

WHO WILL CARE FOR US?: THE LOOMING CRISIS OF HEALTH WORKFORCE SHORTAGES

HEARING

BEFORE THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

ON

EXAMINING THE LOOMING CRISIS OF HEALTH CARE WORKER
SHORTAGE

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C O N T E N T S

STATEMENTS

MONDAY, JULY 15, 2002

	Page
Reed, Hon. Jack, a U.S. Senator from the State of Rhode Island	1
Sepe, Thomas D., President, Community College of Rhode Island	1
Fogarty, Hon. Charles J., Lieutenant Governor, State of Rhode Island	2
Prepared statement	5
Chafee, Hon. Lincoln, a U.S. Senator from the State of Rhode Island	10
Langevin, Hon. James, a Representative in Congress from the State of Rhode Island	10
King, Roderick K., Director, Boston Field Office, Region I (New England), Health Resources and Services Administration	13
Prepared statement	16
Amaral, Joseph, M.D., President and Chief Executive Officer, Rhode Island Hospital,	18
Prepared statement	21
Besdine, Richard W., M.D., FACP, Interim Dean, Brown Medical School	23
Prepared statement	25
Roberts, Nancy, MSN, RN, President and Chief Executive Officer, Care New England Home Health	27
Prepared statement	29
Owens, Norma J., Pharm.D., Professor of Pharmacy, Department of Pharmacy Practice, University of Rhode Island	32
Prepared statement	34
McKinney, William Lynn, Dean, College of Human Science and Services, University of Rhode Island	39
Prepared statement	41
McGarry, Maureen E., RN, Ph.D., NCC, Dean of Health and Rehabilitative Services, CCRI-Flanagan Campus	42
Prepared statement	44
Schepps, Barbara, M.D., Director, Anne C. Pappas Center for Breast Imaging, Rhode Island Hospital; Professor (Clinical), Brown University Medical School	48
Prepared statement	50
McNulty, James, President, National Alliance for the Mentally Ill,	53
Prepared statement	55
Laprade, Wendy, RN, Staff Nurse, Women and Infants Hospital	56
Prepared statement	63

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:	
Senator Reed	72
“Washington Post Highlights Critical Shortage of Pharmacists”	73
The Pharmacist Education Aid Act of 2001	76
Barbara Rayner	77
Patricia Ryan Recupero, M.D.	78
Jane Williams	79

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MONDAY, JULY 15, 2002

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, D.C.

The committee met, pursuant to notice, at 11 a.m., in the Presentation Room, fourth floor, Community College of Rhode Island, Warwick, RI, Senator Reed, presiding.

Present: Senators Reed and Chafee.

OPENING STATEMENT OF SENATOR REED

Senator REED. Thank you for joining us this morning. We have a lot to do, and I'll give everyone fair notice that I have to catch a 2:00 flight to DC. for votes this afternoon, so about 1:00 we are going to be winding up, and if I run out the door, it is nothing personal, so forgive me.

I would like now to thank and recognize President Tom Sepe from the Community College of Rhode Island for his hospitality and his presence here. Thank you.

[The prepared statement of Senator Reed follows:]

STATEMENT OF THOMAS D. SEPE, PRESIDENT, COMMUNITY COLLEGE OF RHODE ISLAND

Mr. SEPE. Thank you, Senator, and welcome everyone. My position back here is, I'll let you know, I will be right behind you 100 percent.

It is really important to have a meeting like we have today. We all know this is literally a crisis that we all face, and CCRI is the largest single provider of healthcare workers, and certainly feel a special obligation to respond to this crisis.

We know that it is not the quality of our graduates that we at higher education are producing, but it is a question of quantity that we are producing for the field.

It is also very important that we recognize the fact that we have had increased cooperation and collaboration among the partners, not only within higher education, but also in the health care providers and education, as teams.

I would suggest to you that one of the issues that we need to face in dealing with this issue is, one, looking at the education-work, education-work, education-work cycle.

