1987

Constituent Forum, 12-88; Series I; File 36

Juanita Hunter

#36
CONSTITUENT FORUM
12/88

DRAFT

Constituent Forum
December 8-9, 1988
Agenda Item 17.1 & 17.2

DEFINITION OF DIFFERENTIATED PRACTICE

Definition has not been reviewed by NCNIP governing board as yet; therefore this is a draft copy

DIFFERENTIATED PRACTICE MODELS CREATE NEW ROLES FOR TODAY'S REGISTERED NURSES WHICH ARE BASED ON KNOWLEDGE, SKILLS, ABILITIES AND EDUCATIONAL PREPARATION. THESE ROLES ARE THE RESULT OF ANALYSIS OF DIRECT NURSING CARE AND SUBSEQUENT REDESIGN OF NURSING PRACTICE BEGINNING WITH THE STAFF NURSE ROLE. SUCCESSFUL DIFFERENTIATED PRACTICE MODELS RESULT IN IMPROVED PATIENT CARE OUTCOMES, ENHANCED NURSE SATISFACTION AND AN EXPANSION OF THE ORGANIZATION'S VIABILITY.

NCNIP
National Commission on Nursing
Implementation Project

Vivien DeBack, Ph.D., R.N.
Project Director

3401 S. 39th St., Milwaukee, Wisconsin 53215
(414) 382-6191

STATEMENT OF UNDERSTANDING

BETWEEN THE AMERICAN NURSES' ASSOCIATION AND

CONSTITUENT MEMBER STATE NURSES' ASSOCIATIONS

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PREAMBLE:

Whereas, the American Nurses' Association (ANA) and the constituent member state nurses' associations (SNAs) desire to further their common purposes by: 1) working for the improvement of health standards, and availability of health care services for all people, 2) fostering high standards of nursing, 3) stimulating and promoting the professional development of nurses, and 4) advancing the economic and general welfare of nurses,

Whereas, the organizational strength of ANA and the SNAs is interdependent,

Whereas, the functioning of ANA and SNAs is enhanced to the extent that business relationships and respective rights and responsibilities are: 1) clear and complementary, 2) agreed upon and adhered to and, 3) permit room for change, growth, and accommodation of special circumstances

Whereas, the business arrangements and respective rights and responsibilities must reinforce and not supplant, or circumvent, or supercede, or subvert the ANA Bylaws, as the basic contractual agreement between the ANA and its constituent members,

Therefore, ANA and the SNAs set forth their respective business arrangements and rights and responsibilities:

ASSESSMENT

The assessment paid to ANA by the SNAs shall be in accord with the policy adopted by the ANA House of Delegates. (Appendix A) ANA and the SNA shall not impose activities/costs on the other party without prior agreement to such activities/costs.

ANA will provide at least the following services to SNAs without charge to the SNA:

- A Central Billing and Dues Collection System which the SNA may choose to use. The system provided shall be able to accommodate varying categories of dues assessments by SNAs.
- One meeting of two representatives of the Constituent Forum and two meetings of the Constituent Forum Executive Committee.
- Annual workshop for SNA executive directors.
- Field services, as defined by ANA policy, to support SNAs in confronting workplace issues and in collective bargaining activities.
- Litigation determined to be in the national interest of nursing.
- Communications regarding labor relations.

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- o One copy of The American Nurse mailed to each SNA and each SNA member. Up to four copies will be mailed to SNA headquarters upon request.
- o One or more copies of materials including, but not limited to the following: Capitol Update; The Political Nurse; Nursing Practice Update agenda and summary of action of the ANA Board of Directors; media releases; ANA publications; National Nurses Day materials; reports from ANA committees, cabinets, and councils; annual report of ANA; summary of proceedings of annual meeting of the House of Delegates; summary of annual survey of SNAs; selected testimony; and reports of activities of other organizations, as appropriate.
- o Consultation, as defined by ANA policy, regarding the legal regulation of nursing practice.
- o Development and supply of a maximum of 500 copies of generic membership recruitment and retention materials and consultation as requested by SNAs.
- o Reports from ANA clearinghouse systems.

ANA will provide services to SNAs which are funded by cost-sharing arrangements between ANA and the SNAs, including but not limited to the following:

- o Leadership development for SNA officials and SNA staff related to:
  - labor relations (basic and advanced content)
  - state legislation
  - nursing practice
  - membership recruitment and retention
- o Meetings of the ANA House of Delegates including facilities, materials and on-site resources.

  SNAs or members of SNAs will provide funds for travel, lodging and meals for attending the House of Delegates. ANA will not charge SNA delegates a fee to attend the House of Delegates.

Before ANA intervenes as a party in SNA litigation, the parties will develop and sign an operating agreement.

ANA will provide the following services to SNAs for a fee, including but not limited to the following:

- o Accreditation as a provider and/or approver of continuing education in nursing.
- o Loans, as defined by ANA policy, with payment of interest.

- o Labels.
- o Computer software.
- o Group insurance programs for SNA staff.
- o Publications.
- o Capitol Update (at cost in bulk quantities).
- o Generic Membership Recruitment and Retention materials (at cost in bulk quantities beyond 500).

ANA will provide services to members of SNAs for a fee, including but not limited to the following:

- o Certification.
- o Continuing education offerings.
- o Biennial convention.
- o Non-delegate attendance at meetings of the ANA House of Delegates.
- o Council affiliation.
- o Installment or electronic dues payment plans.
- o Publications

  SNA members may receive, without fee, one copy of the ANA Bylaws, Code for Nurses with Interpretive Statements, Standards of Practice, statements from ANA cabinets, economic and general welfare brochures, and Nursing: A Social Policy Statement.
- o Enrollment in one or more ANA endorsed group insurance programs.

SNAs will provide the following services to ANA without charge, including but not limited to:

- o Notification of any change in the SNA's chief executive officer.
- o Notification of any change in the address or telephone number of the SNA's corporate offices.
- o Recognition of ANA as the national professional nursing organization to SNA members and the public.

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- Information to SNA members about ANA's mission, purposes and programs and the resources needed for ANA to fulfill its mission and purposes.
- Response to ANA requests for action or reviewing information, such as nominations, proposed documents, SNA survey, group purchase proposals, lists of delegates to the ANA House of Delegates, SNA annual meeting schedule, SNA membership list, dues assessment and other matters.
- Encouragement of SNA members to seek ANA certification.
- One or more copies of official publications distributed to SNA members.
- One or more copies of SNA publications, as appropriate.

SNAs may offer certain services to ANA for a fee. These services will include, but are not limited to:

- transcripts of court or legal proceedings
- computer software
- continuing education
- labels
- SNA publications
- consultation services
- advertising space in SNA publications.

CRITERIA FOR THE DEVELOPMENT AND IMPLEMENTATION OF ANA/SNA SPONSORED PROGRAMS

Criteria for Programs

The American Nurses' Association and the state nurses associations agree that the following criteria shall exist when determining the sponsorship of nondues revenue programs. In developing these criteria, two categories of programs were identified. The criteria does not include such ANA nondues revenue programs as certification, accreditation of continuing education, label sales and grants and contracts.

ANA Sponsored Programs

These nondues revenue programs are sponsored by ANA. ANA will receive all revenue and be responsible for all expenses.

If ANA desires to sponsor a nondues revenue program, all of the following conditions must be satisfied before it is directly marketed to SNA members.

1. Proposals from vendors shall indicate the necessity for a national market in relationship to the following areas:
   a. Cost-effectiveness.
   b. Marketing management.
   c. Limited project availability.
2. The program must not conflict or compete with any program currently sponsored by the SNA or which the SNA plans to sponsor unless the SNA permits ANA to market the program to its members.
3. ANA shall insure that the program is revenue independent and no direct or indirect use of dues assessment funds shall be required.
4. ANA shall secure written certification from each SNA that the SNA has no interest in the selected program and authorizes ANA to market the program to the SNA members.
5. The SNA shall retain the right to withdraw authorization to market the program to its members with the proviso that ANA can continue to service current participants.
6. The SNA may authorize ANA to market a program to the SNA members without endorsing or promoting the product.
7. The SNA may authorize ANA to market a program to the SNA members without sponsoring, endorsing or promoting the program.

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ANA and SNA Sponsored Programs

These are nondues revenue programs sponsored jointly by ANA and the SNA with revenue and expense sharing based on an agreement completed prior to initiation of the program. An SNA may select to participate in a joint venture fully or in part.

The following conditions shall guide the development of SNA and ANA sponsored programs.

1. The SNA does not have the resources or interest to investigate, develop and administer the nondues revenue program.

2. The SNA is willing to allow ANA to market the program to the SNA members

3. The ANA and SNA are willing to share revenue and expenses through an SNA/ANA joint sponsored program.

4. ANA is willing to investigate, develop and administer specific joint sponsored nondues revenue programs with the SNA.

Program Implementation

ANA will develop nondues revenue programs which will be made available to all SNAs.

