SB211 C S0

Claim: *The solution to the staffing is to train more nurses.*

Response: This solution is convenient for the hospital association because it does not focus attention on their own operations. As the hospitals would have it, the nursing shortage is a product of environmental factors beyond their control, and they are the passive victims. In fact, much of the nursing shortage has been brought on by short-sighted management practices. Recruitment alone is obviously an incomplete response, because if working conditions are not improved newly trained nurses will not be retained. In fact, these recruitment efforts themselves may fail. As nursing expert Suzanne Gordon has recently written: "Veteran nurses and even recent nursing graduates are discouraging others from entering the field and even advising nursing students to get out of bedside care as soon as they can. Without substantive changes in working conditions, luring more people into the profession will aggravate, not alleviate, the situation and encourage the "management by churn" that has reduced customer service quality in fast food, retail sales, and telemarketing, where the consequences are far less serious for customers than in health care."

Claim: *Banning mandatory overtime is dangerous for patients because of the shortage of nurses. If the bill is passed, patients will not get the care they need.*

Response: This claim is obviously entirely inconsistent with the claim that mandatory overtime is rare, and only used in emergencies. Moreover, numbers from a recent General Accounting Office study released earlier this year, and from a workforce study released by the Wisconsin Health and Hospital Association last week, demonstrate that the nursing shortage has not yet hit Wisconsin as it has the rest of the country. According to hospital association, vacancy rates in Wisconsin hospitals are nearly half the national average. This means we have time to get at the root causes of the shortage, by improving working conditions. In addition to aggravating the nursing shortage, mandatory overtime is a practice that is very dangerous for patients. Fatigued nurses are much more likely to make errors, or to miss subtle changes in the condition of patients. Although 75% of hospitals do not report medical errors, a major federal study found that as many as 98,000 people die each year as a result of medical errors in hospitals.

Claim: *SB 211 needs a tighter definition of emergency*

Response: This argument is disingenuous, because opponents of the bill have made it clear that they would also oppose more specific definitions. The definition in this bill is designed to allow some flexibility, to assure that nurses will be available in any unforseen emergency. The federal mandatory overtime bill, and the bills introduced in many other states, actually require a unit of government to declare an emergency. Ironically, before SB 211 was introduced it was attacked by one hospital spokesperson for requiring a governmental unit to declare a state of emergency. I cannot speak for the sponsors and co-sponsors of the bill, but we would certainly be open to any constructive discussions about how to define an emergency, as long as the aim of these discussions is not to undermine the bill, but to make it better.

Senator Lasee
109 South

Senate

Committee on Labor and Agriculture
Senator Dave Hansen, Chair

PAPER BALLOT

Date: **October 17, 2001**

Bill: **Senate Bill 211 -- Relating to: mandatory overtime hours worked by health care workers employed by health care facilities and providing penalties.**

Motion: **Passage**

Moved by: **Hansen**

Seconded by: Baumgart

Aye: _____ **No:** ✓

Alan Lasee

Senator Alan Lasee

Please return to Senator Hansen's office (by messenger) by **noon Thursday, October 18, 2001.**

Please call the Committee Clerk, Lisa Ellinger, at 266-5670 if you have any questions.

Senator Harsdorf
3 South

Senate

Committee on Labor and Agriculture
Senator Dave Hansen, Chair

PAPER BALLOT

Date: **October 17, 2001**

Bill: **Senate Bill 211 -- Relating to: mandatory overtime hours worked by health care workers employed by health care facilities and providing penalties.**

Motion: **Passage**

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Seconded by: **Baumgart**

Aye: _____ **No:** ✓

Sheila Harsdorf
Senator Sheila Harsdorf

Please return to Senator Hansen's office (by messenger) by **noon Thursday, October 18, 2001.**

Please call the Committee Clerk, Lisa Ellinger, at 266-5670 if you have any questions.

Vote Record

Senate - Committee on Labor and Agriculture

Date: 10-17-01
Moved by: Hansen
Seconded by: Baumgart
Clearinghouse Rule:
Appointment:
Other:

AB: SB: 211
AJR: SJR:
AR: SR:

A/S Amdt:
A/S Amdt: to A/S Amdt:
A/S Sub Amdt:
A/S Amdt: to A/S Sub Amdt:
A/S Amdt: to A/S Amdt: to A/S Sub Amdt:

Be recommended for:
- [x] Passage
- [ ] Introduction
- [ ] Adoption
- [ ] Rejection
- [ ] Indefinite Postponement
- [ ] Tabling
- [ ] Concurrence
- [ ] Nonconcurrence
- [ ] Confirmation

Committee Member	Aye	No	Absent	Not Voting
Sen. David Hansen, Chair	☑	☐	☐	☐
Sen. Russell Decker	☑	☐	☐	☐
Sen. Jim Baumgart	☑	☐	☐	☐
Sen. Alan Lasee	☐	☐	☐	☐
Sen. Sheila Harsdorf	☐	☐	☐	☐
Totals:	3	0		

- [x] Motion Carried
- [ ] Motion Failed

WISCONSIN FEDERATION OF NURSES & HEALTH PROFESSIONALS

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AFT, AFL-CIO

Testimony of Jeannine Davis, RN
Wisconsin State Senate Committee on Labor and Agriculture

Support for Senate Bill 211
October 17, 2001

Good afternoon members of the committee and thank you for this opportunity to speak to you today. I am a registered nurse who has personally had to deal with mandatory overtime and the consequences of it. Mandatory overtime is bad for nurses and even worse for patients.

My personal experience with mandatory overtime occurred in a Milwaukee hospital. On our floor I was responsible for six patients who had either had surgery that day or very recently. It was my job to make sure everything was being done correctly on these patients, and check that the physician had ordered everything he meant to and everything he needed to. I had to check to see that pharmacy had transcribed the orders properly on the medication sheets, and that none of these medications were contraindicated in my patient due to an allergy or organ insufficiency. Of course, I also had to actually spend some time with the patients and their families as well. Having six patients for eight hours only gave me one hour and ten minutes per patient to assess, chart, help the patient get to the bathroom and up to a chair, check the labs and report to the physician any abnormals, read the physician notes, talk with the family members present as well as those who call, talk to the physician when he calls, and instruct the patient on how to take care of himself at home. Needless to say, by the end of the eight-hour shift I was exhausted.

On days when I was mandated, the hospital supervisor would come down two hours before my shift was to end and tell me I couldn't go home. She or he would tell me I had to stay for another eight hours. I worked the evening shift, which means I worked from 3 in the afternoon until 11:30 at night. Being mandated for eight hours meant I would be up all night as well. I generally got up around 8 or 9 in the morning. Being

mandated for eight hours meant I was up from 8 in the morning until 8 the next. I was then expected back by 3 in the afternoon again for my next scheduled shift. I am sure I do not need to tell you how poorly I was functioning overnight and the risk my patients were put in when I was forced to work these long hours. I am also sure you would not have wanted me to be caring for you or a family member you love. This is what is occurring in health care today with mandatory overtime. Nurses are being forced to work in unsafe conditions putting the patients and themselves at risk.

The Institute of Medicine reports that as many as 98,000 patients die from medical errors every year. If 98,000 die, how many more are being injured? Everyone knows that when they are tired they make more mistakes. In nursing this becomes a very serious problem. In an area hospital, an incident was reported in which an exhausted nurse on her 14th or 15th hour meant to give a patient an antibiotic and instead gave a paralytic. The paralytic paralyzed him making him unable to breathe on his own. Luckily, this patient was on a ventilator, which kicked in when he stopped taking breaths on his own. An error in judgment or lack of attention to details can be life threatening. The nurse is responsible for the lives of all of her patients. If something starts to go wrong, she/he is the one who is going to notice and respond. Many interventions can be done for a patient to keep them out of harms way before the physician is even notified. Many patients who have become critically ill will tell you it was the nurse who saved their life by identifying what was wrong and immediately doing something about it. Your nurse needs to be well rested and alert in order to be able to function. There are limits on the work hours of truckers, airline pilots, rail workers, and even flight attendants, because alertness is critical to the safe performance of their jobs. Why wouldn't nurses be just as important? By passing Senate Bill 211 we can insure the same level of safety for Wisconsin health care consumers. Mandatory overtime increases the risk of medical errors, thus putting the patient at risk for harm and the nurse at risk for losing her license, and this must stop.

The hospital association will tell you that with the nursing shortage mandatory overtime is a necessary solution to staffing problems. As a nurse who is in such high demand, I will tell you that I left the hospital I had been working at in part due to mandatory overtime. I was being forced to chose between possibly being sued and losing my license and my profession, or losing my job because I wouldn't stay an additional eight

hours. Other nurses are leaving the profession for the same reason: eight hours doesn't mean eight hours anymore. Mandatory overtime is adding to the problem of the nursing shortage. It is putting health care workers and patients at risk, and is forcing nurses to chose between their family life and their job.

At the aforementioned facility, the hospital supervisor tried to force a mother who was nursing her newborn child to stay for sixteen hours. The mother had not planned on this and, therefore, had no extra breast milk at home for her child to eat. This didn't matter--someone had to stay, and the rest of the nurses on that unit had already been mandated in the last week or two. Thus it was her turn. This nurse had to leave the job she loved because it interfered with the care of her newborn son. Many nurses work the opposite shift of their spouse so that mom or dad is always home to care for the children. A nurse I know worked the night shift and her husband worked the day shift. When she was mandated, she would be notified at 5 o'clock in the morning that she would not be able to go home at the end of her shift. She then had to struggle at 5 o'clock in the morning to find someone to watch her baby. You can imagine how difficult this was. Day care centers are not open at that hour and most family and friends are not awake. The anxiety of wondering who she was going to be able to find to care for her child, the guilt of waking up friends and family at 5 in the morning, and the guilt of knowing she was not going to be able to see her infant until the next day were just a few of the emotions she was feeling. Mandatory overtime is disrupting the families of health care workers. No one should be forced to neglect their family for their job.

Senate Bill 211 will keep patients safe by helping to insure that health care workers are not forced to work unsafe hours. It will keep patients safe by reducing the risk of medical errors. It will prevent nurses from having to choose between a job or a profession that they love and their family. Nurses, health care workers, and patients support this bill. People of Wisconsin support this bill. Do you want your loved one in the care of a nurse who is on her 13th or 14th hour of work?

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AFT, AFL-CIO

Testimony of Barbara Janusiak, RN
Wisconsin State Senate Committee on Labor and Agriculture
Support for Senate Bill 211
October 17, 2001
Madison, Wisconsin

Good afternoon Chairman Hansen and members of the Senate Labor and Agriculture Committee. My name is Barbara Janusiak and I have been a registered nurse for more than 20 years and I work in a critical care unit. Thank you for the opportunity to speak to you about the need to pass Senate Bill 211 which would put an end to forced overtime for Wisconsin's nurses and health care workers.

Mandatory overtime is risky business for Wisconsin hospitals. When hospitals and other health care providers force their nurses and health care workers to work beyond the end of their shift they are playing with patient's lives. For too long nurses have been put in a position of being forced to work another shift, often with little notice or warning. This dangerous practice plays havoc with not only with the nurse's personal life, but also puts patients directly in harms way.

At over 50 years of age I personally need to prepare to work more than 8 hours. I do work more than 8 hours voluntarily when I have time to prepare by resting and adjusting my home schedule. But, when I'm tired I'm constantly concerned that I'll make a mistake. When you are working critical care it is very easy to make a life threatening error. I don't want that error to mean the loss of life for me of my patients and probably a loss of license for me. In addition, I may not be able to work in nursing again because of the devastation from such an error.