Now, there is a terminal process where students come into an educational system and go to work and that is the end of it. We know that people in today's life cycle in and out of work, in and out of education throughout their whole life, but my suggestion to you today is we also consider this as a cycle, as a system of higher education and work, more closely integrated than we thought in the past.

Part of the system I'm talking about, we need to improve the way we allow entry, reentry, the way we upgrade and promote people who do have educational credentials.

We also need to improve the number and the motivation and the educational preparedness of students coming out of our high schools for our educational systems. We can only introduce qualified graduates through higher education if the resources coming to us are sufficient.

Last, certainly resources cannot be avoided. We cannot throw money at a problem and make it go away, but certainly the kind of problem we are talking about is going to require financial and human resources to increase the number of students going through the pipeline that we have created between education and the workplace.

As an example, every nursing student that we enroll costs us \$1,000 more than the tuition and State aid that we have received. So to increase the pipeline for CCRI is to make me find a profit center somewhere else within my organization, to supplement that cost or to get outside resources. Costs of educating individuals into this field are not inexpensive by its very nature, so we cannot avoid the issue of resources, for that resource alone is certainly not the issue.

There is no simple answer. It is a complex issue, and the assemblage we have today I believe is the basis for our dialog which should address this issue, and, hopefully, we will look forward to some good outcomes today to start us on the track.

It is important for us to begin to talk as a system, not as individual components. It is important today, I think, and Senator Reed, who can appreciate your initiative for bringing us together for this important topic.

It is now my pleasure to welcome and introduce Charles Fogarty, Lieutenant Governor, who himself has done a great deal in this field and to follow-up the program.

Charles.

STATEMENT OF HON. CHARLES J. FOGARTY, LIEUTENANT GOVERNOR, STATE OF RHODE ISLAND

Mr. FOGARTY. Thank you very much. Thank you very much, President Sepe, Senator Reed, Senator Chafee and Congressman Langevin and distinguished guests.

Thank you, Senator Reed, for your concerns about this crucial issue and for hosting today's field hearing in Rhode Island. I am pleased to share some of my thoughts about how the issue impacts our State and some of the actions we have taken to date to address it. It is noteworthy that today's hearing is here at CCRI, an institution with a long and proud history of educating and training so many of our health care professionals and para-professionals.

The health care worker shortage is particularly important here in Rhode Island for several reasons:

First, as we all know, as we grow older we tend to need and use more health care services. The Rhode Island population is older on average than the rest of the country. The 2000 Census showed that 14.5 percent of the Rhode Island population is age 65 and older as compared to the national average of 12.4 percent. But of even greater importance is the fact that the older cohort of our senior population—those 85 and older—are the fastest growing. The number of persons in the State age 85-plus is projected to increase by 1.2 percent annually between 2001 and 2006. The implications of these demographics for our health care workforce are enormous. We need to assess our capacity to meet their health care needs and the adequacy of our education and training programs to supply the array of necessary workers, from geriatricians, to nurses, dentists, pharmacists, therapists and technicians to direct “hands-on” long-term care staff.

A second reason that the adequacy of the health care workforce is so important for our State is the impact that health care has on our economy. As noted in the 2001 Annual Report of the Governor’s Advisory Council on Health (GACH), slightly more than 9 percent of Rhode Islanders are working in the health care industry. This is significantly higher than the U.S. average of 6.9 percent and higher than our neighboring States of Massachusetts and Connecticut. There are efforts underway to position Rhode Island hospitals and other health service providers as regional leaders in offering expert and quality health care. It is imperative, therefore, that we take steps to ensure an adequate number of well-trained health professionals as well as non-skilled health workers to both ensure that our residents are able to receive the highest quality care by in-state providers and to take advantage of opportunities to market our health care services beyond our borders.

I know you will be hearing today from many experts who will be sharing information about supply and educational and training issues relating to specific health professions and I look forward to listening to their comments and learning from them.

I would like to take a few minutes to talk about one particular area—nursing—that I have been working on and some of the actions we have taken at the State level to address critical shortage issues in this area.

Let me tell you briefly about some of the steps we have taken in our State to address the work shortage.