1. Annually, ANA will send a survey to all SNAs to determine interest in various sponsored programs. The survey will include a list of programs with a specific response from each SNA on each program as follows:

   A. Will endorse
      Yes _____ No _____

   B. Will promote
      Yes _____ No _____

   C. Will not endorse or promote, but will permit ANA to directly market to SNA members.
      Yes _____ No _____

   D. Will not endorse, promote or permit to be directly marketed to SNA members
      Yes _____ No _____

This survey will require a specific time for response. The survey will include a brief overview for each program. It will describe the program, provide implementation data, potential revenue and expenses, specific vendors being considered, and information on each party's obligation.

2. ANA will report the results of the survey by category of response. ANA will use the results of the survey to determine the feasibility of recommending specific group programs to be implemented in the next budget year. This report will be presented to the Committee on Finance. The report will include evidence of SNA interest, revenue and expense potential, marketing potential, competition, vendors willing to offer the program, and other relevant information.

3. A specific recommendation will be made to the ANA Committee on Finance about which programs to sponsor during the coming budget year.

4. When the budget is adopted, SNAs will be notified which sponsored programs will be implemented.

5. Before pursuing a specific program, ANA will outline the program in detail and send the information to all SNAs requesting that they review the program, including a marketing plan, implementation data, projected income and expenses for ANA and the SNA, specific vendor offering the program and an overview of each party's obligation.

6. The SNA will negotiate the agreement with ANA based on its willingness and ability to support, market, and generate nondues revenue through a program sponsored by ANA and the SNA.

7. The SNA executive director or designated staff person will sign and return the agreement. The agreement will include the expected income and expenses of the program for ANA and the SNA.

8. ANA will monitor the sponsored programs and issue periodic reports to the Board of Directors and the SNAs.

9. If, during the budget year, ANA learns of a new program that would be timely to implement during that budget year, SNAs will be surveyed as provided above. If there is sufficient interest in the program, ANA will follow the process for preparing a recommendation to the Board of Directors. The final recommendation will be provided to the Board of Directors at a regularly scheduled meeting.

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CONFLICT RESOLUTION

A conflict that arises over interpretation or application of this Statement of Understanding shall be resolved in accordance with the following process.

1. Either ANA or an SNA may initiate the conflict resolution process by sending written notice by certified mail, return receipt requested, to the other. Within thirty (30) days following receipt of the notice, the parties shall agree on an arbitrator select an arbitrator from the panel of arbitrators (Appendix B) to hear and decide the conflict.

2. The arbitrator shall set a time for the hearing which shall be no later than thirty (30) days after the arbitrator accepts appointment.

3. Each party may submit to the arbitrator a position statement and supporting documentation; copies shall be provided to the arbitrator at least ten (10) days prior to the hearing.

4. The hearing shall proceed as follows:

   A. The party which initiated the conflict resolution process shall speak first and shall have a reasonable time to present its position.

   B. The other party shall have a reasonable time to present its position.

   C. The arbitrator may address questions to either party.

   D. The party which initiated the conflict resolution process shall have an opportunity for rebuttal and summation.

   E. The other party shall have an opportunity for rebuttal and summation.

5. The arbitrator shall render a decision in writing within thirty (30) days after hearing the conflict. A copy of the decision shall be sent by certified mail, return receipt requested, to ANA, the SNA and the chairperson of the ANA Constituent Forum. The decision of the arbitrator shall be final.

6. ANA and the SNA shall share equally the fee for the arbitrator's services. The cost of ANA participating in the conflict resolution process shall be borne by ANA, and the cost of the SNA participating in the conflict resolution process shall be borne by the SNA.

Effective Date

The Statement of Understanding shall be for the period January 1, 1989, through December 31, 1990. This document shall be executed between ANA and its SNAs. Revisions to the document will be negotiated between the ANA Board of Directors and the Constituent Forum on behalf of the SNAs. This document will be reviewed biennially by the ANA Board of Directors and the Constituent Forum Executive Committee. Either negotiating party may request a review of the statement, provided such request is made by November 1, 1989.

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APPENDIX A

AMERICAN NURSES' ASSOCIATION

Assessment of ANA Dues from SNAs

In order to provide the financial resources necessary for the effective execution of the functions of the American Nurses' Association, the 1984 House of Delegates adopted the following recommendations related to assessment.

The method of assessment is based on two principles: (1) that each state nurses' association bears an equitable obligation to provide the resources needed to execute the functions of ANA, and (2) that within a federated structure, ANA has an obligation to assure maximum flexibility within which members can fulfill their obligation to the American Nurses' Association and to each other.

1. That ANA recognize the SNA's right to establish dues categories.

2. That ANA dues be based on a percentage (%) of total dues income collected by each SNA per the conversion factor formula.

   The conversion factor is defined by the following formula:

$$\frac{\text{ANA Dues Conversion Factor}}{\text{ANA Dues Conversion Factor} + \text{SNA Dues per Member}}$$

3. The amount of SNA dues owned ANA be adjusted monthly based on the actual dues dollar received as of 12:01 a.m. on the day following the last day of the month.

4. That the amount of dues owed ANA by the SNA be due and payable by the last day of the month following the month for which the SNA is paying.

5. That ANA remit dues collected on behalf of the SNA to the SNA by the last day of the month following the month for which the dues have been collected.

6. That all SNAs provide documentation and verification of total state dues revenue and the dues remitted to ANA for the fiscal year. Written verification of these revenue records should be done by a professional auditor or outside-of-SNA accountant utilizing generally accepted accounting principles and procedures. If the ANA Board of Directors has questions about documentation and verification of dues, ANA, at its own expense, may conduct an independent audit.

   If there is an overage or underage in payment of ANA dues for the fiscal year, the SNA and ANA will reconcile the account within 60 days of the auditor's/accountant report to the ANA director, Corporate Finance.

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7. That any change in the amount of ANA Dues Conversion Factor established by the House of Delegates become effective January 1 of the calendar year following the date on which it was enacted by the House of Delegates.

8. That any SNA which does not pay its dues within 20 days following the date on which they are due, shall pay a late charge of interest at the rate to be determined by the ANA Board of Directors. Payments received shall be applied to the oldest outstanding balance. ANA shall send a past dues notice to the SNA president, treasurer, and executive director on the day after the dues are payable.

That ANA, if billing, collecting and disbursing dues on behalf of an SNA, pays interest at the same rate of interest applicable to the SNAs on the unpaid balance ANA owes to the SNA if ANA does not remit dues owed to the SNA within 20 days following the date on which the dues are payable to the SNA.

9. That an SNA, which at any time falls three (3) months in arrears on dues payments and/or interest owed to ANA and has not entered into an agreement mutually acceptable to ANA and the SNA for satisfying the obligation, shall be considered delinquent in payment of dues to ANA and subject to disciplinary action in accordance with ANA Bylaws, policies and procedures.

APPENDIX B

Panel of Arbitrators

(TO BE IDENTIFIED)

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Constituent Forum
December 8-9, 1988
Agenda Item 18.3

AMERICAN NURSES' ASSOCIATION

Report on the Status of the
ANA/SNA Professional Liability Insurance Program

to

Constituent Forum
November, 1988

More than 45,000 members of state nurses associations currently participate in the ANA/SNA professional liability insurance program. The plan is administered by Maginnis and Associates and underwritten by Transamerica Insurance Company.

Status of Liability Program

The ANA/SNA liability program is currently endorsed by every state except Iowa, New York and Washington. The united effort of SNAs has been effective in assuring that the program meets the needs of the majority of nurses.

ANA's continuing efforts to work with Maginnis and Associates and the underwriter has recently resulted in the lowering of rates in several areas of practice. In October, Transamerica agreed to lower the rates for public health, home health, psychiatric, organ procurement and flight nurses from category "B" prices into the general category "A". This lowers premiums from $158 to $79 for $1 million/$3 million in coverage. Additionally, premiums for ob/gyn nurses who are not involved in labor and delivery were lowered from category "C" to category "A" prices. This lowered premiums from $350 to $79 per year. Earlier in the year premiums for psychiatric/mental health nurse practitioners were lowered from $650 to $500.

ANA has also worked with Maginnis and Transamerica to establish a new program for graduate nurses. In order to enhance SNA's membership marketing efforts, the underwriter has agreed to provide a rate of $58 for $1 million/$3 million of coverage for a nurse who becomes licensed as an R.N. and applies to the program within six months of graduation.

Transamerica is currently in the process of re-writing its liability policy and will change the current "personal" insurance to "supplemental" liability insurance that will be secondary to an SNA member's homeowner policy. The company is also increasing the wage reimbursement benefit if a nurse is forced to take off work for a court appearance.

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Liability Insurance Education Campaign

As an incentive to SNAs to educate their members about the importance of professional liability insurance, Maginnis and Associates agreed to fund a number of prizes for a special promotion campaign this fall. The campaign is divided into three categories -- those with membership under 2,000, from 2,000 to 5,000, and over 5,000. Maginnis will award a two-bedroom suite and reception for the delegates from the SNA that has the largest percentage increase in the number of insureds participating in the ANA/SNA insurance program during the last quarter of the year. Additionally, the winner of each category will be eligible to win a complimentary hotel room from Maginnis and Associates during the House of Delegates. During the month of November, the state in each category that has the greatest increase will win dinner for two during the House of Delegates meeting. The theme for the promotion is "Protect Your Future" and includes an advertisement, news release and stickers that can be utilized by SNAs.