You have heard from nursing administrators who opposed the bill to stop mandatory overtime. You heard from administrators who asked you and all of Wisconsin's patients to make a choice: They said that we must choose between a fatigued nurse or no nurse at all. Is this really the choice we are left with in Wisconsin? Must we make a choice between poor quality health care or no health care at all? Wisconsin's patients deserve better.

You have heard hospital administrators who told us the reason they had to mandate nurses to work forced overtime is because of the nursing shortage. While it is very true that we are in the midst of a severe nursing shortage that will likely worsen, the answer is not to drive the current nurses out of the profession by forcing them to work overtime.

A recent poll commissioned by the Federation of Nurses and Healthcare Professionals, my union, and conducted by Peter Hart Associates shows that fully one fifth of the nations nurses are ready to leave right now because they are fed up with horrendous working conditions. One out of five nurses plans to leave the nursing profession in the next five years. The nurses, ages 18 – 59 plan to leave not to retire, but to get away from oppressive working conditions. An even more alarming result of the survey tells us that 50 percent of current nurses say they have thought about leaving nursing and this number excludes nurses who are thinking of retiring.

Mandatory overtime is a cause of the nursing shortage it is not the cure. A nurse I know in West Bend was mandated to work on her day off so often that she finally quit working critical care. Critical care is one of the areas of greatest shortage and mandating her did nothing to help that shortage.

Forcing exhausted nurses to care for seriously ill patients is irresponsible. A recent study found that after 17 – 19 hours without sleep, the performance of subjects was equivalent or worse than at a blood alcohol level of 0.05 percent. After 24 hours of

sustained wakefulness, the impairment was equivalent to that caused by a blood alcohol concentration of 0.10 percent.

This bill would place limits only on involuntary overtime. Voluntary overtime will continue as always. It is quite different to prepare in advance for a shift, which has been voluntarily accepted. The nurse will ensure she has enough rest before her shift, she will plan ahead for the care of her children, and she will begin the shift knowing that she chose to work an extra shift. It is quite different to be forced, often at the last minute to stay another shift, against your will and better judgement.

This bill would allow the use of mandatory overtime in cases of "unforeseen emergencies" if necessary. Chemical explosions, car crashes, floods, fires, outbreaks of contagious diseases, and other disasters would all allow administrators to mandate nurses and health care workers to work overtime. But the reality is that whenever there is a disaster, nurses and health care workers are the first ones to respond by voluntarily coming in to work. I have never heard of an instance that hospital administrators actually had to force a nurse to work overtime in a serious emergency. Every hospital has a disaster plan and health care workers rise to the occasion to care for the sick and the injured whenever they are needed.

This bill would ban the use of indiscriminate forced overtime. No one should be surprised when schedules are posted with holes that there are not enough nurses to staff the shifts. It is not an emergency when a shift normally requires 8 nurses and only 5 are scheduled to work.

Jeopardizing patient safety should not be an option in Wisconsin. We deserve to be cared for by health care workers who are alert and prepared to meet the day's challenges. Patients deserve quality health care and they deserve to never knowingly be put in a situation where their care is in danger. I urge you to support SB 211 and make sure that no patient has to choose between a fatigued nurse and no nurse at all.

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UNITED PROFESSIONALS, LEADING THE WAY TO QUALITY HEALTH CARE

Testimony of Ann Louise Tetreault, RN, BSN
Member of SEIU District 1199W/UP

Before the
Senate Labor Committee
SB211: Prohibition on Mandatory Overtime for Health Care Workers

October 17, 2001

Good Afternoon Senators!

My name is Ann Louise Tetreault, RN, BSN. I am also a Care Team Leader with primary responsibility to make sure my unit operates effectively and efficiently with the best clinical care possible for all patients. I am approaching 25 years of experience and dedication as an RN at University Hospital and Clinics in a variety of inpatient units.

I have been a willing and active participant in many clinical and process improvement committees at UWHC over the years. Most recently, I have served on the Healthy Work Environment Committee, CEO Appointed Strategic Planning Committee on Recruitment and Retention, and the Care Team Leader Task Force.

Nurses are required to make critical assessments on a continuous basis. We need to look at symptoms of different systemic problems, physical assessments on a regular interval, drawing and evaluating lab work, assessing and treating fall risks, treating chronic and acute pain, evaluating and treating cardiac arrhythmias, assessing coping and psychological distress, etc. More frequently we are seeing post-operative patients on all of our general care units because of overflow from surgical cases. We are boarding patients on different units because the primary unit can't handle them due to short staffing.

We alert physicians of any change in status and many times suggest appropriate treatment. We are the front line bedside caregivers. If we miss something critical, however subtle, there is no one to back us up. Our mistakes can lead to further injury or even death. Therefore, we must stay alert to insure the safety of our patients.

Over the last few years, holdovers of staff have become a daily staffing model all over the hospital. There are many reasons given for this mandatory overtime practice that are supposedly "unforeseen" by management:

1) Vacations granted over 6 months ago
2) Maternity leaves, jury duty, etc.
3) Illness, medical leaves, funerals

4) Terminations
5) Sick calls
6) Increase in patient census
7) Clinic procedures and appointments lasting longer than scheduled.

All of the above examples are everyday occurrences at UWHC. They are not unforeseen. Most of the holdovers are not done voluntarily, but out of commitment, dedication, frustration, fear of termination, and cultural norm at the UWHC.

Make no mistake there is a major difference between working voluntary overtime and mandatory overtime. A nurse asks herself several important questions: 1) how tired am I? 2) Will my family be able to manage without me? 3) Will I be able to rest adequately tomorrow? 4) Will I be safe driving home after work? 5) How heavy is the patient assignment? Can I do it safely? 6) Am I being offered fair compensation for the work? 7) Is it in the best interests of my patients? In volunteering, we can ask ourselves these important questions but when we are mandated, we can't. We simply must just do the work, whether it is safe or not.

I have witnessed staff "volunteer" for a 4-hour holdover so they wouldn't be mandated for an 8-hour hole later in the week. I have witnessed people working that are not very alert and they feared their ability to practice safely. A nurse that has been awake 24 hours is not very safe in the last hours of work.

The mandated overtime shifts are driving my colleagues from inpatient nursing and producing our nursing shortage in hospitals. Nurses are going to the clinics, administrative positions or just plain leaving the profession. At UWHC during the last three years, approximately 100 nurses have left just during probation because of the mandatory overtime requirements and understaffing. We don't have a recruitment problem but we do have a major retention problem. Mandatory overtime is causing a hemorrhage in the inpatient nursing profession.

As mandatory overtime results in insufficient retention of staff, the resulting staffing crisis leads to patient diversions and medical errors. It is not a coincidence that as mandatory overtime has increased in the last five years that we have seen a resulting increase in patient diversions to other hospitals and medical errors. New studies underway suggest a direct correlation.

The management's documentation of holdovers is under-reported and misleading. UWHC admits to 17,062 hours of mandatory overtime in the year 2000. The less than 3½ hour mandated shifts are not even counted. I have witnessed examples of staff holdovers because patients were transferred from one inpatient unit where they were boarded to the primary unit the physician practiced on resulting in a mandated shift for the primary unit. The head nurse condoned this practice. I have witnessed several instances when 1-3 people per shift were under the threat of holdover for 8 hours for 1 or more days in a week.

If mandatory overtime was rare and only in emergencies as the hospital asserts, would this be one of the highest priority issues for inpatient staff RNs holding up our union contract settlement? Obviously not!

I do acknowledge this lack of attention to the manner in which the management is coding the holdovers provides less documentation for this committee. We can't validate their numbers but we can document it with our experiences, our daily workloads, and the number of nurses leaving the inpatient

units and the impression it leaves on young nurses. We try to document unsafe staffing levels, but management dismisses their validity.

I personally have experienced the effects of working double shifts. I had an accident driving home one morning after having worked all afternoon and night. Rather than put myself in more harms way, I decided to move closer to the hospital, however, I still must drive home when I am dead tired and need sleep. I have colleagues who have major day care problems because of mandated shifts. Recently, one of my co-workers had to have her father take care of her child because the day care provider was no longer available. It took some maneuvering to make all this happen at the end of the shift. A colleague's wife went into labor while he was working a double shift. He had to find his own replacement before he could be with his wife. I know of nurses who could not get back on their sleep cycle and were sick for days because of the disruption in their circadian rhythms. One of my colleagues recently quit because she was so devastated when her very young daughter couldn't understand why Mom wasn't home on Sunday mornings to take her to church. Her daughter thought she didn't want to go to church with her anymore. She had been mandated over so many times that her daughter thought it was her fault her mother wasn't at home. Some of my colleagues with legitimate health problems resort to getting medical excuses so they cannot be mandated anymore.

Nurses know what an emergency is and are more than willing to volunteer in those instances. For the hospital association to assert that any nurse would walk over a patient in order to leave after her shift, is an insult to every nurse. Nurses have traditionally gone over and above the call of duty to provide quality patient care.

Truly voluntary extra hours again are not issues to raise for your consideration and assistance, but rather the quantity and practice of holdovers as they exist at UWHC are a bad practice. We urge you to support SB211 as written. It would go a long way to providing safe care for our aging citizens of Wisconsin who are cared for by an aging RN workforce, in facilities that have no staff-patient ratio or acuity controls to limit the RNs case load per shift.

Thank you for your time and attention to this matter. Should you have questions, I would be glad to address them.

Ann Louise Tetreault, RN
UW Hospital & Clinics Authority
D6/4 Geriatrics/GMED/Schilling Hospitalist Unit
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Phone: (608) 231-3196

isconsin
ate Council

SEIU
Stronger Together

Senate Labor and Agriculture Committee
Madison, October 17, 2001

Testimony of Robert Kraig, Ph.D.
Political Director, SEIU Wisconsin State Council

SB 211: Mandatory Overtime for Health Care Workers

I want to thank Chairman Hansen for the series of hearings you have held on this issue.

My name is Robert Kraig, and I am the Wisconsin Political Director for Service Employees International Union (SEIU). SEIU is the largest health care union in North America, and the largest and fastest growing union in the national AFL-CIO. In Wisconsin, SEIU represents thousands of health care workers who would be affected by SB 211

In Green Bay I talked with you about some of the major objections to this bill that have been raised by opponents. What I would like to do today is to briefly respond to some of the additional objections that have been made since that hearing, especially during the 5 ½ hour hearing last week on the companion bill (AB 457) before the Assembly Health Committee.

Claim: *It is not the role of government to tell hospitals what staffing practices they should follow.*

Answer: This may have been the prevailing view in the 19th Century, but in the 21st Century it is well accepted that government, as the representative of the people, has a responsibility to regulate private entities when they act in a way that is egregiously contrary to the public interest. This is especially the case for vital services that the public relies on for its basic needs, such as health care institutions.

Few would argue that we should repeal governmental requirements on the books limiting the hours of airline piolets and truck drivers–although one hospital administrator did defend this course of action in Janesville. The work of direct care health care workers is as critical as that of truck drivers and airline pilots. An exhausted nurse can be just as risky as a tired truck driver.

Specifically on the mandatory overtime issue, it is ironic that the hospital association would complain about the allegedly heavy hand of government

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mandates, when many of them have so irresponsibly mandated their nurses and other health care workers to work unsafe hours.

As public servants you should look beyond all the glittering generalities, and keep in mind that hospitals are large (publicly funded) private bureaucracies whose interest are not identical to the public interest. To be sure, hospitals provide a invaluable public service, and are on the whole a great benefit to society, but when their own imperatives come into conflict with the public interest, it is the right and responsibility of elected leaders to step in and create basic ground rules.

Claim: *Before the Assembly Health Committee, the hospital association cited a study by our International Union, SEIU, that medical errors were more closely related to short staffing than hours worked. They concluded from this that banning mandatory overtime would increase medical errors.*

This claim is based on chop logic of the worst kind because it takes a study which supports staffing reform (which the hospital association is vehemently opposed to) to justify a practice that is aggravating the staffing shortage.