Last year, hospitals in Rhode Island had over 400 budgeted vacant nursing positions. Yes, the number of enrollments in nursing schools dropped 17 percent between 1998 and 2000, and the number of new persons taking the RN licensing exam dropped from 523 in 1996 to only 294 in 2000. And all this is happening at the same time that our nursing population is aging. The average age of Rhode Island licensed nurses was 47 years, which in my book is pretty young, 2 years higher than the national average of 45.

To help deal with this problem have worked with the Rhode Island Student Loan Authority and the Hospital Association of Rhode Island and various nursing organizations of our State to create a nursing program for 2001, which the legislature passed. This pro-

gram forgives the interest on student loans for nurses who practice in Rhode Island licensed health care facilities. It provides up to 250 of those loans each and every year.

In talking to Ed Freeland before this meeting I am told that there's been a significant number of inquiries to the Rhode Island Student Loan program regarding this program, and there's been a slight decrease in the number of vacant positions. So this is the first step. I think the State and Federal Government must do more to provide financial assistance as well as incentives to recruit people to this vital field.

In fact, Senator Reed, I want to recognize you for your assistance on this issue to the Federal Government.

As Chairman of the State Long-Term Care Council, I am particularly concerned about a long-term care workforce.

Last year our Council issued a fairly comprehensive report showing the dimensions of this crisis. An increase in the CNA vacancy rate of 5 percent in 1997 to almost 12 percent in 1999 and in the turnover rate going from 59.2 percent in 1997 to 82.6 percent in 1999. The question that comes out of all of this is how do we guarantee quality health care for those in need with figures like that.

Our Council reported ten recommendations to deal with this issue, including an appropriation of approximately \$16 million to fund a direct care worker pass-through program for long-term care providers.

Although we were not able to secure the entire amount of the recommended funding for the compensation pass-through, \$4.5 million was provided for nursing homes to increase staff compensation or staffing and 3 percent increase in reimbursement for other providers to be used for staff compensation. We do not have formal data on what effect these pass-through funds have had, but we do have anecdotal reports that in some instances wages for CNA's were increased by as much as \$1.50 per hour, that the use of nursing pools to adequately staff nursing homes has decreased and that worker retention, but not recruitments, has improved for home care providers. In the meantime, reports are that the long-term care sector is experiencing increasing shortages of professional nursing staff with reported vacancy rates of 18 percent.

In closing, I would like to note two innovative projects initiated by State government to address the health care workforce. The first is a Health Care Labor Market Project to be conducted by the University of Rhode Island with a small grant from the State Department of Human Services. This project will help us address data gaps in understanding our health care labor market. It will analyze factors determining health care labor demand and supply and make suggestions for improving data and future research.

The second is the new opportunities for mature workers project initiated by the Department of Elderly Affairs. Under a coalition of Federal Title V Senior Community Service Employment Programs and long-term-care providers, mature workers will be recruited, trained and placed in a variety of para-professional and service positions and long-term care settings. We believe these projects have significant potential. However, given the severe fiscal constraints faced by the State, funding to implement innovative State projects that seek to address the health care workforce shortage is limited.

So I would encourage the Committee to consider providing Federal grant opportunities to the States to encourage them to design and implement more programs such as these and to fund recommendations such as those outlined in our Council's report on the CNA crisis.

Finally, I want to emphasize the importance in adequate funding for Medicare and Medicaid to ensure that we can provide compensation levels that retain persons for the workforce.

Once again, Senator Reed, Senator Chafee, Congressman Langevin, thank you for conducting this important hearing and we look forward to working with you in the years ahead to address this issue.

[The prepared statement of Lt. Gov. Charles J. Fogarty follows:]

PREPARED STATEMENT OF CHARLES J. FOGARTY

Thank you, Senator Reed, for your concerns about this crucial issue and for hosting today's field hearing in Rhode Island. I am pleased to share some of my thoughts about how the issue impacts our State and some of the actions we have taken to date to address it. It is noteworthy that today's hearing is here at CCRI, an institution with a long and proud history of educating and training so many of our health care professionals and para-professionals.