In-Dues Insurance Research

Interest from SNAs in a national program that would provide a minimal amount of professional liability insurance as part of dues has been significant. A recent survey of SNAs indicated that 83% of the SNAs responding would be interested in a program that would provide professional liability as a part of dues.

An automatic in-dues professional liability insurance program could be an effective tool for recruiting and retaining members, as well as providing important liability protection. It would be an excellent public relations tool, it would provide a vehicle for educating members about liability and insurance, and it would allow ANA to develop a credible data base more quickly.

This type of program would essentially serve as a "legal defense fund" that would assure that every SNA member had access to their own attorney. It would not replace the current liability program, but simply supplement it by providing up to $10,000 of legal coverage or indemnity. Because there would be a $10,000 cap on the amount of exposure, this has the potential of being a self-insured program that would allow the ANA/SNA liability program to develop future surplus dollars that could be used to capitalize a captive or risk retention group for the entire program. It is estimated that if the program is implemented on a national basis, the cost would be less than $6.50 per member on an annual basis.

Claims Study Reveals Significant Losses by Nurses

During the past two years, ANA has attempted to gather a comprehensive loss history of nurses' professional liability claims. Despite extensive investigation by one of the nation's leading actuarial firms, it was discovered that very little specific information exists on claims against nurses. In order to gain a better understanding of losses, ANA retained Tillinghast, a Towers Perrin Company, to analyze the national loss experience of Interstate Insurance Group's (IIG) professional liability program for nurses.

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The results of the study indicate that while the number of losses against nurses has not been significant, the average cost of a claim seems to be much higher than anticipated. The expected average loss for claims filed against nurses is $145,397. This is substantially higher than most in the nursing profession have realized.

The actuarial study projects that the expected number of claims with indemnity, per 10,000 insured nurses, will be 6.3 annually. One startling factor was that it takes an estimated 12 years for all claims to be reported. This indicates the importance of an "occurrence insurance policy." An occurrence insurance policy covers incidents that occur during the period for which premiums are paid, regardless of whether or not the insured has maintained the policy.

The study concluded that the rates currently charged by the company for general duty nurses -- $79 for $1 million/$3 million coverage -- is 25% higher than projected losses in the program. However, the report stressed that the degree of risk inherent in this type of insurance may justify the difference. It also indicated that the previous premium structure resulted in the insurance company operating at a combined loss ratio of more than 100% during the 1982-1985 time period. During 1982 - 1985 the company paid out or reserved an average of $1.06 in claims for every dollar collected.

Recommendations of the study were for ANA to continue to attempt to obtain claims history from companies underwriting nurses professional liability insurance ... that ANA expand its risk management programs ... that the profession continue to develop and support the National Nurses' Claims Data Base ... that ANA work with the underwriter to assure that the rate structure is reasonable for all categories of nursing ... and that the association continue to investigate the feasibility of implementing and controlling its own self-insured risk financing program for professional liability exposure for members of state nurses associations.

Claims Data Base Begins to Compile Statistics

During the past year, the National Nurses' Claims Data Base has collected information on more than 30 liability claims and incidents involving nurses. While the number of reported claims is small, the information on those will be very helpful in developing a loss history for the profession.

Half of the 30 incidents reported to the data base have not yet resulted in legal action. The other half are claims made against nurses. Ten of those claims are closed and five have resulted in payment. The total paid out in those cases was nearly $261,000 with the largest payment -- $250,000 -- made in a claim against a nurse midwife. Nurses named in the liability claims include general duty nurses, nurse practitioners, a nurse midwife, a nurse administrator, a home health nurse and an operating room nurse.

The claims filed with the data base include alleged failure to provide proper prenatal care, alleged inadequate diagnosis, alleged wrong treatment for tonsillectomy and adenoidectomy and alleged complications during birth. Not all claims involved malpractice. Claims were filed against nurses over alleged sexual abuse, alleged failure to protect a patient from staff, alleged civil rights violation and alleged slanderous remarks.

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Reporting forms for the data base are available from ANA and many state nurses associations and national specialty organizations.

Malpractice Seminars to be Available in 1989

Twenty-eight states have indicated an interest in either sponsoring or promoting risk management seminars in 1989. ANA is developing a model program design -- featuring nurse attorney Sheryl Feutz -- that states can utilize for seminars. It will involve a day and a half seminar that covers legal concepts for nurses, types of liability, documentation principles and common pitfalls, state law affecting nursing practice, trends in nursing liability, informed consent, ethical issues, anatomy of a lawsuit and a mock deposition, and general information on liability insurance coverage.

It is anticipated that up to nine seminars will be held from March through December on the subject of "Understanding and Avoiding Nursing Malpractice."

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AMERICAN NURSES ASSOCIATION -- Proposed Changes

Constituent Forum Operating Guidelines
December 8-9, 1988

PROPOSED CHANGES

CURRENT	COMMENTS
II. Organization and Structure	
D. Executive Committee	
3. Responsibilities	Creates a new "a", with the existing language to be re-lettered in sequence.
The executive committee shall --	
a. Formulate a recommended budget for submission to the ANA Board of Directors	
b. Plan meetings of the Constituent Forum and develop the agenda for such meetings	This change was suggested by an SNA.
c. Prepare reports to the ANA Board of Directors and House of Delegates as required	
d. Provide members of the Constituent Forum with copies of reports and recommendations made to the ANA Board when requested	
e. Assume other duties as delegated by the Constituent Forum or the ANA Board.	

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American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720
Fax: (816) 471-4903

MEDIA COVERAGE AT AMA INTERIM MEETING
DALLAS, TEXAS
DECEMBER 4 - 7, 1988

Organized nursing was highly visible during the interim meeting of the American Medical Association's House of Delegates December 4 - 7 in Dallas. ANA President Lucille Joel, EdD, RN, FAAN, Texas Nurses' Association Executive Director Clair Jordan, RN, and members of TNA attended reference hearings, sessions of the house and other functions at the meeting.

Throughout the four-day event, there was significant media attention to the registered care technologist (RCT) proposal and nursing's solutions to the nursing shortage. ANA President Joel and TNA representatives were interviewed by the following news organizations during the Dallas meeting:

Cable News Network (CNN)
United Press International
Dallas Times Herald
Dallas Morning News
Fort Worth Star - Telegram
Houston Chronicle
WFAA-TV Channel 8 (ABC affiliate)
KDFW-TV Channel 4 (CBS affiliate)
KOZY-FM
KOAI- FM
KMGC-FM
KERA-FM, North Texas Public Broadcasting
KRLD-AM
Modern Healthcare
Physician's Weekly

Constituent Forum
December 8-9, 1988
Agenda Item #9

AMERICAN NURSES' ASSOCIATION, INC.

Treasurer's Report to Constituent Forum

December, 1988

Through October, ANA's General Fund has resulted in revenue of $13,153,000 and expense of $11,823,000 for an excess of revenue over expense totalling $1,330,000. This positive variance is due to better than expected results from certification revenue, ANA's 1988 Convention and savings in expenses for some programs accomplished at less than budget. It is anticipated that the General Fund bottom line will decrease from $1,330,000 during the last two months as most of a key revenue item (certification) has been received through October, and heavier expenses will occur for certification, publications, action related to issues such as pay equity and RCT, and several meetings of elected and appointed officials. However, it is expected that the General Fund operations will maintain a surplus position by year-end of an estimated $500,000.

ANA's Capital Improvements Fund has decreased by $36,000 as investment income of $91,000 has been offset by net fixed asset additions and costs related to relocation planning. As of the October 31, 1988, financial statement, the market value of the Capital Improvements Fund is $1,436,000 compared to a cost basis of $1,424,000, an unrealized appreciation of $12,000.

ANA's Reserve Fund has increased by $162,000 with $150,000 in dividends/interest and $12,000 in capital gains. As of the October 31, 1988, financial statement, the market value of the Reserve Fund is $3,137,000 compared to a cost basis of $2,964,000, an unrealized appreciation of $173,000.

Attached are summary documents describing ANA revenue and expense (Schedule A) and ANA's financial position (Schedule B).

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Schedule A

AMERICAN NURSES' ASSOCIATION, INC.
Revenue and Expense Summary - General Fund
For the Ten Months Ending October 31, 1988

	Ten Months Ended 10/31/88	Ten Months Ended 10/31/88
Revenue:		
SNA Membership Dues	$ 7,530,000	$ 7,297,000
Other Revenue	5,623,000	3,812,000
Total General Fund Revenue	$13,153,000	$11,109,000
Expense:	$11,823,000	$10,461,000
Excess Revenue Over Expense - General Fund	$ 1,330,000	$ 648,000

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Schedule B

AMERICAN NURSES' ASSOCIATION, INC
Financial Position
December 31, 1987 and October 31, 1988

	12/31/87	10/31/88
ASSETS		
UNRESTRICTED:		
General Fund	$ 72,000	$ 1,329,000
Cash and Short-term Investments	3,576,000	3,619,000
Receivables and Other Assets	$ 3,648,000	$ 4,948,000
Capital Improvements Fund Investments	$ 1,460,000	$ 1,425,000
Reserve Fund Investments	2,803,000	2,964,000
TOTAL UNRESTRICTED FUND ASSETS	$ 7,911,000	$ 9,337,000
RESTRICTED FUND INVESTMENTS	$ 74,000	$ 77,000
LIABILITIES AND FUND BALANCE		
General Fund Payables and Accruals	$ 2,844,000	$ 2,679,000
Unrestricted Fund Balance	$ 5,067,000	$ 6,658,000
TOTAL UNRESTRICTED FUND LIABILITIES AND FUND BALANCE	$ 7,911,000	$ 9,337,000
RESTRICTED FUND BALANCE	$ 74,000	$ 77,000

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Illinois Nurses Association

TO: Mary Beth Struwe, Chairperson
Executive Committee, Constituent Forum
American Nurses Association

FROM: Louise Soares, Executive Administrator
Illinois Nurses Association

DATE: November 29, 1988

RE: Informational meeting of SNA Executive Directors, Chicago

On October 5, I served as convenor of Executive Directors of SNAs with major economic and general welfare programs. We understand that informal meetings may create unnecessary concern among our colleagues and wish to report our intent for the meeting to the Constituent Forum Executive Committee.