This argument points up a gaping hole in the hospital association's argument. Despite overwhelming evidence, including studies this year by the GAO, the University of Pennsylvania, and even a hospital credit reporting firm, that nurses are leaving bed side care in droves because of poor working conditions, they insist on assuming that hospital staffing is a zero sum game, that is that the only way to increase staffing is to train more nurses.

The evidence is overwhelmingly that the problem is the other way around. Poor working conditions have caused a retention crisis, and training more nurses alone will not solve the problem because they will not be retained in sufficient numbers because of mandatory overtime and other poor working conditions. Hospitals are moving in the direction of for-profit nursing homes, where all the new nurse aides in the world cannot overcome their 94% turnover rates.

Some hospital witnesses have chided that we cannot simply act on the faith that nurses will return to the bedside after the state bans mandatory overtime. What they fail to acknowledge is that if something is not done, nurses will continue to leave the profession and the staffing crisis will grow worse. This will lead to a spiral of more mandatory overtime, and more staff turnover, that will be much harder to break down the road. As I discussed last time, by the numbers Wisconsin has yet to feel the full brunt of the nursing shortage. Now is the time to take preventative action.

The hospital association has to date offered absolutely no response to the evidence of a retention crisis, and have offered no proposals aimed addressing the crisis in nursing work conditions. On retention and working conditions, to quote a former college professor of mine, the hospital

association has been "significantly silent."

I want to thank the committee again for taking testimony around the state on this critical issue. I will be happy to answer any questions you may have.

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UNITED PROFESSIONALS, LEADING THE WAY TO QUALITY HEALTH CARE

Testimony of Dian Palmer, RN
President, SEIU District 1199W/United Professionals

Senate Labor Committee
October 17, 2001

SB 211: Prohibition on Mandatory Overtime for Health Care Workers in Non-Emergency Situations

My name is Dian Palmer. I am a registered nurse, and I am president of the largest union of health care professionals in Wisconsin–SEIU District 1199W/UP.

I want to thank Chairperson Hansen, and the members of the Labor Committee, for conducting this important hearing.

Mandatory overtime has rapidly become a burning issue for nurses because of major changes in the way hospitals and other health care facilities are operated. Beginning in the 1990s, the "down-sizing" theories that had swept through many industrial sectors reached the hospital industry. In a deliberate attempt to cut costs, many hospitals thinned out their nursing staffs. This trend began on the coasts, as bad things often do, but it had reached many Wisconsin hospitals within the last few years.

The burden of this shift in management philosophy has fallen most heavily on nurses, who, as anyone who has spent any time in a hospital knows, provide the bulk of hands-on patient care. At the same time, acuity rates have increased substantially, putting additional pressure on already over-stressed nursing staffs.

One of the results of this deliberate thinning of nursing staffs has been an increased dependence on mandatory overtime. While mandatory overtime had been traditionally used only during extreme emergencies, an increasing number of hospitals now use it as a regular practice to fill permanent holes in their staffing schedules. The hospital association claims that mandatory overtime is rare, and yet hospitals are not required to keep or publish any statistics on mandations. The testimony of thousands of nurses throughout the state, and the hospital association's vehement opposition to this bill, both say otherwise.

The dramatic deterioration of working conditions has driven many nurses out of the profession, and many others into non-direct care settings. I can tell you, from personal experience, that acute care nursing was very stressful and difficult even before hospital restructuring took place. When I came out of nursing school 21 years ago, I began my career in a healthcare setting. I worked at a nursing home and later at Froedtert Hospital. Although I found the work rewarding, it was much more demanding than I ever imagined. The increased acuity levels of patients, along with the physical demands and increasing patient loads, left me physically and mentally exhausted at the end of the workday. I saw no immediate relief from hospital administration. I therefore chose to leave Froedtert Hospital and bedside nursing.

Today, with shorter staffing and the increasing use of mandatory overtime as a regular staffing strategy, the stresses on acute care nurses are much more severe than they were when I worked at Froedtert. Mandatory overtime is literally driving nurses out of the profession, and into non-direct care settings. Recent studies by the federal government, major universities, and even a report by a hospital credit reporting firm, have shown that oppressive working conditions have prompted tens of thousands of nurses to vote with their feet, either by seeking non-direct care nursing positions or leaving the professional altogether. A record half-million nurses are not even using their licenses. Even worse, according to a study by the University of Pennsylvania one in three nurses under 30 years of age plan to leave the profession within the next year because of unbearable working conditions.

A ban on non-emergency mandatory overtime treats the primary cause of the nursing shortage--the deterioration of working conditions. To stem the nursing shortage, hospitals need to focus on retention, and the best way to do that is to improve working conditions. Limiting mandatory overtime would be a major step in this direction. As the *Chicago Tribune* concluded in a major investigative series on hospital care last year: "Hospitals across the country regularly blame the shortage of nurses for staffing deficiencies, but in reality, there is more often a shortage of nurses willing to work in hospitals. Deteriorating oppressive working conditions–from mandatory overtime to stagnant pay–have made hospital jobs less appealing...Mandatory overtime and 16-hour shifts have driven many nurses away."

Hospital administrators claim that mandatory overtime is rare, and is only used in emergency situations. If this is really true, opponents should not oppose the bill. All SB 211 does is codify this practice, allowing mandatory overtime exclusively in unforeseen emergencies. The bill will affect only hospitals that use mandatory overtime as a regular staffing practice. As a union that represents hospital workers in Wisconsin and throughout the country, we see a wide variance between different hospitals. Some hospitals have used a variety of creative practices to virtually eliminate mandatory overtime. Others have been far less responsive to the problem, relying on forced overtime as a replacement for sound and sustainable staffing practices.

Critics of this bill propose programs to train more nurses as the "real" solution. This is convenient for the hospitals because it does not focus attention on their own operations. As the hospitals would have it, the nursing shortage is a product of environmental factors beyond their control, and they are the passive victims. In fact, much of the nursing shortage has been brought on by shortsighted management practices.

Recruitment alone is a patently incomplete response. If working conditions are not improved newly trained nurses will not be retained. As nursing expert Suzanne Gordon has recently written: "Veteran nurses and even recent nursing graduates are discouraging others from entering the field and even advising nursing students to get out of bedside care as soon as they can. Without substantive changes in working conditions, luring more people into the profession will aggravate, not alleviate, the situation and encourage the "management by churn" that has reduced customer service quality in fast food, retail sales, and telemarketing, where the consequences are far less serious for customers than in health care."

Some hospital administrators assert that SB 211 will endanger patients. This claim is obviously entirely inconsistent with the claim that mandatory overtime is rare, and only used in emergencies. It is also an insult to nurses, who are well known for volunteering to work extra during emergency situations. SB 211 bans only mandatory overtime, not voluntary overtime.

Moreover, there is still time in Wisconsin to improve working conditions without creating an immediate shortage of available nurses. Numbers from a recent General Accounting Office study released earlier this year, and from a workforce study released by the Wisconsin Health and Hospital Association in September, demonstrate that the nursing shortage has not yet hit Wisconsin as it has the rest of the country. According to hospital association, vacancy rates in Wisconsin hospitals are nearly half the national average. This means we have time to get at the root causes of the shortage, by improving working conditions.

In addition to aggravating the nursing shortage, as other witnesses will point out today, mandatory overtime is a practice that is very dangerous for patients. Fatigued nurses are much more likely to make errors, or to miss subtle changes in the condition of patients. Although 75% of hospitals do not report medical errors, a major federal study found that as many as 98,000 people die each year as a result of medical errors in hospitals.

In closing, I urge you to support this common sense piece of legislation. Forced overtime is a dangerous and self-defeating practice. The nurses of Wisconsin are looking to you to demonstrate leadership on this vital issue.

Dian Palmer, RN
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DISTRICT 1199W/UP

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UNITED PROFESSIONALS FOR QUALITY HEALTH CARE

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UNITED PROFESSIONALS, LEADING THE WAY TO QUALITY HEALTH CARE

Testimony of Darlyne Jacobson, RN, BSN
Member of SEIU District 1199W/UP

Before the
Senate Labor Committee
SB211: Prohibition on Mandatory Overtime for Health Care Workers

October 17, 2001

I have heard the Wisconsin Health and Hospital Association say that some care is better than no care.

I have heard Hospital Administrators say that they are using (creative) management tools to fulfill staff schedules other than mandatory overtime, yet still insist that mandatory overtime be left as an option.

I have heard a personal account from a woman who feared that care for her severely ill sister may not have been available if not for mandatory overtime.

I have heard (and can understand) that Hospital management wants assurance that patient care will be provided.

I have not heard Hospital managers discuss the implications of forced overtime on patient care and safety, and I have not heard them trust the professionalism of nurses.

Hospital management has stated that they need an assurance of patient care provision, however, they are forgetting the training, duty and the scope of practice that an RN carries. RN's are the leading advocate for patient safety. Our core is that of compassion and empathy. We are accountable to the patient and their families. Our scope of practice dictates that we must protect the safety of our clients. Patient advocacy, patient safety, public policy has been a part of our vocabulary and duty long before it became fashionable for doctors and administrators. We will not leave the side of a patient's bed, nor can we tolerate the abuse of mandatory overtime used by management.

The continued use of mandatory overtime to fill holes in the schedule is the result of poor management. This will continue as long as it is legal. If hospital administrators say that they have developed other ways to cover the schedule and that they value their employees, then why be afraid of a bill that protects against abuse of forced overtime and thus the safety of our public? This bill is about mandating those institutions with poor administrators to be more creative, to find another solution, and perhaps collaborate with nurses.

The public needs to be aware of what mandatory overtime means to them. Use and abuse of mandatory overtime places great strain on the nurse resulting in increased stress, fatigue, frustration and anger. These elements are not conducive to patient care. Patient care in this environment could define the "some care is better than no care" that satisfies the Hospital Association. However for the nurse and the patient, this translates to substandard care. Today the acuity of patent care admitted to the hospitals dictates a minimum of adequate care. Furthermore, if it was your mother, son, or grandfather, you would demand excellent care.

Substandard care from forced overtime causes medication errors, reduction in critical thinking and effective decision-making and decreased communication with the patient and family. This has jeopardized patient safety in the past and will continue to do so in the future.

This is the red flag that I am sending to the public. Because mandatory overtime is legal, hospital management will continue to use it as a means to provide patient care. This creates patient care that is substandard and it affects the basic needs of our society.

Because hospitals administrators refuse to acknowledge our professional concerns, nurses are now turning to the government. Our state must now hear the plea to stop the practice of mandatory overtime, to not only to protect the nurse from unfail labor practices, but to ensure the most prudent of public policy, our safety.

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UNITED PROFESSIONALS, LEADING THE WAY TO QUALITY HEALTH CARE

Testimony of Marian Stokes, RN, BSN
Member of SEIU District 1199W/UP

Before the
Senate Labor Committee
SB211: Prohibition on Mandatory Overtime for Health Care Workers

October 17, 2001

It's 2:30 in the afternoon. You've been working since 7 a.m. It's been a busy day, 6 now 7 patients – 2 discharges, 3 admissions; one of your patients is total care , including feeding; another patient spiked a temp and is now on IV antibiotics. You grabbed a quick 10 minute lunch in the break room. Guess you didn't need a bathroom break because you didn't take one. Now, at 2:30 there is a tap on your shoulder. Your unit is short two nurse for the evening shift; you are told you have to stay. Now your workday is suddenly 7 to 11:30 instead of 7 to 3:30. No one volunteered to stay and it's your turn to be mandated. The supervisor didn't ask "are you up to it?" or "do you have child care problems?" or " do you have other commitments?". The patients were not told that their nurse has already worked 8 hours and is now working a second 8 hours.