The healthcare worker shortage is particularly important here in Rhode Island for several reasons.

First, as we all know, as we grow older we tend to need and use more healthcare services. The Rhode Island population is older on average than the rest of the country. The 2000 census showed that 14.5 percent of the Rhode Island population is age 65 and older as compared to the national average of 12.4 percent. But of even greater importance is the fact that the older cohort of our senior population—those age 85 and older—are the fastest growing. The number of persons in the State age 85-plus is projected to increase by 1.2 percent annually between 2001 and 2006. The implications of these demographics for our health care workforce are enormous. We need to assess our capacity to meet their health care needs and the adequacy of our education and training programs to supply the array of necessary workers—from geriatricians, to nurses, dentists, pharmacists, therapists and technicians to direct "hands-on" long-term care staff.

A second reason that the adequacy of the healthcare workforce is so important for our State is the impact that health care has on our economy. As noted in the 2001 Annual Report of the Governor's Advisory Council on Health (GACH), slightly more than 9 percent of Rhode Islanders are working in the health care industry. This is significantly higher than the U.S. average of 6.9 percent and higher than our neighboring States of Massachusetts and Connecticut. There are efforts underway to position Rhode Island hospitals and other health service providers as regional leaders in offering expert and quality health care. It is imperative, therefore, that we take steps to ensure an adequate number of well-trained health professionals as well as non-skilled health workers to both ensure that our residents are able to receive the highest quality care by in-state providers and to take advantage of opportunities to market our healthcare services beyond our borders.

I know you will be hearing today from many experts who will be sharing information about supply and educational and training issues relating to specific health professions and I look forward to listening to their comments and learning from them. I would like to take a few minutes to talk about one particular area—nursing—that I have been working on and some of the actions we have taken at the State level to address critical shortage issues in this area.

Last year, the Hospital Association of Rhode Island (HARI), together with United Nurses and Allied Professionals (UNAP) and Rhode Island State Nurses Association (RISNA) brought the nursing shortage issue to my attention. Hospitals in Rhode Island had over 400 budgeted vacant nurse positions, the number of enrollments in nursing schools dropped 17 percent between 1998 and 2000, the number of new persons taking the RN licensing exam dropped from 523 in 1996 to 294 in 2000 and the average age of Rhode Island licensed nurses was 47 years, 2 years higher than the national average of 45 years. Armed with these facts, we worked with the Rhode Island Student Loan Authority to develop and enact legislation—The Nurse Reward Program—to forgive the interest on student loans for nurses who practice in Rhode Island licensed health care facilities. This new program, which is now in effect, is

a small but good first step to provide incentives for students to choose nursing careers. We have also joined with HARI and nursing organizations this year on a media campaign to promote nursing and to recruit persons to this vital profession. However, both the State and Federal Governments must do more to provide financial assistance and incentives to recruit persons into this vital field.

As Chairman of the Long-Term-Care Coordinating Council, I have a special responsibility to look at the adequacy of our long-term care workforce. This sector, which serves thousands of frail elders and persons with disabilities, depends heavily on semi-skilled para-professionals for direct hands-on care. Last year it faced a crisis in recruitment and retaining workers. This crisis was documented in reports issued by the council (*Crisis in Care: A Report of the CNA Study Group*) and the Direct Care Task Force, a study group comprised of the Rhode Island Health Care Association, The Rhode Island Association of Facilities and Services for the Aged and the Alliance for Better Long-Term Care. Surveys conducted by the Direct Care Task Force showed the dimensions of the crisis—an increase in the CNA vacancy rate from 5 percent in 1997 to 11.8 percent in 1999, and in the turnover rate from 59.2 percent in 1997 to 82.6 percent in 1999. The councils' report included a ten-step set of recommendations including appropriations of approximately \$16 million to fund a direct-care worker pass-through program for long-term-care providers. A copy of these recommendations is attached (See Attachment A).