At the Executive Director workshop in August, we identified a number of common issues which affect the internal operation of our E&GW programs. We decided that these specialized concerns require our collective attention, and that we will meet periodically to exchange information and to advise one another regarding E&GW program issues and problem resolution.

At the October 5 meeting our agenda included experiences related to recent court decisions which affect organizing, fair share or agency fees, and Veteran's Hospital units. We discussed strike fund policies and guidelines, and explored possibility of shared services among SNAs related to collective bargaining programs. Finally, we discussed need to update the data regarding contract language related to patient care issues, or "professionalizing contracts."

We consider opportunity for this kind of specialized discussion to be an important adjunct to the ongoing relationship with other colleagues in regional groupings and in the Constituent Forum.

LS/sam

20 North Wacker Drive • Chicago, Illinois 60606 • (312) 236-9708

AMERICAN NURSES' ASSOCIATION

Task Force on Shared Services
Report to the Constituent Forum -- December 1988

The Task Force on Shared Services was created as a result of action of the June 1988 Constituent Forum, and was charged to "identify ways that state nurses' associations may provide services between SNAs including, but not limited to economic and general welfare services."

The task force met October 27-28, 1988 in Kansas City, Missouri.

The task force's discussions were based on the following underlying philosophical assumptions:

- Self determination and a geographic identity are important to each SNA.
- Written contractual agreements are essential between SNAs entering into a shared service arrangement.
- ANA and constituent SNAs exist in a highly competitive environment with other nursing organizations, labor organizations and various companies.
- The organization at the national and state level must continue to enhance its competitive edge in attracting and retaining members through the provision of services.
- Nurses' needs and access to services must be addressed by the SNA. If the SNA is unable to offer a service or services it must facilitate, rather than prohibit or impede, access to these services through ANA or other SNAs, whenever feasible. Before an SNA proceeds to provide a service in another state or states, it is important to ascertain whether the geographic SNA has an interest in, and capability of, offering that service itself.

In its discussions specifically addressing the provision of economic and general welfare services, the task force identified the following underlying philosophical assumptions:

- That the American Nurses' Association is committed to collective bargaining for nurses, evidenced by the ANA Bylaws (article I, section 3k).
- That the pool of nurses wanting to be represented by a collective bargaining agent will find a union to represent them.

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- That competing labor unions will intensify organizing efforts of nurses and raiding of existing SNA local bargaining units through at least the 1990's.

- That the pool of nurses wanting to be represented by a non-SNA collective bargaining agent includes some SNA members, and that the others in the pool are potential SNA members.

- That collective bargaining representation by a state nurses' association continues to be imperative for the profession and an important mission for the association; as contrasted with representation by a non-SNA collective bargaining agent.

The Task Force recommends the following to the Constituent Forum:

REC #1: **That an SNA inform the geographic SNA that it plans to organize nurses within that state's borders; and that communication be ongoing throughout the organizing efforts and contract negotiations.**

While an SNA does not have the legal right to prohibit another SNA from coming within its state borders to provide services to nurses, the task force believes that the geographic SNA should be shown consideration and respect. The task force recommends that a "gentle person's agreement", based on honest communication and a commitment to collaborate among SNAs, should be the SNAs' guide in arranging for provision of collective bargaining services (or other services) to be provided to a state's nurses by the SNA in another state.

REC #2: **That the Constituent Forum request that by June 1989 each SNA will have a plan developed addressing how it will provide collective bargaining services for the nurses in its state.**

The potential for conflict concerning the provision of collective bargaining services for nurses may be lessened if SNAs consider in advance how these services may be made available. The task force envisions development of a national plan through SNAs' discussions addressing how services will be provided to nurses within a given geographical area, including shared services across states. Such discussions should begin during the June 1989 Constituent Forum meeting.

REC #3: **That the Constituent Forum recommend to the ANA Board of Directors that the Cabinet on Economic and General Welfare address the provision of leadership development at the local unit level and explore options to provide for paid positions for local unit leaders.**

The task force observed that competing labor unions have greater resources available for collective bargaining activities, including the expertise of paid union officials who have worked their way up the ranks. This recommendation is designed to lead toward the development of a broader base of collective bargaining expertise within the association.

REC #4: **That the Constituent Forum recommend to the ANA Board of Directors that the Cabinet on Economic and General Welfare address the question of what the association's future relationship should be with other unions.**

The task force identified the trend toward increased organizing efforts of competing unions to represent nurses. The task force 1) believes SNAs must represent nurses for collective bargaining, and 2) recognizes that other labor unions have some agreements on their respective organizing and representation of target groups. In this context, the task force identified the importance of the association considering its future relationships with other unions.

REC #5: **That the Constituent Forum recommend to the ANA Board of Directors that information about how SNAs can establish subsidiaries be included as a topic in the next Executive Directors' Workshop.**

In its discussion of possibilities for shared services other than economic and general welfare services, the task force considered joint ventures and collective investments among SNAs. Such ventures might necessitate the formation of a subsidiary organization, and it was realized that many SNAs may not have information about how and why subsidiaries are formed.

REC #6: **That the Constituent Forum hold a team-building workshop with both an intra- and inter-state focus.**

The task force identified a need for efforts aimed at team building and leadership development within the SNAs that goes beyond a board/staff orientation session. The purpose of team building would be to define effective collaborative working relationships which recognize clearly delineated roles for volunteers and staff, with mutual respect for these roles and the individuals in them. It is expected that the outcome of mentoring efforts would be greater harmony among the SNA leadership and staff, and reduced turnover in SNA executive director positions.

REC #7: **That the Constituent Forum promote communication by encouraging that SNAs look into the availability of computers in their area, and that the Constituent Forum promote the joint purchase of computers by the SNAs.**

The task force discussed its perceived need for rapid communication among SNAs and between SNAs and ANA, and identified electronic communications as a means of communicating which will become increasingly more important. The expense of computers has kept some SNAs from purchasing the equipment necessary for electronic communications. The task force identified ways to broaden access to computers for all SNAs (including accessing computers through schools of nursing, libraries and other organizations' offices).

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Possibilities for Shared Services Between SNAs

The task force identified numerous other services which could be shared between and among SNAs, in addition to economic and general welfare services. These were identified as being advantageous to SNAs because of fiscal and human resource savings; the opportunity to share creative efforts and expertise; the opportunity to generate non-dues revenue; and the opportunity to provide a greater range of services to members than an SNA would otherwise be able to afford to do. The task force members identified the following possibilities, noting that their list was not exhaustive:

- Joint executive director, other staff or lobbyist services
- Shared legal services
- Peer assistance (or other) consultation among SNAs
- Sharing of bylaws language, model contracts, etc.
- Periodic sessions for inter-state planning, research and development
- Membership records and central billing services
- Convention/workshop management
- Holding conventions together
- Provision of continuing education approval services
- Provision of continuing education programming
- Newsletter and brochure development, including assistance with newsletter content, joint brochure development and offering desktop publishing services
- Sharing of marketing and public relations ideas and expertise
- Collaborative grant writing
- Joint purchases of office equipment, etc.
- Joint ventures/investments
- Team building/leadership development, mentoring and support

As a mechanism to bring together SNAs interested in collaborating on an activity or in purchasing services from another SNA, the task force envisioned a listing of services to be offered and services needed, to be compiled twice yearly just in advance of the meetings of the Constituent Forum.