This scenario is played out over and over again in our hospitals: Day to evening shift, evening to night shift, and even night to day shift. The issue of how safe is that nurse in his/her 2nd 8 hours is not asked by management: How are his/her assessment skills in the 12th, 13th and continuing hours? Is he/she remembering all the medications for the patients? Is he/she remembering to check the dosages? Are the patient's physical and emotional needs being met? What if that nurse makes a mistake? What if he/she is too exhausted to notice a change in a patient? In that 16th hour no one can be as sharp as in the 1st 8 hours.

The issue of licensure is not dealt with. What happens if there is a mistake? The nurse's license is on the line. The nurse has legal responsibility. It could mean his/her job; it could affect him/her professionally for life.

The issue of what else is going on in that nurse's life is not asked? Maybe there is a latchkey child at home for much longer than the usual 20 minutes; maybe there is an infant or toddler in

daycare to be picked up; maybe that nurse has a night class which now will be missed; maybe that nurse was tired or didn't feel well but came to work thinking he/she could manage 8 hours.

The issue of how repeated mandates can cause burnout is not dealt with. We currently have a nursing shortage, both in our state and nationwide. Since the age of the average nurse is in her 40's, it will only get worse. Driving new young nurses out of nursing through burnout caused by mandates, job stress, and poor hours can only exacerbate the problem – and it is the new nurses who face mandates much more frequently.

There are limits to the number of contiguous hours a truck driver can drive. There are limits on the hours of flight crews. Why not put limits on the hours of nurses? On a hospital unit, the nurse is the eyes and ears for the physician, notifying the doctor of significant changes. He/she is the hands carrying out prescribed treatments. He/she is the advocate for her patients, in a complex health care system. How can these life and death responsibilities be carried out by exhausted staff? How can judgment skills be clear after 12, 14, 16 hours?

When the family leave law was passed, many in the business community said that it would drive them to bankruptcy? It did not. Businesses found instead that it helped to retain good employees who had a temporary family crisis. The hospital association and its hospitals will say that they have to be able to mandate nurses to staff the hospital. That is because there has been no effort to find other solutions. Some solutions are obvious: if the hospital is short 20 nurses on a daily basis, there needs to be hiring. Other problems, such as wildly unpredictable changes in patient census, will require more creative, thoughtful solutions. Hospitals and nurses working together can do this. What we need from you, the Senate, is the line in the sand saying that mandates are banned; saying that hospitals working with nurses will find a better way to provide safe, good care for patients.

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TO: Senator Dave Hansen, Chair and Members of the Senate Labor Committee
FROM: Gina Dennik-Champion MSN, RN, MSHA
Wisconsin Nurses Association Executive Director
DATE: October 17, 2001
RE: Support for SB 211 - Banning of Forced Overtime for Health Care Workers

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Good afternoon Chairperson Hansen and members of the Senate Health Committee. My name is Gina Dennik-Champion. I am a registered nurse and Executive Director of the Wisconsin Nurses Association (WNA). I am here today to share WNA's support of SB 211 and the companion bill AB 457 - Banning of Forced Overtime for Health Care Workers.

Inappropriate staffing is the number one concern of nurses today. Nurses already face great stress and challenges on the job — they are expected to care for greater numbers of patients than ever before. These patients in hospitals, nursing homes, home care and other settings, are more acutely ill than in the past thus requiring greater nursing care and supervision. At the same time, we have seen the continuation of increase in cost controls implemented by health care organizations and with that decisions that directly effect the number of patients assigned to the nurse. Nurses are trying to respond to these cost control decisions which have a direct impact patient care. Having said that, comes another significant variable impacting patient care outcomes related to nursing services. I am referring to the increase use of mandating nurses to work shifts beyond what was scheduled — that is up to 16 to 20 hours at a time. There is also the expectation that this same nurse will report to work the next day to work his/her next scheduled shift. This cost saving measure does not put the patient first.

WNA supports a health care system that provides quality health care that is accessible to and affordable for all Wisconsin residents. We support quality health care services and systems that promote patient protection. It is the view of WNA that when the health care system fails and patient safety is put at risk, legislation may be necessary to improve the safety system. I want to tell you that patient safety is at risk. Right now we have physically fatigued RN's, emotionally fatigued RN's, and/or mentally fatigued RN's being forced to work additional shifts. Fatigue impacts the ability to perform skills and critically think and reason. These are essential performance requirements the RN needs to demonstrate as part of his/her competence. These skills and abilities are what is necessary for safe patient care. Forcing tired nurses to work excessive hours compromises patient safety.

We have heard about recent emphasis on addressing and reducing errors among health care practitioners, including nurses, through examination and improvement of systems. One can easily surmise that improving safe patient care requires nurses who are alert, competent, and able to execute the sophisticated thinking, decision making and technical skills that are necessary to

deliver quality care.

My question to you is how does forcing the RN to work an additional 8, 10, 12 and even 20 hours, when he/she is stating that she cannot, support patient safety? How does forcing a 46 year old single parent who is balancing other life responsibilities such as parenting and/or caring for an older parent(s) support patient safety? How does the employer discounting the professional judgement of the RN who is stating I cannot work extra support patient safety? The answer to all three of these questions is that it does not. Our patients deserve better. They come to us vulnerable and trusting. They trust that the care they receive is being delivered in an environment that respects the integrity of the worker, the mission of the institution and supporting safety. It is not okay to mandate extra hours despite objection and risk of harm but it is okay to legislate the banning of forced overtime because it ties the hands of the employer.

The legal liability issues for the RN also come into play when being forced to work additional hours. When the RN accepts a patient assignment either voluntarily or forced, and a negative patient outcome results, the nurse remains personally and legally responsible, accountable and liable for that outcome under his/her license. Once a nurse accepts the forced overtime assignment, their license to practice is in jeopardy.

Supporting SB 211 is good for patients and good for nurses. SB 211 accomplishes the following:

1. It puts the patient first by promoting patient safety.
2. It allows the RN to say no to overtime requests without fear of retaliation.
3. Nurses will continue to "rise to the occasion" when unforeseen circumstances exist for the employer and the need to stay over arises.
4. No health care professional should have to be put into the situation choosing if I work and I cause harm I loose my license. If I say no and reject the mandatory assignment I can loose my job and with that health insurance, my pension and other benefits I have worked hard for.
5. SB 211 forces the employer to utilize other solutions such as use of outside agencies, in-house pool, canceling elective surgeries, closing beds, diversions to other hospitals, and using monetary bonuses to encourage part time nurses to pick up extra shifts and involvement of nursing staff to address lack of adequate staff issues.

WNA would like to thank Senator Judy Robson for sponsoring SB 211 and thank Representative DuWayne Johnsrud for sponsoring AB 457. I also want to thank those members of the Health Committee who have signed on in support. I respectfully request that this bill be voted out of committee and passed. It is the position of WNA that failure to do so supports the assumption that our health care system is okay the way it is. That is, patient safety can be compromised and that a "warm body" is better that no body. Such deception should not be tolerated.

Thank you for providing me the opportunity to present WNA's position today. I will gladly answer any questions or concerns you may have.

Wisconsin Association of Homes and Services for the Aging, Inc.
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October 17, 2001

To: State Senator Dave Hansen, Chair
Members, Senate Labor and Agriculture Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: **WAHSA Opposition to 2001 Senate Bill 211, The Mandatory Overtime Ban Bill**

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving elderly and disabled persons. Membership is comprised of 197 religious, fraternal, private and governmental not-for-profit organizations which own, operate and/or sponsor 154 private and 47 county-operated nursing facilities, 65 community-based residential facilities, 32 residential care apartment complexes, 95 senior housing complexes, 26 facilities for the developmentally disabled, 10 licensed home health agencies, and over 300 community service agencies which offer programs ranging from Alzheimer's support, child daycare, hospice and home care to Meals on Wheels.

WAHSA's not-for-profit members oppose SB 211 and its Assembly companion bill, AB 457. Our members, who are leery of any legislative solution to a business management problem, believe that if mandatory overtime for health care workers is to be prohibited, there should be three exceptions to that prohibition: 1) In order to protect the health, safety and welfare of facility residents/patients; 2) In order to comply with federal or state staffing requirements; or 3) In order to adhere to provisions in a collective bargaining agreement.

At the outset of our position statement, we would like to state our belief that virtually everyone who has an interest in these bills, either in support or in opposition, concurs that mandatory overtime is something to be avoided if at all possible, that it exacerbates the health care worker shortage situation and may threaten quality care. However, we believe the method chosen under SB 211/AB 457 to rectify this problem does not offer a solution.

Indeed, the entire premise upon which SB 211 and AB 457 is based was summed up in one sentence from a September 17, 2001 letter on SB 211 to Senator Hansen from the author of AB 457, State Representative DuWayne Johnsrud (R-Eastman):

"Mandatory overtime is one of the causes of an escalating shortage of health care workers in this state, not a symptom," wrote Representative Johnsrud.

This very statement is the basis for our opposition to SB 211/AB 457 because we believe mandatory overtime, in fact, is a symptom of the health care worker shortage disease. The problem with SB 211/AB 457 is both bills treat the symptom while their proponents assume that will be enough to cure the disease; WAHSA members, who have been battling this labor shortage for years, say it won't.

In order for these bills to make any sense, proponents must argue (and, we believe, prove) that health care facilities intentionally use mandatory overtime as a tool to avoid hiring the additional staff needed to provide adequate, if not quality, care. In other words, facilities are spending money to pay for mandated overtime in order to make money overall through lower staffing costs, and hoping that the staff mandated to work overtime will be able to uphold the quality of care at their facilities. We think there are serious flaws to that argument:

1) If mandating staff overtime were anything other than a response to a staffing emergency, paying time-and-a-half or double time to current staff for their overtime work would dilute most of the supposed economic incentive to mandate overtime. The savings would be negligible, if there were savings at all.
2) Nursing homes are subject to fines and forfeitures of up to $10,000 per day for violations of state and federal codes and statutes pertaining to quality care. CBRFs are subject to fines and forfeitures of a lesser level and to other intermediate sanctions if they are found to be providing poor care. In both cases, the State has the power to revoke their licenses for care violations. Proponents of SB 211/AB 457 must assume providers are prepared to accept those economic risks in order to control their staffing costs. WAHSA members see this more as a road to economic suicide.
3) Nursing homes must meet minimum staffing level requirements outlined under s.50.04(2)(d), Wis. Stats., in addition to federal requirements under Sections 1819(b)(4)(A)(i) and 1919(b)(4)(A)(i) of the Social Security Act. CBRF staffing requirements are found under HFS 83.15(1)(a), Wis. Adm. Code. For residential care apartment complexes, staffing requirements are spelled out under HFS 89.23(1), Wis. Adm. Code. Our concern is a situation where a facility's only option to meet these staffing requirements is the use of mandatory overtime. If SB 211/AB 457 were to pass, facilities may be placed in the untenable situation of complying with the mandatory overtime law but, by doing so, failing to comply with statutory/code staffing requirements, or vice-versa.
4) Committee members should ask themselves if it makes any sense for the health care industry, or any other industry, which is facing a severe staffing shortage, to intentionally maintain a business practice (i.e., mandatory overtime) which will drive current staff away and possibly hinder the recruitment of new staff. If you agree with us that this is a dubious business practice, then why else would an industry invoke the use of mandatory overtime other than to address an emergency?
5) Proponents of these mandatory overtime bills must operate from the premise that those in the business of providing health care are really in the business of making money and their interest in the well-being of their staff and residents is only secondary. Such cynicism is truly disturbing. Do committee members truly believe it?

Health care providers which do mandate overtime argue it is the course of last resort that is implemented only when the staff needed to fill necessary positions cannot be found. They state that to ensure quality care at a time of a health care worker shortage, they rely on mandatory overtime when all else fails. Mandatory overtime is driven by the worker shortage, not the other way around.

