the hospital and require other expensive treatments. (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998.)

Institutions attempting to decrease costs through health care worker reductions may, in the final analysis, incur higher costs as a result of higher rates of nosocomial infection, longer hospital stays and use of expensive antimicrobials and increased mortality. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-48, 1997.)

Staffing ratios and workload limitations help recruit and retain registered nurses and other health professionals.

- Applications for registered nurse licenses in the state of California increased over 60% in the three years after passage of the nurse-patient ratio law. (Sacramento Business Journal, 1/19/04)
- Hi-Desert Hospital in Joshua Tree, CA went from fifty percent vacancy rate in its nursing staff to one percent vacancy rate six months after establishing ratios of 1:4 on day shift and 1:5 on second shift. ("A Favorable RN-to-Patient Staffing Ratio is an Effective Recruitment Tool," Patient Care Staffing Report, October, 2001.)
- Each additional patient per nurse (above 4) is associated with a twenty-three percent increase in the odds of nurse burnout and a fifteen percent increase in the odds of job dissatisfaction. (Aiken, Linda, et. Al. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction." Journal of the American Medical Association, October 23/30, 2002)
- Ninety-one percent of certified nurse assistants, seventy-eight percent of respiratory therapists and sixty-eight percent of radiology techs say that improving staffing ratios would help recruit and retain members of their profession. (Peter D. Hart Research Associates, April, 2002)
- In a national survey of nurses, eighty-three percent of respondents said that improving staffing ratios would "very effective" in improving job satisfaction, recruiting and retaining quality nurses. (Peter D. Hart Research Associates, March, 2001)

ASHNHA Position on Senate Bill 28 - April 3, 2007

Prepared by: Rod Betit, President/CEO

WHO DOES ASHNHA REPRESENT?

The *Alaska State Hospital and Nursing Home Association* represents 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 nursing facilities. Nine of our 24 acute care hospitals also include nursing home beds. We believe ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. ASHNHA's membership evaluates health care legislation weekly and has authorized the position expressed here.

ASHNHA's POSITION ON SB28: OPPOSED TO SB 28

While ASHNHA's membership has always appreciated Senator Davis' important work on health care legislation, the overwhelming response by ASHNHA membership to SB 28 is that this legislation is unnecessary and would place facility management in an unfair position when negotiating work hour agreements with their nursing staff. ASHNHA's members rarely use mandatory overtime to address nursing shortages. Rather, nursing shortages are managed through use of voluntary overtime and hire of temporary nursing staff. Patient safety is always foremost in ASHNHA's members' minds, and CEOs would not allow use of nurse staffing practices that would jeopardize patient care or would place nurses in working conditions that would put them in untenable situations.

SUPPORTING TESTIMONY:

- The attached chart compares 2004 and 2005 overtime usage in some of ASHNHA's facilities. With the exception of API, ASHNHA's members do not use mandatory overtime to fill their nursing gaps. With respect to API, the 2006 Legislature provided additional funding to improve starting salary levels to allow API to reduce mandatory overtime usage in the future.
- In all facilities except API, when nursing shortages exist facility management uses a combination of voluntary overtime and temporary nursing staff rather than imposing mandatory overtime (see 'pink' columns on attached chart). This practice has avoided the need to rely on mandatory overtime to fill gaps in nursing staff schedules except in rare situations.
- In addition, ASHNHA's members have worked to reduce the nursing shortage problem in Alaska by contributing substantial funding over the last four years to help support an expanded nursing program at the University of Alaska. This program is now graduating 200 nurses annually compared to 100 nurses before the program's expansion.
- Proponents of SB28 have not presented any evidence that facilities are imposing mandatory overtime on nursing staff. Nor have complaints of unsafe patient care been filed with the Alaska Department of Health & Social Services licensing section asserting that facilities have improperly used nursing staff.
- Passage of SB 28 would adversely impact delivery of patient care in several important ways including:
 1. "Sec. 18.20.400(a) Limitations on nursing overtime" would place the decision to accept overtime assignments in the hands of the nurse rather than with management. Generally, collective bargaining agreements give management the right to prescribe reasonable work rules, develop qualifications for all new and existing positions,

ASHNHA Position on Senate Bill 28 - April 3, 2007

Prepared by: Rod Betit, President/CEO

establish work schedules, assign work and work times, create, eliminate or modify positions, and establish and/or modify locations and standards of work. SB 28 would place management in an unfair position when negotiating work hour agreements acceptable to all parties, and could potentially affect the facility's ability to provide safe patient care by placing staffing decisions with the judgment of the nurse versus maintaining these as management rights and responsibilities.