Guidelines for Shared Services Contracts Between SNAs

Before SNAs enter into joint ventures, agree to purchase services from one another, or provide for collective bargaining across states, the task force recommends that SNAs develop a contract outlining their respective expectations and responsibilities. Such a contract should be developed with the advice and review of legal counsel and should address at least the following:

- environmental assessment -- What resources (monetary and human) are available within each SNA to devote to the venture?
- parameters of involvement -- How involved shall each SNA be in this venture? The parameters of involvement range from no involvement on one SNA's part to a completely shared joint venture.
- goal -- What is the goal or expected outcome of this venture? Do each of the SNAs share the same expectation of the outcome?
- authority and responsibility -- Who shall be responsible for seeing that the work is done? How shall responsibility for the work be divided?
- purchase of services -- If an SNA plans to purchase services from another SNA, what is the agreed-upon financial obligation? Will the debt be paid with cash, or with an exchange of other goods or services (barter)?
- legal implications -- Which respective state's laws shall apply to the venture?
- sharing of income/loss -- How shall the income or loss realized in this venture be divided?
- relevant established policies -- Do the SNAs to be involved in this venture have any established policies which are relevant to the work to be done? Are there any conflicts in policies?
- limitations/time frame -- What timeframe or limitations shall govern the completion of this venture?
- SNA membership/dues income -- How shall questions of SNA membership and the receipt of dues income be decided, in regard to collective bargaining activity across states? Shall SNA membership and dues income be shared in some way between the SNAs? How does this impact SNA and national representation for election to offices and voting apportionment in the House of Delegates?
- certification of collective bargaining units -- Which SNA shall be identified as the collective bargaining agent, in regard to collective bargaining activity across states?
- insulation of collective bargaining units -- Is the SNA organized in such a way that it is sufficiently insulated to carry out collective bargaining activities? If not, how will insulation be ensured?

REC #8: That the Constituent Forum adopt these guidelines for shared services contracts between and among SNAs.

Conflict Resolution

The task force considered how conflicts which may arise between SNAs over the provision of services across states could be resolved. The task force suggested the conflict resolution process which is set down in the "Statement of Understanding Between the American Nurses' Association and Constituent Member State Nurses' Associations" as a model. Once contractual agreements have been established between the parties to a shared service, their interactions would be legal and enforceable. Without a contract (or in advance of the development of a contract), SNAs are urged to communicate openly with other involved SNAs about their plans to offer services across states. It is the task force's hope that no SNA will enter another state to provide services to nurses there without communicating with the geographic SNA in advance.

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Conclusion

In its deliberations, the task force returned again and again to the importance of self determination and a geographic identity for each SNA, at the same time recognizing the extremely competitive environment in which ANA and the SNAs exist regarding collective bargaining activities. It was the task force's conclusion that it is imperative that the association continue to enhance its competitive edge in vying with other labor organizations to represent nurses in collective bargaining agreements, and that this will at times necessitate the provision of services across states. The task force urges SNAs to be as flexible and creative as they possibly can be, in finding ways to meet the needs of the nurses in their states.

Members of the Constituent Forum Task Force on Shared Services:

Sandy Houglan, Oregon, chairperson
Jean Duncan, Kentucky
Carol Franck, Michigan
Sylvia Weber, Rhode Island

CFTFRPT

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American Nurses' Association, Inc.

2420 Pershing Road, Kansas City, Missouri 64108

(816) 474-5720

Fax: (816) 471-4903

Lucille A. Joel, Ed.D., R.N., F.A.A.N.
President

Judith A. Ryan, Ph.D., R.N.
Executive Director

TO: SNA Presidents and Executive Directors

FROM: Pamela Cipriano, M.N., R.N.
ANA Treasurer

DATE: December 6, 1988

RE: Review of Proposed Funded and Proposed Not Funded Activities for 1989

In keeping with the **Guidelines and Timetable for Strategic Planning and Budgeting** accepted by the ANA Board of Directors in June 1988, the **American Nurses' Association's Strategic Plan and Program Outcomes Costed Out for 1989**, with proposed funded and proposed not funded activities as recommended by the ANA Committee on Finance at its November 1988 meeting is attached for your review and comment.

The **1989 Budget Assumptions** approved by the ANA board in September 1988 are as follows:

- The General Fund will be balanced in 1989.
- The Reserve and Capital Improvement Funds investment income will remain in these funds.
- The Capital Improvements Fund may be used to support expenses related to corporate relocation.

A balanced operating budget for 1989 has been proposed. In addition to the 1989 Budget Assumptions, the balanced budget is based on projecting a 5% increase in member dues revenue and use of the expected 1988 surplus to fund program outcomes 6350 (reach closure on pay equity) and 7102 (provide support for COAR), which are viewed as extraordinary, unexpected expenses anticipated for a limited time. The committee is recommending funding of expenses related to corporate relocation in program outcome 7120 from the Capital Improvements Fund. A 5% inflation factor was also used in developing the budget.

As you review the attached document, you will note that some important programs are proposed as not funded. Other programs are only partially funded. The committee had to make several difficult choices in recommending a balanced budget. Inflation alone represents an increase in expenses of nearly $700,000 for 1989. Without an increase in the ANA dues conversion factor, funding available for programs continues to decline.

Please share your comments related to the recommended proposed funded and not funded activities as described on the attached document with Paula Massey, M.N., R.N., Constituent Forum representative to the ANA Committee on Finance before you leave the meeting. She will report this feedback to the Committee on Finance at its December 12-13, 1988 meeting. Your input will be considered by the committee in making its final recommendations to the ANA Board of Directors related to the proposed operating budget for 1989. On behalf of the committee, your immediate review and response will be appreciated.

cc: ANA Board of Directors
Judith A. Ryan, Ph.D., R.N., exective director
Linda Shinn, M.B.A., R.N., deputy executive director
Kenneth E. Dyer, C.P.A., director, corporate finance
Karen S. Tucker, corporate financial planner & analyst

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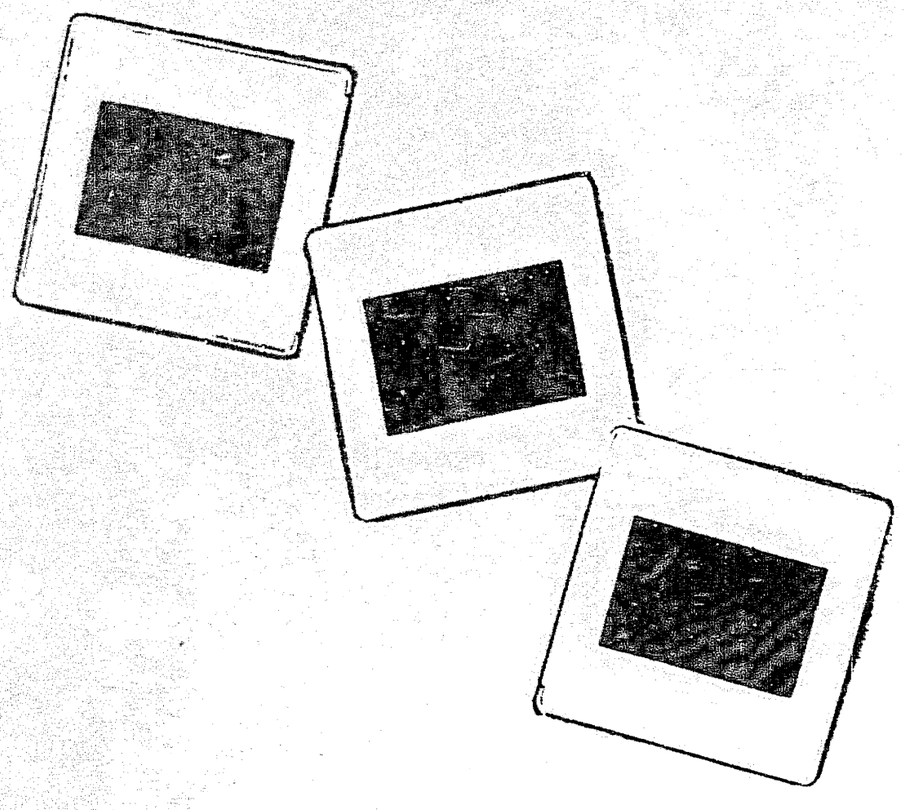
THE NURSING SHORTAGE

Real Problems, Real Solutions



Slide Presentation and Script
American Nurses' Association

TIPS FOR USING THIS SLIDE PRESENTATION AND SCRIPT

The enclosed slide presentation and accompanying script have been prepared in response to the need to inform the nursing profession and the public about the magnitude and causes of the nursing shortage, proposals by other health care professionals to resolve the shortage and nursing's solutions to the shortage.

This script should be used as resource material and tailored to fit particular situations and needs. The script can be made appealing to a particular audience by inserting localized data and personal anecdotes where appropriate.

For example, vacancy rates for a particular state may be inserted on page 8. State projections for RN supply and demand may be placed on page 10. Localized numbers of enrollments and graduations may be inserted on page 12. Experiences in your state or locale to work with hospitals to resolve the shortage and efforts in collective bargining can be inserted on page 27. Other information may be used when available. Slides are indicated prior to the paragraph containing the relevant information.

Studies have shown audience interest wanes if scripts are read word for word. Vary each presentation when appropriate by describing a significant personal experience from a practice area or institution. Don't be afraid to use creativity to bring the seriousness of the nursing shortage to life for your audience. Be sure and share your ideas with others who may wish to use the script.

This presentation was prepared initially in the spring of 1988 with updated data added as of October 15, 1988. Many of the ideas and concepts were originally developed by former ANA president Margretta M. Styles, Ed.D., R.N., F.A.A.N.

Information should be checked periodically to ensure that statistics correspond with the most current data available. *The Nursing Shortage: Situation and Solutions* brochure is available as a handout to accompany this presentation. Bulk quantities may be obtained by contacting the Communications Unit at the American Nurses' Association, 816-474-5724.