To disprove this, it would appear proponents of SB 211/AB 457 must prove that qualified health care staff are available in today's marketplace but providers simply have chosen not to hire them. WAHSA members believe they'll have a difficult time doing so.

1) The final report on labor shortage of the Private Sector Discussion Group of the Legislative Council Special Committee on Labor Shortage earlier this year identified three sectors of the Wisconsin economy which are experiencing worker shortages: the construction, service and health care industries.
2) The United States General Accounting Office (GAO) provided May 17, 2001 testimony to the U.S. Senate Health, Education, Labor and Pensions Committee entitled "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern." In its testimony, the GAO stated: "With the aging of the population, demand for nurse aides is expected to grow dramatically, while the supply of workers who have traditionally filled these jobs will remain virtually unchanged. According to the Institute of Medicine, advocacy groups, and provider associations, a serious shortage of nurse aides already exists." The GAO indicated that in 1999, 30 states were addressing nurse aide recruitment and retention through task forces, initiatives and research.
3) A survey of 257 Wisconsin nursing homes in December 2000 found: 15.9% of budgeted CNA positions were vacant; 15% of budgeted LPN positions were vacant; 14.5% of budgeted RN positions were vacant. Slightly over 31% of the nursing homes responding to the survey (80 out of 257) indicated they had denied admissions to their facility in the last 6 months because of insufficient staff to provide care, a course of action no facility willingly takes.
4) There were four full pages of "Health Care" want ads in the10/7/01 Wisconsin State Journal. Of the 92 total listings, we estimate that over half of those ads were from "health care facilities" as defined under s.146.999(1)(b) of SB 211/AB 457 for "health care workers" as defined under s.146.999(1)(c) of both bills.

From the health care provider's perspective, the situation is this: We can't find the staff needed to care for the people we serve. If we cannot use mandatory overtime as a last resort, who will care for our residents/patients?

We have described to this point our philosophical opposition to mandatory overtime legislation. The following are our specific problems/concerns with SB 211/AB 457:

1) Unless "except in cases of 'unforeseeable emergency' in which a health care facility has first exhausted 'all other options' " under s.146.999(2) is defined or further clarified, enforcement of this bill will be an administrative nightmare and a certain vehicle for litigation. Indeed, we would argue that in most instances, an emergency which warrants mandatory overtime is foreseen but unavoidable. That is why we suggest that if mandatory overtime is to be prohibited, that prohibition would not apply if mandatory overtime were used to protect resident/patient health, safety and welfare, to comply with federal/state staffing requirements, or to adhere to provisions contained in a collective bargaining agreement.

2) The bill will be extraordinarily costly, as indicated by the 9/10/01 DHFS fiscal note alone. However, WAHSA members believe this fiscal note is only the tip of the iceberg: the 7/26/01 Department of Veterans Affairs (DVA) fiscal note is even more telling. Points #4 and #5 of the DVA fiscal note indicate that the vast majority of overtime hours will have to be contracted out to "pool agencies" if mandatory overtime is eliminated. That is exactly what will happen to the remaining 450 nursing homes in the state, or at least those which need overtime hours but can't convince current staff to volunteer for those overtime hours. If mandatory overtime is eliminated and the use of "pool help," which is generally 1½ to double the hourly cost that FTEs are paid at a facility, is one of the "other options" that first must be exhausted under SB 211/AB 457, imagine the true fiscal effect of these bills to the Medicaid program for all nursing facilities, not simply the three Centers for the Developmentally Disabled and the Veterans Home at King.

3) Not only is the use of "pool help" costly; it negatively impacts staff morale, resident continuity of care and ultimately the facility's quality of care. Health care facilities seek to avoid "pool help" at all costs; SB 211/AB 457, however, most assuredly will increase the utilization of "pool help." Ironically, our friends in organized labor who historically have fought long and hard, and justifiably so, to curtail the use of pool agencies are supporting legislation which invariably will lead to greater reliance on pools.

4) How prevalent is the use of mandatory overtime? WAHSA conducted a survey of its membership during this past summer to answer that question. As of 9/10/01, there were 76 respondents: 52 indicated they did not mandate overtime (68.4%); 24 indicated they did have a mandatory overtime contract provision (31.6%), although only one-third of those facilities indicated they have invoked that provision. Those that have invoked mandatory overtime all stated they only use it when voluntary overtime fails to meet their staffing requirements and they apply it in reverse seniority.

5) Of the 24 facilities in the WAHSA survey which indicated they have a mandatory overtime clause in their contracts, health care workers in 21 of those facilities are represented by organized labor. Mandatory overtime is a bargainable item in the contracts of 15 of those facilities. The question then becomes: If mandatory overtime is a bargainable item that ultimately winds up in a contract, doesn't that assume the workers and the union that represents them at a given facility had higher priorities? And is it an appropriate role of the Legislature to become indirect participants in the collective bargaining process?

6) The 24 WAHSA members (15 of which are county facilities) which have a mandatory overtime clause were asked what impact the elimination of mandatory overtime would have on their operations: 12 said there would be a greater reliance on "pool agencies;" 9 indicated they would be forced to curtail admissions.

7) We concur with proponents of SB 211/AB 457 who argue that mandatory overtime has a negative impact on staff retention. However, we believe this issue is one of staff recruitment, that mandatory overtime is a last recourse but a direct result of facilities' inability to recruit staff, not retain staff. SB 211/AB 457 would have little, if any, impact on staff recruitment.

8) Proponents of mandatory overtime legislation argue that these provisions are necessary to protect resident/patient safety, that fatigued workers are much more prone to commit errors that could threaten the well-being of residents/patients. But SB 211/AB 457 do not prohibit overtime, only mandatory overtime. Are we to believe, then, that staff which volunteer to work overtime, which is allowed under both bills, present less a threat to resident/patient safety than those who are mandated to work overtime? Is fatigue less a factor to those who want to work overtime? And if we truly wish to protect resident/patient safety, why aren't doctors covered under the SB 211/AB 457 overtime prohibitions?

9) Is legislation such as SB 211/AB 458, which impacts so many health care facilities, truly necessary when the real problem appears to be between a few hospitals and the unions which represent their workers?

10) If a facility has vacant positions which it has made a good faith effort to fill but failed, and current staff is unwilling to voluntarily work overtime, can a facility implement mandatory overtime under SB 211/AB 457? Who will determine and define what a good faith effort is? And if this good faith effort is not sufficient to enable a facility to use mandatory overtime under SB 211/AB 457, who will care for the residents/patients in that short-staffed facility?

For information contact: Diane Peters or Matt Sande
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Will Wisconsin have enough health care workers in the future?
The answer is yes, if we work together and start now

THE PROBLEM:

A national shortage of qualified workers greatly affects the ability of those serving in the field to care for the nation's women, men and children. If nurses, physicians, respiratory therapists, medical technologists and scores of others who take care of our nation's ill and injured are not available, our mission will be threatened. While hospitals are recruiting to fill positions in many departments, the most visible shortage is a lack of nurses needed to provide critical bedside care.

WHAT ARE WE DOING NOW

- In Wisconsin, 52 hospitals joined with the Wisconsin Health and Hospital Association to sponsor a multi-media campaign to attract new workers to health care professions. The first phase of the campaign, implemented in September 2001, focused on attracting students and young adults between the ages of 13-27 by placing 30 second television ads on programs that appeal to that young age group. (See press coverage of this campaign in *Wall Street Journal* article and state dailies, included in this packet.)
- WHA established a coalition of health care organizations to address the workforce shortage. (See list of participants in packet.)
- WHA collaborated with the Bureau of Health Information (BHI) to conduct a statewide health care workforce survey, the results of which are included in two handouts contained in the packet. This survey will be repeated in October 2002.
- WHA, in collaboration with the Governor's Work-based Learning Board, expanded the Healthcare Youth apprenticeship programs in 37 additional hospitals over the last 12 months.

- In collaboration with the Wisconsin Nurses Association, the Nursing Home Association, BHI, DWD, and the Department of Regulation and Licensing, an in-depth analysis of current RNs in Wisconsin is under development for implementation in November 2002.
- WHA is working with the Technical College Board and health care deans on a health occupation program.
- In collaboration with the Wisconsin Society of Healthcare Human Resources Administration, the Wisconsin Organization of Nurse Executives and the Wisconsin Nurses Association, WHA is implementing a retention strategy. The West Central Workforce Development Council received a federal grant to form a health care alliance to address shortages in western Wisconsin.

The public's demand for the highest quality patient care at the lowest possible cost has come face-to-face with the tightest labor market in the past 30 years. A recent survey of AHA members revealed that hospitals have up to 168,000 open positions – 126,000 of those positions, or 75 percent, are for registered nurses. Vacancy rates among hospital staff are:

- 21% for pharmacists
- 18% for radiological technicians
- 12% for laboratory technicians
- 11% for registered nurses

Today's staffing shortages are affecting access to care. Some hospitals are being forced to reduce the number of inpatient beds available, postpone or cancel elective surgeries, and tell ambulances to bypass their overflowing emergency departments.

THE PAPERWORK BURDEN

Nurses, and everyone involved in health care delivery are spending an increasing amount of time and resources on regulatory paperwork, which takes valuable time away from patient care. The current regulatory environment buries dedicated employees in bureaucratic paperwork.

- A recent study by PricewaterhouseCoopers found that every hour of care in the emergency department requires one hour of paperwork.
- Every hour of care for surgery and acute inpatient care requires 36 minutes of paperwork and every hour of home health care requires 48 minutes of paperwork.

RECRUITMENT AND RETENTION STRATEGIES: WHAT WE ARE DOING NOW

To overcome this shortage, hospitals are employing innovative recruitment and retention strategies. Along with other health care facilities around the country, we are looking at a variety of options to retain our current staff while we attract new employees. Hospital administrators report using a number of incentives to minimize their current shortages.

- **In Wisconsin, hospitals are spending millions of dollars to retain their workforce by offering increases in pay, more flexibility in scheduling, and tuition reimbursement programs.**

CONCLUSION

We have a critical shortage of women and men serving in health care. Before it becomes a greater crisis, we must work together toward solutions that allow us to continue our mission of providing high quality and compassionate care to all Americans.

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WHCA
Wisconsin Health Care Association

TO: Senator Dave Hansen, Chair, and Members of the Senate Labor and Agriculture Committee

FROM: Jim McGinn, Wisconsin Health Care Association (WHCA)

DATE: October 17, 2001

RE: Opposition to Senate Bill 211

The Wisconsin Health Care Association (WHCA) is a non-profit organization which represents the interests of 220 proprietary, non-profit, county and municipal nursing homes. Its' members employ over 27,000 dedicated workers and health care professionals who provide care to approximately 26,000 Wisconsin nursing home residents. Our member facilities offer a wide spectrum of services and settings to meet the needs of Wisconsin's frail elderly and disabled.

WHCA is opposed to SB 211, which prohibits a health care facility from requiring a direct care employee to work more than 40 hours per week without the employee's consent.

WHCA has always maintained that our state's frail elderly and disabled residing in long-term care facilities must receive the highest quality of care by a sufficiently staffed facility. Current federal nursing home regulations state that a "facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psycho- social well-being of each resident, as determined by resident assessments and individual plans of care." Thus, if facilities are not staffed adequately, they will be cited as violating federal nursing home regulations by state surveyors.

In addition, the Legislature recently (1998) increased the minimum staffing requirements that nursing homes provide at least a specified number of hours of service to residents by RN's,LPN's, and CNA's. Wisconsin Statute 50.04 (2) (d) identifies those staffing requirements. Also, Wi. Administrative Code DHFS 132 specifies the state staffing requirements for nursing homes, including the requirement that "there shall be adequate nursing personnel assigned to care for the specific needs of each resident on each tour of duty". Again, if facilities are not staffed adequately, they will be cited as violating state regulations by state surveyors.