2. "Sec. 18.20.400(d) would define an 'unforeseen emergency' to exclude all 'foreseeable' events. This is a vague standard that cannot be reasonably applied given the variety of staffing challenges that arise in a facility on any given day. While facilities are generally able to fill these staffing gaps using voluntary overtime and temporary nursing staff, there may occasionally be a need for some mandatory overtime to meet patient care needs. Management should have the discretion to exercise that option within the scope of the bargaining agreement negotiated for that facility.
3. "Sec 18.20.430. Report Requirements" would impose a whole new set of onerous reporting requirements for facilities. These reports would have to be filed semi-annually and must contain detailed work hour information for each staff nurse employed by the facility as well as each contract nurse hired during the reporting period. The time needed to compile these reports would be significant and simply not justified given the responsible manner in which Alaska's facilities have handled the use of mandatory overtime.

☉ In summary, SB 28 is unnecessary legislation. SB 28 would limit the ability of facilities to negotiate labor contracts to manage the workforce and respond to the varying demands of patient care; it would impose onerous and unnecessary financial penalties on facilities that are already struggling to survive financially; imposes onerous reporting requirements around the use of overtime; and introduces legislation where good management practices are all that is needed.

☉ ASHNHA's membership respectfully requests that you not move SB 28 forward from this Committee.

Thank you for the opportunity to testify and express ASHNHA's members concerns around this legislation.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Manillaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgumbe 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, St. Elias Acute Care Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, and 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		2004	2005	# of OT experiences filed
					2004	2005	2004	2005	Requires Certain Units	# times /month			
Alaska Regional Hospital	No	Yes	Worse	8,10,12	4 to 6%	4 to 6%	NONE	NONE	Certain Units	varies	3766 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		unknown
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	20%	30%	unknown	48 hrs	No	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	8816 hrs	NONE
Cordova Community Medical Center	No	No	No Chg.	12	10%	20%	NONE	NONE	Certain Units	varies	1872 hrs	3946 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	6144 hrs	12175 hrs	NONE
Heritage Place Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Kanakanak General Hospital	No	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	10800 hrs	10800 hrs	NONE
Manillaq Health Center	No	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 Certain Units	NONE	NONE		NONE
M-I-Su Regional Medical Center	No	No	No Chg.	8 & 12	10%	12%	unknown	unknown	Certain Units	7 X	1488 hrs	1488 hrs	NONE
Mt. Edgcomb SEARHC Hospital	No	No	Worse	8, 10, 12	15%	15%	NONE	NONE	Certain Units	8 X	4200 hrs	4200 hrs	NONE
North Star Behavioral Health System	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Norton Sound Regional Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Petersburg Medical Center	No	No	Worse	8 & 10	5%	5%	unknown	NONE	Yes Certain Units	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 Certain Units	NONE	NONE	NONE	NONE
Providence Kodiak Island Medical Center	No	Yes	No Chg.	12	10%	10%	NONE	NONE	Certain Units	NA	unknown	4000 hrs	NONE
Providence Seward Medical & Care Center	No	No	No Chg.	8 & 12	unknown	5%	NONE	NONE	Yes	3 X	NONE	NONE	NONE
Providence Valdez Medical Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Sitka Community Hospital	No	No	No Chg.	12	20%	20%	NONE	NONE	Certain Units	varies	5847 hrs	4736 hrs	NONE
South Peninsula Hospital	No	Yes	No Chg.	8,10,12	6%	3%	NONE	NONE	Certain Units	15 X	144 hrs	1688 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	60 hrs	NONE
Wrangell Medical Center	No	No	No Chg.	8 & 12	0%	0%	unknown	NONE	Yes Certain Units	55 hrs	NONE	NONE	NONE
Yukon Kuskokwim Delta Regional Hospital	No	No	Better	8 & 10	40%	28%	NONE	NONE	Certain Units	NONE	34000 hrs	22388 hrs	NONE
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											104301 hrs	126617 hrs	\$24.17

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB28-COM-OL-04-04-07
 Bill Version: SB 28
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title Limit Overtime For Registered Nurses RDU Corp. Bus & Prof Licensing (117)
 Component Corp. Bus & Prof Licensing
 Sponsor Davis
 Requester Senate HES Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
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 ()						

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 (FY2007) cost: 0.0
 Check this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation amends various provisions of AS 18.20, Hospitals and Nursing Facilities to add specifications regarding overtime for registered nurses. This is not expected to impact the operations of the division.