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The Nursing Shortage:
Real Problems, Real Solutions

All of nursing faces challenging times. Increasing patient acuity, expanding technology, wider career opportunities, particularly for women, and an overall declining college-age population have all contributed to a growing nursing shortage. Although the profession has experienced cyclical shortages in the past, all indications point to the fact that the current situation is different. The current shortage is affecting not only nursing but the entire health care system--both patients and consumers.

Slide #1

The Nursing Shortage: Real Problems--Real Solutions

Without a doubt, the number one challenge faced by nursing today is ensuring an adequate supply of appropriately prepared nurses for a revolutionized health care system and a changing population, both now and for the future. The health of the *people* depends upon our doing so. The health of the *profession* depends upon our doing so.

This presentation explores the history, nature, dimensions, causes and solutions to the current nursing shortage, a proposal by the American Medical Association to create registered care technologists as a solution to the nursing shortage, and what organized nursing believes to be workable solutions to the shortage.

Slide #2

Media Coverage

The nursing shortage hit the headlines in 1986 and has been an ongoing media event for the health care industry since that time.

Slide #3

Media Coverage

In 1987 over 65 million Americans learned about the shortage through ANA's efforts alone

Slide #4

Media Coverage

This serious situation was and continues to be reported in the *New York Times, USA Today, The Washington Post, The Wall Street Journal,* and on all three major news networks and public television.

Slide #5

Two Types of Shortages: Statistical Shortage Hidden Shortage

It is in listening to nurses that we become aware of two nursing shortages--a statistical shortage and a hidden shortage. Both must be understood and conveyed if solutions are to be found. The statistical shortage is *measured* through surveys of health care facilities, nursing schools, and nursing personnel data sources. The statistical shortage is *expressed* in terms of graphs, charts and tables of patient acuity, hospital days, RN vacancies and enrollments. The hidden shortage is buried in the various data. However, it is not silent. It is expressed in the laments of practicing nurses.

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Slide #6

Statistical Shortage Hidden Shortage

The American Hospital Association acknowledged these two shortages in its 1987 research report, *The Nursing Shortage: Facts, Figures, and Feelings*. The two shortages fuel each other. The facts of the situation influence the feelings of nurses about their jobs. These feelings, in turn, influence nurses' work performance, whether they remain on the job, the image they project to the public and to potential recruits, and ultimately, how health care will be affected.

Slide #7

Two Types of Nursing Shortage:

• Statistical Shortage

• Hidden Shortage

What are the facts and figures of the statistical shortage? In

Slide #8

The Critical Equation

Nursepower = Supply: Demand/Need

simplest terms, nursepower is defined by a simple supply and demand relationship. Sometimes we substitute need for demand--need reflecting nurses' professional judgment for optimal staffing for patient care, and demand reflecting actual positions available in the job market.

Slide #9

The Critical Equation

Nursepower = Supply Demand/Need

Recruitment Retention Utilization Requirements

Supply, in turn, is determined by factors related to recruitment and retention. Demand is determined by how nurses are actually utilized and by how many nurses employers are actually willing to hire at particular wage rates. Thus, it is typical for nurses' evaluation of the number of nurses *needed* to exceed the number of nurses *demanded* by employers. This difference is the source of the hidden shortage. The hidden shortage is the gap between *need* and *supply*.

The statistical shortage, however, considers the gap between *demand* and *supply*. Because need is greater than demand, the hidden shortage is larger than the statistical shortage.

Slide #10

The Critical Equation

*Nursepower = **Supply:** Demand/Need*

On the supply side of the nursepower ratio, we see that

Slide #11

More Nurses Than Ever Before Are on the Job

more nurses than ever before are on the job. Of two million registered nurses, more than one and one-half million, or 79 percent, are employed in nursing. Ten years ago, only 70 percent of RNs were working in the field. Seventy-nine percent is an extremely high workforce participation rate, especially in a 97 percent female profession.

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The average workforce participation rate for all American women who work outside the home is 58 percent. Of the approximately 20 percent of RNs licensed but not employed in nursing, some are retired but most are either over age 55 or are married with pre-school aged children. It is also interesting to note that the average age of employed RNs in this country is on the rise, now approaching 40.

Slide #12

Are Nurses Working Fewer Hours?

Yes, more nurses than ever are practicing nursing, but are they working fewer hours? Part-time employment today is chosen by about one-third of employed nurses. It is difficult to measure how many hours part-timers are averaging per week. However, we suspect that the number of nurses working part time may be an increasing factor in the shortage, especially since many employers have established incentives to encourage part-time employment.

Slide #13

The Critical Equation

Nursepower = Supply: **Demand/Need**

There are many interesting facts and figures, some paradoxes, and some startling revelations on the demand/need side of the relationship. Demand for nurses is surging, not only because of dramatically changing health care standards, but because of personnel utilization patterns as well.

Slide #14

Nurses Are Everywhere

First, it should be noted that nurses are everywhere--with the sick and with the healthy in all types of settings. An increased demand for nurses exists throughout the health care system. New roles, new settings and new areas of practice are emerging.

Despite this widening sphere of demand and need for nurses, the vast majority of nurses,

Slide #15

More Nurses Than Ever

Are Working in Hospitals

68 percent, are employed in hospitals. This is an increase of six percent in the past decade. Why is this true? Has the number of hospital beds increased? Quite the contrary.

Slide #16

The Number of Hospital Beds

Has Declined

The number has declined steadily since 1976. It is here that RN utilization comes into play as a key factor.

Hospital patients are sicker as a result of the prospective pricing system and its pressures to shorten the hospital stay. Also, as the older population increases, the number of patients with complex, multisystem illnesses is on the rise. In addition, technology has expanded at a rapid pace

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Slide #17

More Patients Require Special Care

So, although there has been a 10-year, five percent decrease in total hospital beds, the number of special care beds has increased 38 percent. In addition, sicker patients are found throughout hospitals, not only in specialty and intensive care units.

How has this acuity problem and the financial pressures felt by hospitals affected the utilization of nurses? Because of their ability to perform a wide range of services without supervision, RNs have been forced to bear the dual strain of more complex care coupled with fiscal economies.

What is the evidence? In the first place, the nurse to patient

Slide #18

More Nurses Are Employed Per Patient

ratio has increased by 50 percent, from six-tenths to nine-tenths nurses per patient

Slide #19

The Proportion of RNs to LPNs

In Hospitals Has Increased

since 1977. Secondly, the RN portion of the nursing personnel complement has been enriched. The ratio of RNs to LPNs has more than doubled. And nurses make up a larger percentage of the hospital workforce. While total hospital full-time equivalent employees (FTEs),

Slide #20

More of the Work Is Being Done by RNs

have declined since 1983, the number of RN FTEs has continued to rise. A downward, upward, and lateral substitution of RNs has occurred.

Can there be any question that RNs have been called in to save the day? Can there be any question that nurses are carrying a greater share of the burden? Can there be any question that nurses are working with fewer support systems?

Yes, demand for nurses has increased. But is there a shortage?

An imbalance between demand and supply is often measured in terms of unfilled budgeted positions and the time required to fill those vacancies.

Slide #21

RN Vacancy Rate Is Climbing Fast

Between 1985 and 1986 the RN vacancy rate in U.S. hospitals climbed from 6.3 to 11 percent and increased to 11.3 percent in 1987. One out of every six or seven positions was open. Where was this additional workload absorbed? Undoubtedly, by adding proportionately to the workload of other nurses. And how long were these positions vacant?

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Slide #22

How Long Does It Take To Fill a Vacancy?

Generally More Than 60 Days

More than 60 days in a majority of the cases. Forty-seven percent of hospitals surveyed indicated it took more than 60 days to fill positions in the operating room. That's not the worst, but the best. Sixty-eight percent of reporting hospitals experienced this degree of difficulty in recruiting intensive care and critical-care nursing staff.

These figures may be viewed as conservative estimates for a number of reasons. Many hospitals were thinly staffed even when budgeted positions were filled. Moreover, there is a tendency to under-report vacancies in the fear that shortages will inhibit recruitment and worsen the situation. And finally, many hospitals had already closed beds, in almost all cases attributing this move to the nursing shortage.

These data have related to hospitals only. It is difficult to determine the extent of the shortage in other settings. However, we do know that admissions to long-term care facilities and home health agencies have increased 33 percent in the past few years. Industry spokespersons report an acute need for nursing personnel in these settings.

Slide #23

Collage of Want Ads

Yes, there is a nursing shortage! Virtually all employers are recruiting. There is, however, some variability by region, size of hospital, shift and specialty. Latest reports indicate the shortage is most acute in the Middle Atlantic, East North Central and Pacific regions. Almost all of the larger hospitals reported vacancies, with many small city hospitals reporting none. Small rural hospitals were hardest hit, with 20 percent of RN positions unfilled. As might be expected, the

shortage is greatest on unpopular shifts. And, according to a recent survey, most nursing service administrators prefer to hire baccalaureate graduates.

And are there any projections as to what will happen in the future?

Slide #24

Shortage to Continue

Through the Year 2000

If we look at forecasts made by the federal government, the need for RNs may exceed supply by 200,000 in 1990 and by 500,000 at the turn of the century.