Since current federal and state regulations clearly require facilities to staff appropriately to ensure that the residents we serve receive the proper outcomes, it is WHCA's belief that, notwithstanding the provisions in SB 211, our facilities are required to request overtime, seek "pool help", or provide staffing some other way that meets the needs of our residents.

If SB 211 is approved, nursing homes will be placed in the position of deciding which law to violate, the prohibition on mandatory overtime, or failure to comply with federal and state laws and regulations regarding staffing requirements. Since a violation of either law includes fines and forfeitures from $1,000 to $10,000 per day, nursing homes will be assessed and required to pay a fine, which contributes nothing to health, safety, and welfare of the facility's residents.

It is necessary for facilities to provide appropriate, quality care to our residents by a caring and competent work force. It is difficult for nursing homes to recruit RN's, LPN's, and CNA's to work in long-term care because of the hard work, long hours, and low pay. Recognizing the retention and recruiting problems confronting WHCA members, our facilities do not want to overwork or place undue stress on our employees. However, there is no doubt that all health care providers are experiencing worker shortages, and if nursing homes cannot find the staff needed to care for the residents we serve, who will care for our residents if mandatory overtime is prohibited?

It is WHCA's hope that the Committee will not recommend SB 211 for passage.

TO: Representative Hanson, Chair and Members of the Senate Labor Committee

FROM: Julie Fargen, R.N., BSN
Tiffany Richard, R.N., BSN

DATE: October 17, 2001

RE: Information related to the cross sectional survey conducted regarding the Prevalence of Mandatory Overtime for Health Care Workers

---

Good afternoon Chairperson Hanson and members of the Senate Labor Committee. My name is Tiffany Richards; I am a registered nurse, a full time graduate student, and I work part time for the Wisconsin Nurses Association. The person presenting with me is Julie Fargen. We are here to testify for informational purposes related to the cross sectional survey we conducted on the prevalence of mandatory overtime within the state of Wisconsin this year.

The purpose of our survey was to determine the extent and effects of mandatory overtime on staff nurses personally and professionally, and the reasons for its use in the state of Wisconsin.

The sampling frame was chosen from the list of licensed registered nurses in the state of Wisconsin, using simple random sampling. The questionnaire was developed with consultation from a survey research expert at UW-Madison School of Nursing. The first round of questionnaires was sent the week of August 1, using code numbers to permit follow-up on those individuals who did not respond to the first wave. The second wave was sent out the week of August 22 to all non-respondents.

Good afternoon Chairperson Hanson and Senate Labor Committee members. I am Julie Fargen, a registered nurse and graduate student from Viterbo University, and I am currently interning with the Wisconsin Nurses Association. I am going to present to you the results of our survey.

Of the 400 questionnaires mailed, 234 (58%) responded. Of the 234 respondents, 73 (31.2%) were ineligible because they did not provide direct patient care. The number of nurses who provided direct patient care was 160 (68.6%) of the total respondents. These are the individuals who might have experienced mandatory overtime.

A definition of mandatory overtime was provided to participants at the beginning of the survey. The definition was used, "when a health care facility requires that an employee work more than a work shift of 8, 10, 12 hours that has not been determined and agreed to before the performance of the work or to work for more than 40 hours per week without the consent of the health care worker". The investigators asked participants if the facilities in which they were employed used any other terms for mandatory overtime. 15.1% responded positively, the most common terms reported, "required overtime" and "scheduled overtime".

To determine the frequency of mandatory overtime respondents answered the question, how many times in the last two months have you been required to work mandatory overtime? The respondents were given four choices: none, 1-3, 4-6, 6 or more. One third of respondents (51), had been required to work mandatory overtime 1 or more times in the preceding two months. Of those, 12% (6) had been mandated 6 or more times in the preceding two months.

Of the nurses mandated 1-3 times within the last two months, 73.5% worked in the hospital, 17.6% were employed in a clinic setting, 5.9% worked in long term care, and 2.9% worked in other settings. Of the nurses mandated 4 or more times, 60% worked in hospitals, 13.3% worked in clinics, 20% worked in long-term care, and 6.7% worked in other settings. We then analyzed mandatory overtime by hours of operation of the employing facility. Of the individuals who were mandated 1-3 times in the last two months 26.5% worked in a facility that operated anywhere from 8-24 hours and 73.5% worked in a facility that had 24 hour coverage 7 days a week. Of the individuals who had been mandated 4 or more times, 26.7% worked in a facility that provided coverage from 8-24 hours and 73.3% worked in a facility that provided 24 hours 7 days a week coverage. In summary nurse working in hospitals or other health care facilities with 24 hours coverage tended to be more likely to experience mandatory overtime than nurses employed in other facilities although this finding was not statistically significant.

The circumstances respondents gave as resulting in mandatory overtime were call-ins (59.7%), high acuity patients (56.3%), and scheduling vacancies (45.4%). Other reasons given were mass casualties (24.4%), inclement weather (31.9%), and other

reasons (26.1%). Although some individuals indicated they had not worked mandatory overtime within the last two months, they listed circumstances in which mandatory overtime occurs. This may suggest that even more nurses are being mandated to work overtime than reported in the previous question, which inquired about the frequency of occurrence within the last two months.

Ramifications experienced by respondents when mandated to work overtime include, concerns about health (42%), and personal (44.5%), and emotional issues (33.6%). Examples of health ramification included, mental and physical exhaustion, increased back pain, and migraine headaches. Personal ramifications included fatigue, less time with family, lack of childcare options, and decreased time for self. Examples of emotional ramifications included decreased job satisfaction and increased stress at home and work. Professional ramification (16.8%) listed by respondents included: worry about decision-making skills that directly affect the patient and fear of making medication errors.

Incentives employers provided to cover vacancies in the schedule included monetary bonuses, such as increases in hourly wage or a lump sum bonus (35.5%). Other incentives listed, time and a half for greater than 8 hours or greater than 40 hours, flexible scheduling, use of agency staff. 28.3% of the respondents listed no incentive was offered to cover vacancies in the schedule.

The subjects were asked to list how important it was for facilities to address mandatory overtime at this time. Using a 7-point scale with one indicating not important and seven indicating very important, 82.4% of the respondents rated this issue above the midpoint of four. The (mode) or most frequently indicated number was seven and the (mean) or average was 5.69.

In conclusion, mandatory overtime is a concern voiced by nurses throughout the state. Nurses indicated through this survey that it is important for this issue to be addressed now. Mandatory overtime is affecting nurses' lives personally, their health and their emotional status, which is leading to increased stress and decreased job satisfaction. Professionally they are concerned about their ability to make good judgments that directly effect the patients they care for. Circumstances in which mandatory overtime most frequently occurs are call-ins, high patient acuity, and scheduled vacancies. Settings in which mandatory overtime most frequently occurs is hospitals and facilities which operate 24 hours per day. Generalizations may be made from this survey if we believe that the respondents from the randomly selected sample represent Wisconsin nurses. If we can infer that of the approximate 58,929 registered nurses in the state of Wisconsin, that 40,485 nurses provide direct patient care. Of this number if proportions remain constant, 32% have been mandated 1 or more times in the two months preceding the survey, which is approximately 12,955 nurses when results are extrapolated to the state as a whole.

WISCONSIN CATHOLIC CONFERENCE

TO: Honorable Members of the Senate Committee on Labor and Agriculture

FROM: John Huebscher, Executive Director

DATE: October 16, 2001

RE: Support for Senate Bill 211

The Wisconsin Catholic Conference encourages you to support Senate Bill 211 which limits the ability of health care facilities to impose mandatory overtime hours.

Catholic social teaching has reflected on the subject of work for over a century. One of the basic principles of this teaching is that work derives its dignity from the people who perform it. As such, we should always evaluate work in light of how it affects the worker.

This person centered vision of work was at the heart of the bishops' recent Labor Day statement, which challenged citizens of the state to reexamine the role of work in their lives and to strive through their work to "fulfill their potential, care for their families and contribute to the common good of society." As the bishops stated, "All people...are entitled by the fact of their humanity to work and to humane working conditions."

These rights extend to all workers including those in professions critical to health and public safety. The fact that the role of health care workers is a critical one does not justify subjecting them to working conditions that potentially undermine their personal safety and well-being. SB 211 protects health care workers while providing protections for patients to insure that their care is not compromised.

The Church operates a number of different kinds of health care facilities throughout the state. We recognize that there are many health care institutions in Wisconsin that work with employees to deal with staffing shortages and other issues of mutual concern. Ideally, issues such as conditions of employment should be dealt with collaboratively. In fact recent health care directives promulgated by the US Conference of Catholic Bishops state:

> *A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes:... a workplace that promotes employee participation; (and) a work environment that ensures employee safety and well-being...*

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At the same time, the Church recognizes that there is an appropriate role for government to play by defining and outlining just working conditions and terms of employment. In their Labor Day statement, the bishops revisit the historical teaching of Pope John Paul II regarding the concept of the "indirect employer" noting that:

> *While the role of those who own businesses and employ people is primary, these "direct employers" are not solely responsible for working conditions. Equally important are "indirect employers," or those institutions and agencies that influence and affect the work conducted within the whole socioeconomic system. Like other employers, "indirect employers" affect the way labor is organized and influence the formation of just or unjust relationships. Government exerts significant influence through the establishment and enforcement of just labor policies.*

Government has taken steps, for example, to establish a minimum wage, to require certain family leave benefits, and to set standards for overtime pay. If work is to affirm human dignity then it must respect the need for reasonable and reliable working hours.

In addition to considerations regarding the mental and physical well being of health care workers and those they serve, it is reasonable for government to consider the implication of extensive and unpredictable working hours on families. Society often places a higher value on the role of the individual as worker than it does on his or her role as parent. While work enables us to provide sustenance for our families, long and difficult hours potentially undermine family stability.

We recognize that there are pressing health care staffing shortages across the country. Our Catholic institutions know first hand the difficulties and challenges of these shortages. However, we also recognize that imposing working conditions that undermine the safety and well being of those who currently provide health care services will do little to address the problem and potentially exacerbate the situation. We believe that the current "emergency" provision in the bill provides a sufficient safety valve for situations in which institutions need employees to stay on to maintain the standard of care. If the proposed statutory language regarding "emergencies" is deemed insufficient, we would support modification of the language to enable health care facilities to meet the immediate needs of patients.

We appreciate your consideration of this legislation and look forward to the opportunity to work cooperatively with legislators and those in the health care profession to insure that our state's health care system has the capacity to serve all in need and that those providing services find that their work affirms their human dignity.

Wisconsin Health & Hospital Association

Wisconsin Health Care Workforce Policy Paper

[Draft Date 10/16/2001]

Economic Impact

The health service workforce is an important component of Wisconsin's economy. The Wisconsin Department of Workforce Development (DWD) identifies health services as one of the top three industries in Wisconsin that are expected to account for one in every three new jobs in Wisconsin between 1998 and 2008. DWD identifies that the need in Wisconsin for a growing health service workforce is due to an increasing elderly population and advancement in acute and chronic medical treatments.

DWD projects that the health service industry will account for a projected 270,430 jobs by 2008, an increase of 45,530 jobs (20.2% growth) from 1998 to 2008. In addition to the 45,530 new jobs, health services will have to replace 43,720 employees lost through attrition during this same time period. The largest replacements are anticipated in the nursing and physician specialties.