Prepared by: Chris Wyatt, Administrative Manager Phone (907) 465-2572
 Division: Corporations, Business, and Professional Licensing Date/Time 4/4/07 10:11 AM
 Approved by: Emil Notti, Commissioner Date 4/4/2007
 Agency: Commerce, Community, and Economic Development



Dangers of Mandatory Overtime: FATIGUE and ERRORS

**Or why you should support Senate Bill 28
(Often referred to as the
Alaska Safe Nursing and Patient Care Act)**



Danger – Might As Well Of Had a Drink!

The long hours worked by some nurses pose some of the most serious threats to patient safety. Prolonged periods of wakefulness can produce effects that are similar to the effects produced by alcohol intoxication. This may include decreases in reaction time and the speed of mental processes.



Danger – Close to Intoxication

Periods of wakefulness in excess of 16 hours can produce performance decrements equivalent to a blood alcohol concentration (BAC) level of .05 percent. Alcohol intoxication is defined as .05 percent BAC in several western industrialized nations although the level in the U.S. varies from .08 to .10 among the states.



Danger – Patient Safety at Risk

The Report also found the following:

The impact of hours worked, duration of work, and overtime in this study were shown to have a statistically significant impact on patient safety.



Danger –

likely to make at least one error

“The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more...” and “working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.”



Source

**Michigan Nurses Association Public Policy
Associates, Incorporated –**

The Costs of Mandatory Overtime for Nurses,

August 2004



Danger – Nosocomial Infections!

Threats to patient safety that are likely to result from extensive nursing overtime include the following:

- **Nurses being less alert to changes in patients' condition**
- **Nurses having slower reactions**
- **Medication errors – adverse drug events**
- **Increase in nosocomial infections**
- **Increase in decubiti**



Link Found

The authors of this study conclude that these findings imply a link between poor working conditions (long hours and overtime, mandatory or otherwise) and patient safety. In response to this and other admonitions concerning the elimination of mandatory overtime for nurses, almost half of the states in the nation have either enacted or introduced legislation concerning this issue.



**Not A "Bargaining Issue"!
This is a Public Safety Issue**

**The Alaska public has a right to expect
when they walk into a healthcare facility,
that the nurse taking care of them is
properly rested and alert.**

**(And that their RN hasn't been working 16 hours that day
already.)**



**Not A "Bargaining Issue"!
This is a Public Safety Issue**

**At registration, a member of the public
should not have to request a copy of
the most recent Collective Bargaining
Agreement to see how successful their
nursing staff has been in negotiating
reasonable working conditions.**



**Alaska
Nurses
Association**
**Washington State
Passes Law in 2002**

Anne Piazza, lobbyist for WSNA testified before Representative Peggy Wilson's special House HESS committee in January 2006:

"The State of Washington passed a law to prohibit mandatory overtime for nurses with the cooperation of the WSNA, other nursing unions, and the Washington Hospital Association."



**Alaska
Nurses
Association**
Washington State

The goal of this legislation is first, and foremost, to protect the safety and quality of patient care.



Washington State

Mandatory overtime puts patients, nurses and the profession at risk. Many health care facilities have turned to the use of mandatory overtime as a common practice to fill longstanding staffing and scheduling problems.

Shifting the entire burden to employees when there is a labor shortage is not the answer to attracting qualified persons to the profession.



Washington State

One of the reasons that the nursing shortage as it exists today is because qualified nurses are not working in the field or leaving the profession because they can no longer work the long hours or safely taken care of their patients. Forced overtime is adding to that shortage.



Washington State

Since 2002, the Washington state nurses have seen a reduction in forced overtime. They are not aware of any hardship suffered by hospitals in complying with the law....

Anne Piazza



Institute of Medicine Report

The Institute of Medicine estimates between 44,000 to 98,000 hospital deaths can be attributed to medical errors each year. Mandatory overtime is a serious contributing factor to medical errors. The final recommendation of the IOM is that all overtime, voluntary and mandatory/ involuntary done by nurses should be curtailed.