Slide #25

BSN Prepared Nurses

Will be at a Premium

In examining the need for nurses by educational preparation, these same projections indicate a shortage of 400,000 BSN-prepared nurses in 1990 and 600,000 BSN-prepared nurses by the year 2,000.

Slide #26

Nurses with Graduate Degrees

To Be in Great Demand

At the graduate level, 255,000 more master's and doctoral-prepared nurses will be needed than will be available in 1990. This deficit will have increased to 344,000 ten years later.

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Let us turn now to the recruitment aspect of RN supply.

Slide #27

College-Age Population in Decline

First of all, the size of the college-age population provides little basis for optimism. This age group is the basic source of supply for new nurses in the nation, but it declined from just over 30 million to 28.5 million between 1980 and 1988. Projections are that this decline will continue until 1995, when the age group will begin to increase in size again.

As these declining figures of college-bound indicate, there is fiercer competition from other fields. Medicine, law, business, and almost any career is now not only open but is very enticing to many women.

Slide #23

Fewer Freshmen Women Want to Become Nurses

In 1986, for the first time in history, more freshmen women declared medicine as a career choice than nursing. In fact, only four percent of those surveyed indicated they wanted to become nurses, a drop from 10.2 percent in 1974. These data tell us we must make nursing more attractive to this age group. But we must also look to other recruitment pools--second or late career seekers and minority populations underrepresented in higher education. From these figures on the college age population and their career preferences, it is not surprising to see what has happened to nursing school enrollments.

Slide #29

Nursing School Enrollments

Are Declining Precipitously

Approximately 184,000 when last figured, enrollments have declined an alarming 26 percent since 1983, when they reached a high of 250,000 This decline was realized in all three types of basic nursing education programs. On the other hand, part-time student enrollment is up, with fewer than half of the BSN students completing traditional four-year programs. Thus, graduations will decline even more drastically than enrollments.

Can this slide in enrollments be related to the advent of DRGs? Their introduction caused a brief glut of nurses as hospitals scrambled to adjust to the new system. At the same time, the federal government cut its funding for nursing education and nurses' salaries plateaued as the supply of nurses seemed to be adequate.

Let's take a look at salaries, since compensation undoubtedly has effects upon both the recruitment and retention of nurses. What can a career shopper look forward to if he or she selects nursing? And how is the veteran nurse rewarded for what can only be described as tough intellectual, physical and emotional work?

In 1987, the average starting salary for staff nurses across the country was $20,964.

In view of the fact that the majority of new RNs last year were associate degree graduates, that beginning salary may be competitive with fields of comparative preparation. But how much progress has been made over time?

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Slide #30

Average Starting Salaries

For RNs Are Stagnant

RN salaries have not even kept pace with inflation. $20,964 today is equivalent to $10,419 in 1976 dollars, when average salaries were $10,440.

Part of the reason RN salaries have not kept pace is because of the market power of employers. Many communities have only one or a few hospitals which employ an essentially local supply of nurses. Employers can therefore hold down wages because nurses have few alternative employment opportunities.

How does compensation advance over the span of a career? How far is up for nurses who continue to improve themselves and their practice and stay at the bedside?

Slide #31

How Far Up Do Staff Nurses' Salaries Go?

Less Than 40% Over Where They Start

The average maximum salary for staff nurses is $29,088. The nurse with 20 or 30 years' experience is earning only about $6,000 per year more--or less than $3 an hour more-- than the new graduate just out of school. Not much to look forward to for the potential recruit. Not much to look back on for the nurse who has devoted his or her entire career to the practice of nursing.

Perhaps we expect too much. What can other professionals look forward to?

Slide #32

How Does Nurses' Salary Progression

Stack Up with Other Professions? Poorly

Over a career, attorneys can anticipate improving their income by 226.7 percent, accountants 192.7 percent, engineers by 183.6 percent, and computer programmers by 106.1. Nurses can anticipate only a 36.4 percent improvement. We suffer a phenomenon known to economists as salary compression--extreme compression.

These have been some of the facts and figures of the statistical shortage. What can be found in plumbing the depths of the hidden shortage?

Slide #33

Two Types of Nursing Shortage:

*• Statistical Shortage • **Hidden Shortage***

The hidden shortage is hard to illustrate through charts, graphs, statistics or other data. Practicing nurses themselves can best explain the hidden shortage through their individual and collective experiences.

-Nurses know, for example, that the overloaded health care system is in various stages of failure. Nurses know that they and their patients are absorbing most of the shocks within the system.

- Nurses alone can describe the burden of serving as the elastic in an overstretched system, of serving as expandable, interchangeable, and all-purpose parts.

- Nurses know very intimately what it means to their working conditions that, as hospital budgets go up, up, up, the nursing budget does not rise proportionately.

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- Nurses are well aware that budget vacancies, as a measure of the shortage, are just the tip of the iceberg and that under the surface is deliberate, though benign, understaffing.

- Nurses best understand the full impact of patient acuity in today's high tech, sicker-in and quicker-out hospital environment.

- Nurses can best describe how it feels to bear the brunt of eroding support systems. These deteriorating systems require nurses to transport patients and to devote hours to clerical work and other duties which could be assumed by other supportive personnel.

- Nurses are painfully aware that a full-time equivalent, or FTE, is not a nurse. They know that 40 nurse hours per week comprised of part-timers, floats, temporary personnel and aides is not the same as a qualified, permanent, full-time RN. The full-time nurse knows the unit, knows the system, knows the patients and their conditions, and provides continuity and commitment.

- Nurses beg to tell that mandatory double shifts on a stressful unit are fatiguing, demoralizing and dangerous.

- Nurses alone can explain the psychological down-cycle as quality of care slips. They suffer with patients and find themselves even less able to cope.

- Nurses must be heard about the agony of the ethical dilemma, when confronted with the choice between accepting an unsafe assignment and patient abandonment.

- Only nurses can describe the frustration of crushing responsibility without the authority and the humiliation of competence without respect and recognition.

- Only nurses can relate the devastating personal effects of being so poorly compensated for heroic service, of not having enough money for their family needs, of standing still economically and seeing other professionals pass them by a few years into their careers.

- Nurses know the difficulty of projecting a positive image of nursing in view of these circumstances; only they know whether they can and will in good conscience attempt to recruit others into these same circumstances.

- And only nurses can say just how long they will put up with these conditions-- when commitment will surrender to despair and they will seek a career elsewhere.

Does this sound familiar? These are stories of the hidden shortage, stories told by practicing nurses.

The status of the nursepower situation for more than 30 years has been that of chronic shortage, with only occasional, brief periods of remission. Causes of the nursing shortage have been documented time after time and study after study.

The causes, as identified through both objective and subjective data, are

Slide #34

Why Nurses Leave Nursing:

Physical and Psychological Overload

(1) physical and psychological overload,

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Slide #35

Why Nurses Leave Nursing:

Poor Working Conditions

(2) poor working conditions,

Slide #36

Why Nurses Leave Nursing:

Professional Responsibility Without

Professional Autonomy And Recognition

(3) professional responsibility without professional autonomy and recognition,

Slide #37

Inadequate Compensation

(4) inadequate compensation,

Slide #38

Insufficient Support Services

(5) insufficient support services,

Slide #39

Minimal Involvement in Decision-Making

(6) minimal involvement in decision-making, and

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Limited Opportunities for Advancement

(7) limited opportunities for advancement. This list of grievances can be summed up in two words--"non-professional environment."

This same list of shortcomings also bears upon the public image of nursing. It is for many of these same reasons that nursing is rejected as a career field by potential recruits. Kalish and Kalish have documented that the image of nursing has adversely affected nursing as a career. But the question must be asked: "How much is media distortion and how much is fact?"

Before discussing solutions to the problems, we must also look at the flip side--the bright side. After all, there are 1.5 million nurses practicing today. What draws them to the career and keeps them there? What is good about nursing?

Slide #41

What's Good about Nursing?

Full Employment

(1) Nursing is a full employment profession.

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Slide #42

What's Good about Nursing?

Multiple Settings and Roles

(2) There are multiple settings and roles for career growth.

Slide #43

What's Good about Nursing?

Work of Social Value

(3) Nurses are privileged to care for people in an intimate, meaningful way in a profession of social value.

Slide #44

What's Good About Nursing?

Exciting Practice

(4) Practice is exciting.

Slide #45

What's Good about Nursing?

Escalating Compensation

(5) Salaries are starting to climb.

Slide #46

What's Good about Nursing?

Clinical Ladders

(6) Clinical ladders are shooting up, along with tuition benefits which enable nurses to grow up with the job.

Slide #47

What's Good about Nursing?

Opportunity for Change

(7) New reimbursement policies are opening up opportunities for nurses. (8) The critical importance of nursing is beginning to be realized within the industry and government. And (9) The shortage provides leverage for positive change.

As one nurse said recently, "Yes, it's hard work, the hours are long, it's stressful, but there is nothing I would rather do because..." Each of those 1.5 million nurses who is hanging in there determined to improve the situation can fill in the end of the sentence. This is the positive, constructive attitude we must tap in order to turn the shortage around.

Approaches to the shortage must emerge from an understanding of what is right and what is wrong in the current situation. Short-range solutions, band-aids, have never worked in the past and will not work now.