The following chart illustrates some of the health service areas with projected demand and vacancy replacement needs:

	Estimated Employment				Estimated Annual Openings		
Occupational Title	**1998**	**2008**	**Growth**	**%Change**	**Growth**	**Separations**	**Total**
Health Practitioners/Technicians & Related Workers	131,410	157,610	26,200	19.9%	2,620	2,420	5,040
Therapists	10,570	13,770	3,200	30.3%	320	160	480
Respiratory Therapists	1,460	2,130	670	45.9%	70	20	90
Occupational Therapists	2,130	2,740	610	28.6%	60	30	90
Physical Therapists	2,320	2,860	540	23.3%	50	40	90
Registered Nurses	42,420	50,970	8,550	20.2%	860	700	1,560
LPN/Vocational Nurses	12,090	13,810	1,720	14.2%	170	260	430
Med/Clinical Lab Technicians	2,500	2,990	490	19.6%	50	30	80
Radiation Therapists	340	410	70	20.6%	10	10	20
Radiologic Techns/Technologists	3,820	4,520	700	18.3%	70	50	120
Cardiology Technologists/Techns	310	450	140	45.2%	10	10	20
Surgical Technologists	1,240	1,770	530	42.7%	50	30	80
Medical Assistants	4,610	6,720	2,110	45.8%	210	110	320
Nursing Aides/Orderlies/Attnds	38,650	45,590	6,940	18.0%	690	540	1,230
Home Health Aides	8,340	12,310	3,970	47.6%	400	120	520
Personal/Home Care Aides	7,800	11,370	3,570	45.8%	360	200	560
Health Diagnostics Teachers	1,540	2,170	630	40.9%	60	40	100
Health Specialties Teachers	1,250	1,760	510	40.8%	50	40	90

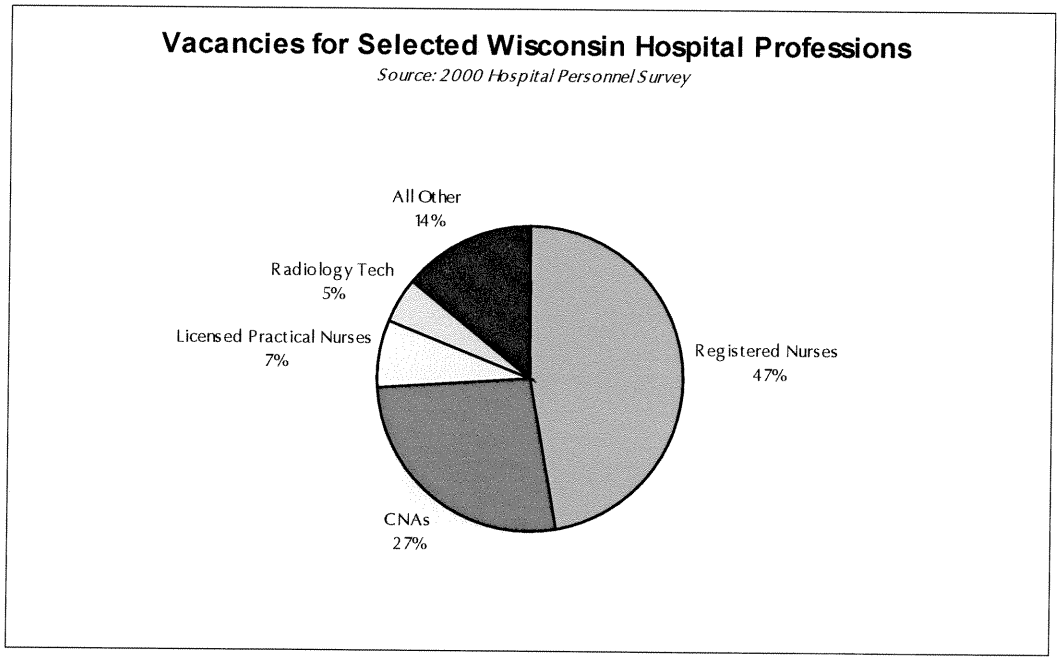
Wisconsin Health & Hospital Association

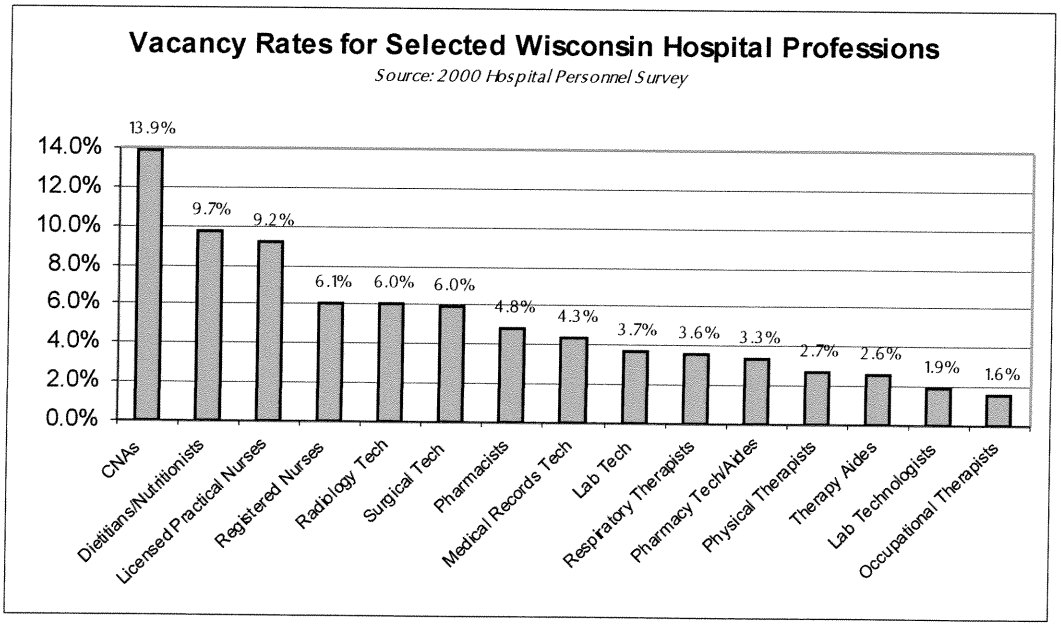
Workforce Vacancies

The Wisconsin Health and Hospital Association, in collaboration with the Department of Health and Family Services' Bureau of Health Information (BHI), completed a survey of Wisconsin hospitals to identify the current personnel needs and other characteristics of 15 health care professions. Data was received from 115 of the 150 hospitals.

Results from the survey indicate that registered nurses make up the highest portion of total vacancies (47% of vacancies), while certified nursing assistants (27%), LPN's (7%) and radiology techs (5%) round out the top four.

Vacancy rates by position ranged from 13.9% for CNA's to 1.6% for occupational therapists (see graphs below).





Wisconsin Health & Hospital Association

Personnel Shortage Issues

Wisconsin hospitals are just beginning to experience a shortage of health care workers, which will continue to grow and worsen over the next 3-10 years. This shortage will affect Wisconsin's access to health services and health care professionals. It will also have a profound economic affect on one of the top three industries in our state.

Wisconsin's health service workforce shortage is just beginning as compared to national shortages. The American Hospital Association (AHA) just released a study, which indicated the following vacancy rates:

- Pharmacists – 21%
- Radiological Techs – 18%
- Lab Techs – 12%
- Registered Nurses – 11%

The AHA reported increased recruitment difficulty for nurses, technicians, pharmacists and support staff. Hospitals experiencing vacancies over 10% are reporting increased crowding in emergency departments, reductions of available beds, emergency department divisions due to lack of staff, increases in surgery waiting time, cancellations of surgeries and reductions in capacity.

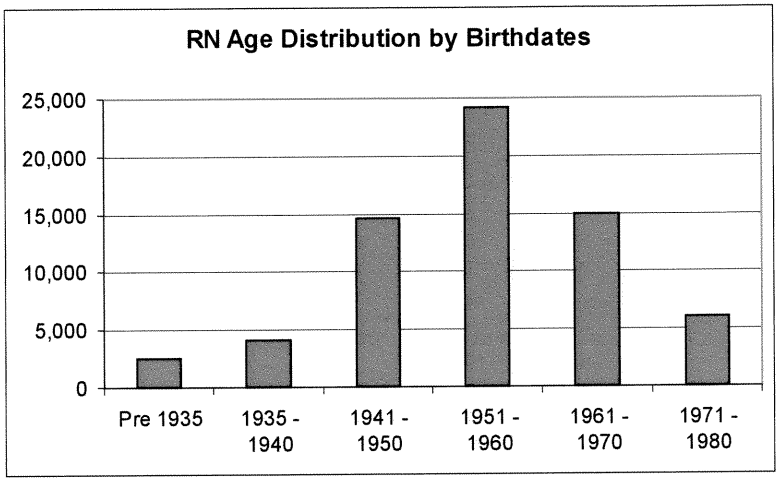
Although Wisconsin is currently just beginning to feel the affects of the reduced supply of health care workers, it is anticipated that the shortage will become more severe as our population ages, the demand for health care increases, the health service workforce ages and vacancies increase.

The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) recently published a national state-by-state profile of the health service workforce. According to HRSA's study, the total population of Wisconsin is only projected to grow by 9% by 2020, while the percentage of our population over 65 is projected to grow 47% during the same time. This is in addition to 25% growth of this age group between 1980 and 2000. As we experience the aging of our general population, there will be a corresponding increase in demand for health services. To complicate matters, we also face the affects of an aging health care workforce.

The WHA personnel survey identified the number of employees in a job classification currently over the age of 55. Values ranged from 14.3% of LPNs over the age of 55 to occupational therapists who reported 0.0% over 55. Other occupation results for personnel over 55 included therapy aides (10.5%), pharmacists (9.1%), nursing assistants (8.8%), lab technologists/technicians and medical record techs (8.0%) and registered nurses (7.2%). As this workforce ages, the demand for replacement positions will increase.

The Wisconsin Department of Regulation and Licensing collects data on those people who have state licenses as a RN and LPN. That data shows that the average age of a licensed RN in Wisconsin is over 45 years old and the average age of an LPN in Wisconsin is over 48 years old. The aging of the nursing workforce will continue to be an issue into the future as fewer new graduates are entering the nursing field (see graphs and data on next page).

Wisconsin Health & Hospital Association

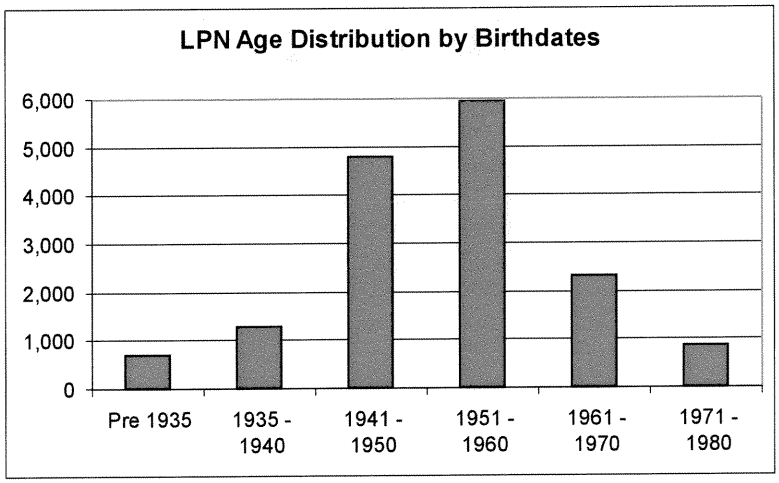


RNs

Birthdates	Number	% of Total
Pre 1935	2,514	3.8%
1935 - 1940	4,107	6.2%
1941 - 1950	14,622	22.0%
1951 - 1960	24,215	36.5%
1961 - 1970	14,938	22.5%
1971 - 1980	6,026	9.1%
Totals	66,422	100.0%

Average Age of RN Licensed in Wisconsin 45.43 years

Median Age of RN Licensed in Wisconsin 45.30 years



LPNs

Birthdates	Number	% of Total
Pre 1935	721	4.5%
1935 - 1940	1,272	8.0%
1941 - 1950	4,804	30.1%
1951 - 1960	5,958	37.3%
1961 - 1970	2,321	14.5%
1971 - 1980	885	5.5%
1981 - 1990	3	0.0%
Totals	15,964	100.0%

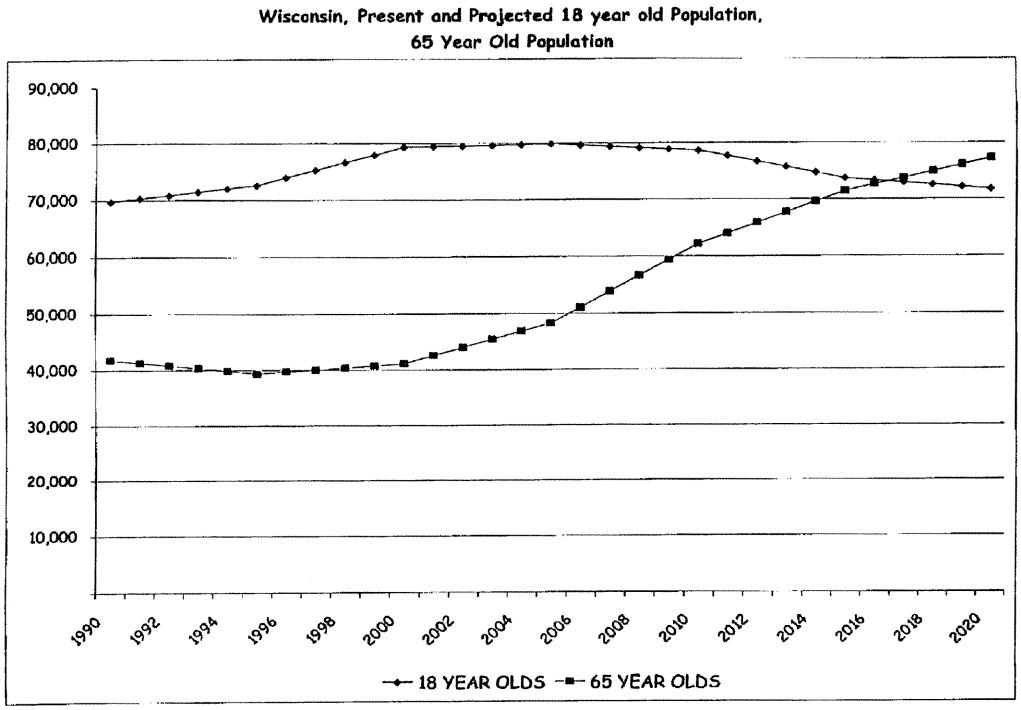
Average Age of LPN Licensed in Wisconsin 48.26 years

Median Age of LPN Licensed in Wisconsin 48.35 years

Wisconsin Health & Hospital Association

Education and Training Issues

As Wisconsin looks to our youth to fill these positions, we will be faced with several challenges. The health service industry is faced with competition for the tight supply of 18 year olds entering the work force. Wisconsin is experiencing a declining number of 18 year olds while the population over 65 years of age continues to grow (see chart below).



In contrast to the documented increasing need for health service workers, the Wisconsin Technical College System reports declining graduates in several shortage occupations.

Programs	Graduates			
	1997	1998	1999	2000
Assoc. Degree-Nursing	927	818	774	772
Radiographic Tech	61	85	84	85
Surgical Tech (2 yr)	20	21	21	30
Surgical Tech (1 yr)	89	100	81	82
LPN	257	242	253	279
Medical Assistants	266	287	217	244
Lab Tech	61	65	53	59

Policy Issues

Wisconsin needs to develop a multi-pronged approach that recognizes the impact and role that the health care industry plays in Wisconsin's infrastructure and economic status. Policies need to be developed collaboratively between legislators, regulators, educators, health professionals, providers and consumers to ensure that Wisconsin has an adequate supply of health care personnel and resources to meet the needs of its citizens. Policies and change will not work unless all stakeholders work toward a future common good and goal. Policy changes need to

look forward at new ways to meet issues and not rely on past traditions and solutions. Current and past policies don't hold the answers for the future on this issue.

Acute care services continue to show strong demand in Wisconsin. Based on the states changing demographics, the need for chronic care services must also be addressed. This includes considering changes in health care delivery and payment from the current per visit basis to population management. The consumer's role in management will need to also change from a passive role to an active preventative and management role. The focus of professionals and educators will need to expand preventative as well as chronic disease and symptom management.

Federal and state legislators and regulators will need to evaluate the cost effectiveness and cost benefits of the current regulation on the health care delivery system and work to ease the burden of ineffective and original legislation and regulation at both state and federal levels. A study completed by Price Waterhouse Coopers (PWC) found there has been a significant increase in paperwork needed to document regulatory compliance. The rules and instructions regulating the Medicare and Medicaid program contain more than 130,000 pages (three times the IRS Code and its federal regulators). Every hour of care that a Medicaid patient received in an acute care inpatient setting resulted in an additional 36 minutes of regulatory paperwork. In the emergency room, every hour of patient care resulted in another hour of paperwork. As the number of Medicare recipients in Wisconsin increase, the cost of regulation will also increase. Can we afford this diversion of direct care resources as an industry or as a state?

Education policies need to address the health and health occupation curriculums and programs of our youth in the K-12 system. Policies that encourage self care and foster exposure to health care services and occupations need to be identified and funded through public/private partnerships with the state school system and the health care industry.

The funding of technical and university health education has to address the critical need for timely, useable data regarding students in health occupation programs. The data has to be useable across and between Wisconsin's technical college and university systems, and be useable by the industry, professionals, and departments (example: DWD, DHFS) concerned with the state health care workforce.

Policies relating to the educational system need to reward innovative educational styles and programs that encourage and reward competency based education, distant learning opportunities, educational ladders for growth and development, and expansion of public/private partnerships for clinical training and competencies.

The lack of statewide health care workforce data is a major policy issue that has to be addressed. Data needs to be systematically collected in a manner that enables cross utilization and comparisons with state and national demographics, and identifies regional workforce needs and specific issues to be addressed.

Wisconsin Health & Hospital Association

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4) Wisconsin Projections 1998-2008, Wisconsin Department of Workforce Development, Division of Workforce Excellence, Bureau of Labor Market Information and Customer Services, January 2001.

5) Wisconsin Technical College System Board's Client Reporting System.

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7) Wisconsin Department of Regulation and Licensing RN and LPN License Data

NEWS

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Individual Hospital Contacts Follow Text Below

COPY

Will Wisconsin Hospitals Have Enough Workers in the Future?
The answer is yes, by recruiting tomorrow's workforce today

Wausau (September 5, 2001)-------Wisconsin Health and Hospital Association, along with 52 member hospitals, today announced a campaign aimed at attracting high school students and young adults to health occupations in an effort to head-off future shortages. As Wisconsin's population ages, the challenge to find and retain health care workers to provide necessary health care services will become increasingly difficult.

"The state is entering a period when more workers will leave the workforce than enter it. With the average age of a registered nurse at 47, we must start recruiting and training people now to replace them as they retire," according to Diane Peters, vice president of workforce development at the Wisconsin Health and Hospital Association. "In the 70's and 80's hospitals experienced nursing shortages. This time, hospitals are reporting shortages in all professions, from food service to pharmacy."

Hospitals nationwide with nurse vacancy rates approaching 20% are beginning to experience increased difficulty in recruitment and retention, emergency room crowding, reductions in bed availability, increases in surgery waiting time, cancellations of elective surgeries, emergency room diversions, and reductions in special services due to unfilled staff positions.

"Staff vacancies create stress for our community hospitals. Vacancies also increase expenses as hospitals are forced to use expensive options, such as temporary staffing agencies to fill open positions. This ultimately leads to increases in health care costs within our communities," Peters said. "This is not acceptable and hospitals are looking at every opportunity they have to recruit and retain employees."

The problem is: Where do hospitals look for workers? The national unemployment rate for nurses and radiological technologists is 1%, which indicates that there are not a lot of people available to hospitals and other health care providers.

"We're not talking about one hospital, one community, or one region that is experiencing shortages. This is a national, even international problem," Peters warned. "We can't solve the problem by 'stealing' employees from other hospitals. The answer is in recruitment, retention and in identifying creative strategies to deliver quality care using new methodologies and technologies."

Wisconsin Hospitals' Approach: Proactive, Not Reactive

Wisconsin hospitals have not taken a wait and see what happens approach to the workforce issues that surround them. The WHA, along with 11 hospitals in central Wisconsin, today started a television advertising campaign designed to attract students and young adults to work in hospitals. The idea is to acquaint potential workers with the benefits of working in a health care setting. As Peters points out, hospitals in Wisconsin are experiencing a "tightening" of the workforce, nothing like the critical shortages of nurses and other personnel that are hitting the coasts of the US and Texas. By starting to recruit now for tomorrow's healthcare workforce needs, hospitals plan to avert major personnel shortages in the future.

The 30-second ad draws on the fact that health care professionals are needed now and will be needed far into the future. The security of employment, along with the rewards of helping others, offers benefits with which other industries cannot compete.

Wisconsin Health &
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WHA Workforce Survey: Nurses Needed

In a survey conducted by WHA, in collaboration with the state's Bureau of Health Information, Wisconsin hospitals identified their current personnel needs in 15 key health professions

Results from the survey show that registered nurses make up the highest portion of vacancies. Certified nursing assistants, licensed practical nurses and radiological technologists round out the top four most sought after positions in hospitals today. The vacancy rates for these positions vary across the state, from a low of 0 to a high of 28.4% for RNs.

In central Wisconsin, the RN vacancy rate is 4.2%. The average vacancy rate for full-time RN's statewide is 6.1%. The American Hospital Association reports a national nurse vacancy rate of 11% that is creeping upwards.

Education and Training Issues

Wisconsin will face several challenges as it looks to youth to fill these positions. The health services industry will face fierce competition for the tight supply of 18 year olds entering the work force because of a declining number of 18 year olds, while the population over 65 years of age continues to grow.

In contrast to the documented increasing need for health service workers, the Wisconsin Technical College System (WTCS) reports declining numbers of graduates in several shortage occupations.

In 1997, the WTCS graduated 927 associate degree nurses, compared to 772 in 2000. Decreases in the number of graduates in positions of radiological technologists, surgical and lab techs, LPNs, and medical assistants also occurred from 1997-1999.

SMS President Raymond Zastrow, MD, points out that a career in health care is much more than "just a job, it is rewarding personally."

"The State Medical Society believes there is nothing more important than access to high quality health care. Without enough dedicated health care professionals, we all suffer. That's why we all have an interest in making sure young people at least consider a health care profession," Zastrow said.

The Legislative Agenda

The impending workforce crisis in health care can be addressed through sound health policy at the state and federal level. At the state level, WHA is pursuing a legislative agenda that includes:

- Development of state-approved curriculum in all health occupation programs in the Wisconsin Technical College System Health Occupations Program;
- Development of core curriculum for health occupations that is to be used by health occupation programs;
- Development of standardized statewide admission/prerequisites for all health occupation programs;
- Implementation of articulation agreements among colleges within the Wisconsin technical system for each health occupation program; and,
- Development of distance educational programs for health occupations in the system.

In addition, WHA would like to see a center for health care workforce data and strategies created within the Department of Workforce Development to provide data to identify effective public policy approaches to ensure an adequate health care workforce in the future.

At the federal level, the American Hospital Association (AHA) is supporting several legislative initiatives that would provide scholarships and loan repayment programs for persons who pursue careers in nursing.