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Anti-RCT headlines

One such band-aid approach is the introduction of bedside caregivers as a solution to the nursing shortage. The American Medical Association (AMA) has taken action to test pilot programs that will train workers known as registered care technologists (RCTs) to deliver bedside care in the absence of nurses. The AMA contends that the RCT plan is a viable solution to the nursing shortage Yet the proposal has met with unequivocal opposition from all of organized nursing. Why? Let's take a look at the fiction and the facts of this proposal:

Slide #49

RCT Fact: Minimal Training

FICTION: The RCT proposal would offer safe bedside care in long-term and acute-care hospitals.

FACT: Recent high school graduates with only two to 18 months' training would be carrying out medical protocols at bedside.

Slide #50

RCT Fact: Cost-Prohibitive

FICTION: The RCT plan would be a cost-effective solution to today's (and tomorrow's) nursing shortage.

FACT: Proposed RCT duties are already within the range of duties of existing personnel (RNs, LPNs, Nurses' Aides). Creating new categories of workers, rather than making more efficient use of existing categories, would cost hospitals and taxpayers more.

Slide #51

RCT Fact: Need More Highly Trained Nurses,

Not Minimally Trained Workers

FICTION: The RCT would adequately fill the bedside void created by the nursing shortage.

FACT: The documented need is for well-prepared nursing personnel, such as RNs and LPNs, not for minimally-trained health care workers.

Slide #52

RCT Fact: Physicians Would Benefit Most

FICTION: The RCT would assist the RN.

FACT: According to the AMA, the RCT "would be responsible for executing physicians' orders." So it's physicians, not nurses, who would benefit most.

Slide #53

RCT Fact: Nursing Shortage Result

of Hospitals Using More RNs

FICTION: Organized nursing has made no progress in implementing solutions to the nursing shortage.

FACT: In 1980, 77 percent of the nation's 1.7 million licensed RNs were employed in nursing. In 1986, when the nursing shortage was first documented, 80 percent of the 2.0 million registered nurses were employed in nursing. The shortage is a result of hospitals using more RNs—not a failure of organized nursing to put more nurses into the workforce

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Photo of Anti-RCT button

We all need to work together with our colleagues in the workplace to reinforce that only well-prepared RNs will solve this nursing shortage once and for all. Seriously ill and frail elderly people admitted to hospitals today require more care by highly-skilled professionals, not a new category of minimally-prepared workers. New categories of caregivers will only duplicate health care career choices and further dilute the pool of available nursing candidates, thus intensifying rather than relieving the nursing shortage.

The American Nurses' Association (ANA) and all of organized nursing has considered the nursing shortage and its potential effects on the delivery of nursing care services as a major priority before the profession and the entire health care delivery system since 1986.

Early analysis of the shortage demonstrated clearly that this nursing shortage was different from those in the past. As the data we have reviewed demonstrate, increasing patient acuity, expanding technology, a growing demand for nurses, expanding career opportunities, particularly for females, and an overall declining college-age population tell us that both short and long-term solutions are necessary to resolve the shortage.

Slide #55

Nursing Shortage: Nursing Solutions

Organized nursing, recognizing the complexity of the problem and the need to mount intensified action to deal with the situation, came together in May, 1988, to develop an action plan to assure that the public would continue to have access to quality nursing care services.

Two short-term strategies, congruent and consistent with nursing's established long range health policy to provide an adequate supply of nurses, were identified at the May meeting.

Slide #56

Short Term Strategy #1

The first short-term strategy identified is to increase the time that registered nurses spend with patients by reallocating resources and designing new staffing systems.

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Short Term Strategy #2

The second is to expand the overall pool of nurses who work in hospitals and long-term care facilities.

Nursing representatives at the May meeting also identified key elements found to be necessary to implement priority short-term strategies. Nursing's action plan was unanimously endorsed by over 45 national nursing organizations and groups demonstrating a united effort on behalf of all organized nursing to resolve the nursing shortage crisis with workable, achievable solutions.

Nursing believes that efforts to resolve the shortage should focus around:

Slide #58

Proper Use of Nursing Expertise

(1) Making better use of nursing expertise by effective utilization of support staff and technology

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Slide #59

Advancement Opportunities and Compensation

(2) Establishing career ladders and related compensation policies that recognize education, expertise and seniority.

Slide #60

Substantial Shift Differentials

(3) Enlarging shift differentials, in some cases permitting nurses to choose between premium dollars and premium hours.

Slide #61

Professional Incentives

(4) Providing professional incentives, such as educational benefits, sabbaticals, research opportunities, etc.

Slide #62

Governance Structures

(5) Creating new governance structures to involve staff nurses in decision-making at higher levels and in positioning them in

Slide #63

Professional Peer Relationships

(6) peer relationships with physicians and other professionals.

In general, the answer to the nursing shortage is a more professional and supportive environment. This environment will, in turn, encourage nursing recruitment.

Slide #64

Nursing Solutions Are Working

Organized nursing is encouraged that these strategies are working in multiple settings throughout the country. Examples of success include:

• The integration of nursing case management with primary nursing in Detroit's Harper Hospital. This has resulted in improved patient care at a cost savings to the hospital, and increased nursing satisfaction, indicated in part by lower nursing attrition.

• An across-the-board eight percent pay increase for nurses at the University of Chicago Medical Center. The hospital has experienced a drop in its nursing vacancy rate from 28 percent to 10 percent.

• The financial support of nurses working to upgrade their education at United Hospital in Grand Forks, North Dakota. There is a waiting list of nurses seeking employment at the hospital, whose other programs include a professional nurse committee, the first clinical career ladder in the state, and the opportunity for students at the University of North Dakota School of Nursing to earn academic credit and wages by working at the hospital.

• The implementation of unit assistants responsible to nurses to perform tasks other than direct patient care has improved nursing morale and allowed Rush-Presbyterian St. Luke's Medical

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Center in Chicago to keep beds open. The hospital has hired as many as 40 assistants after determining 40 percent of their nurses' time was spent in non-direct patient care.

In order to encourage recruitment, both federal and state governments must recognize and fund nursing education as an essential public resource. Student assistance should be targeted to the need for more baccalaureate and higher degree-prepared nurses. Moreover, scholarships could include service payback provisions with incentives for graduates to practice in underserved regions and specialties.

As stated earlier, the nursing shortage not only commands change but provides increased leverage for change. To be in such demand during an era of upheaval within health care in this country is a great opportunity to achieve gains in nursing. Taking advantage of that opportunity is an enormous challenge to organized nursing in the United States.

Every nurse is struggling to make improvements at an individual, institutional and state level. Our collective successes are commendable.

It is often said that the nursing profession is splintered and thus rendered ineffective. This is simply not true. Please do not allow this to be said about us. Fight back when the unfair, destructive charge is made. In fact, all of nursing is working in a unified effort to combat the nursing shortage and to solve other problems facing our profession.

Nursing continues to want the support of organized medicine, the hospital industry, payors and other health care and consumer organizations and groups in the pursuit of our goals. Only through unified efforts can we achieve positive outcomes that are in the best interests of patient care.

Slide #65

We Are Concerned

We are concerned,

Slide #66

We Are Together

we are together,

Slide #67

We Are at Work

we are at work, and most important,

Slide #68

We Are Succeeding

we are succeeding.

The shortage--with its promises and perils--is number one on all of nursing's agendas--on the agenda of the ANA; on the agenda of the Tri-Council for Nursing, comprised of the ANA, American Organization of Nurse Executives within AHA, American Association of Colleges of Nursing, and the National League for Nursing; on the agenda of specialty organizations; and on the agenda of regional and state associations. Maintaining adequate and appropriate nursepower is also a high priority of agencies of government: the U.S. Congress, the U.S. Department of Health

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and Human Services, the Division of Nursing, and the National Institute of Health's Center for Nursing Research. State governments, as well, have formed committees and task forces to address the problem. Private foundations are interested in helping out in innovative new ways.

The message is being heard. And we are getting results. But questions remain: How long, if not now, until you feel improvement in your personal circumstances? And how long until these plans and changes affect recruitment into nursing? And, will the momentum for change by the shortage be sustained? The answers can only be those of conjecture and conviction.

We know that workable and realistic solutions to the nursing shortage have already been proposed and are effectively being carried out. Each of you is part of the solution--by the professionalism, caring and concern you demonstrate in the workplace and by taking your valuable time to participate in programs such as this. You recognize that the only people who are going to solve this shortage are nurses themselves--together.

We are mobilizing forces as never before to combat the nursing shortage and to fight ill-conceived, wasteful proposals to create new categories of bedside caregivers. Each of us, in our own special areas of practice, in our own states, in our own districts and regions, must continue to work together to fight the nursing shortage and to combat plans such as the AMA's RCT proposal. Nurses must continue to say no to these and other faulty schemes that divert the public from the real solutions.

We must continue to offer the broadest range and highest level of nursing care to the public.

We must continue to ensure the public's access to that care.

And we must be recognized and rewarded proportionate to our services in the public interest.

We are united and must look forward to even closer collaboration, stronger conviction and greater victories.

American Nurses' Association
2420 Pershing Road
Kansas City, Missouri 64108

ANA - Equal Opportunity Employer

The Nursing Shortage: Real Problems, Real Solutions

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