Although we were not able to secure the entire amount of the recommended funding for the compensation pass-through, \$4.5 million was provided for nursing homes to increase staff compensation or staffing and a 3 percent increase in reimbursement for other providers to be used for staff compensation. While we do not have formal data on what effect these "pass-through" funds have had, we do have anecdotal reports that in some instances wages for CNA's were increased by as much as \$1.50 per hour, that the use of nursing pools to adequately staff nursing homes has decreased and that worker retention, but not recruitment has improved for home care providers. In the meantime, reports are that the long-term care sector is experiencing increasing shortages of professional nursing staff with reported vacancy rates of 18 percent.

We need to continue to do much more to ensure an adequate long-term care workforce for the future. In anticipation of today's hearing, last week I asked members of the council and long-term-care provider representatives to share their thoughts and concerns with me and I was pleased that several took the time to respond. One provider, Cynthia Conant-Arp, Executive Director of the Feinstein Alzheimer's Center, stated her concerns poignantly: I am sure they reflect the concerns of many in the industry and I would like to read them to you.

"Our workers deserve a living wage and the respect due them for caregiving. Unfortunately, agencies and institutions also need reasonable revenues to survive, and many would not if they paid living wages. Certified nursing assistants, in particular, are poorly paid for backbreaking and physically and emotionally draining work. Even for truly committed workers it is all too enticing to go where the grass is greener and the work is less demanding. In yesterday morning's *Providence Journal*, a certified nursing assistant was quoted on her reasons for choosing to leave the long-term care field for the financial security and benefits of an airport security job. Who can fault her? CNAs are leaving the field in droves, and many of the institutionally based nurses are right behind them! With a burgeoning elderly population, we will soon be facing crisis-level shortages in qualified personnel.

"I do believe that much of the problem in recruiting healthcare workers is a matter of economics and respect. Many agencies are unable to offer full time work and health benefits to their staff. . .another fact that motivates qualified workers to seek employment in other sectors. At some point we have to equate a reasonable employee compensation package with a measure of our respect for the worker and the responsibilities he/she performs, but a bit of public education wouldn't hurt either:

"St. Joseph Hospital recently ran a beautifully done series of nurse-recruitment ads. Perhaps some validating PR, financial incentives and career ladders could assist with worker recruitment and retention. In a time of limited resources, financing will be challenging, but home and community-based waivers and creative use of existing Federal programs may offer hope. States cannot continue to absorb as much of the long-term-care financing burden (mostly reflected in Medicaid spending) without more Federal assistance. In the long run, though, long-term care reform and Medicaid reform needs to be integrated with Medicare and Social Security reform, both in financing and service delivery. Staffing shortages need to be a major discussion point in any reform effort:

“The challenges are enormous, but if we don’t act soon, the crisis will be devastating. The labor force and healthcare/long-term care issues are inextricably linked. Our workers deserve a living wage and the respect due them for caregiving.”

In closing, I would like to note two innovative projects initiated by State government to address the healthcare workforce. The first is a Health Care Labor Market project to be conducted by the University of Rhode Island with a small grant from the State Department of Human Services. This project will help us address data gaps in understanding our health care labor market. It will analyze factors determining health care labor demand and supply and make suggestions for improving data and future research. The second is the New Opportunities for Mature Workers project initiated by the Department of Elderly Affairs. Under a coalition of Federal Title V Senior Community Service Employment Programs (SCSEP) and long-term-care providers, mature workers will be recruited, trained and placed in a variety of para-professional and service positions in long-term care settings. Each of these projects has significant potential. However, given the severe fiscal constraints faced by the State, funding to implement innovative State projects that seek to address the health care workforce shortage is limited. I would encourage the Committee to consider providing Federal grant opportunities to States to encourage them to design and implement more programs such as these and to fund recommendations such as those outlined in our council’s report on the CNA crisis:

Attachment A

Recommendations of CNA Study Group of the Long-Term-Care Coordinating Council

1. Improve CNA compensation (wages and benefits) by adopting the following:
 - 1.1. A nursing home direct care compensation pass-through of at least \$30 million (State and Federal) with accountability measures as proposed by the Direct Care Task Force with allocation mechanisms to be determined by the effected parties. The new funding will be used to the extent permissible by law for direct care staff. Cost Estimate: \$14.1 million (State).
 - 1.2. A home care provider rate increase of \$3 per hour with accountability measures to be determined by the affected parties. The Study Group suggests that of the \$3 per hour rate increase, 87 percent (\$2.61) be provided as a compensation pass-through to CNAs (home health aides) and 13 percent (\$.69) be retained by the provider agency to pay for the increased payroll taxes and workers’ compensation insurance costs associated with the increase. Cost Estimate: \$1,690,000 (State).
 - 1.3. Adequately fund all other providers that employ CNAs through establishment of COLAs as recommended in legislation requested by the Long-Term-Care Coordinating Council to institute a mandated 5 percent COLA for all long-term care providers except nursing homes (which already have a mandated COLA) for FY2002. Thereafter, the COLA will be based on an index to be determined by the purchasing departments in consultation with provider representatives.
 - 1.4. All long-term care providers who participate in State-funded programs shall collect and report annually on turnover and vacancy rates for direct care staff in accordance with reporting provisions developed by the State contracting/purchasing entity.
2. Provide an ongoing source of funding for CNA training and retraining to ensure an adequate pool of qualified nursing assistants to care for Rhode Islanders with chronic care needs across the long-term care service system.
 - 2.1. Implement the CCRI CNA Workforce Development initiative: This will include four components: training, re-engagement of inactive nursing assistants, retraining and testing. Training will take place both at on-campus and off-campus locations such as nursing homes and home care agencies. This program is not intended to displace those non-proprietary programs that offer intense specialized support services and training to students funded by State agencies. (An outline of the CCRI CNA Workforce Development initiative proposal is found on page 17.) Cost estimate: \$208,000.
3. Establish pilot or demonstration workforce redesign program/s specifically targeted to enhancing employee satisfaction and CNA retention. These demonstration programs could be used as “best practices” for replication by other long-term care providers. Potential funding sources include Civil Monetary Penalty (CMP) funds, grant funds from Human Resources Investment Council, and other grant sources:
4. Develop standards for CNA career ladders and explore college credit for training.
5. Develop tuition assistance program for CNA training for low-income persons not eligible under Family Independence program (Note: this is part of the funding recommended in #4 above).

6. Explore ways to facilitate training and certification for persons whose primary language is not English:

7. Develop a database on both quantitative and qualitative CNA employment issues using HEALTH's biennial certification/registration process.

8. The Long-Term Care Coordinating Council, working in collaboration with appropriate State agencies, shall provide technical assistance in disseminating best practices to providers on CNA workforce development issues.

9. The Department of Human Services should encourage child care providers—through the use of incentives and other mechanisms—to collaborate with long-term care providers to address gaps in the child care delivery system that serve as barriers to CNA employment.

10. Support the GACH recommendations calling on the State to establish a strategy for predicting current and future health care workforce needs and identifying methods to meet those needs.

Senator REED. Thank you very much, Lieutenant Governor and thank you for your statements and also for your work in the Long-term Care Coordinating Council any many other activities.

I want to welcome everyone here. I will give my opening statement and then call upon my colleagues, Senator Lincoln Chafee and my colleague Congressman Jim Langevin.

Again, it is a pleasure to have you all here at the official field hearing on the Health, Education, Labor and Pensions Committee.

I want to thank Dr. Tom Sepe, the president, for his hospitality here today and for his opening remarks.

Also, let me thank the witnesses who are here today and all of you who have joined us for this very critical topic, the health care shortage throughout Rhode Island and throughout the Nation.

Health professionals make up roughly 10.5 percent of the Nation's total workforce. In Rhode Island, that figure is 11.8 percent, or 53,000 people, who are employed in the health sector. Amazingly, our small State ranks third in the Nation in per capita health services employment. Health services employment in Rhode Island grew 30 percent between 1988 and 1998, compared to 23 percent nationally. So, as the Lt. Governor pointed out—and others have, this is not just an issue of health care, this is an issue of our economy, since health care plays such a critical role in economy. These figures are only expected to continue to grow robustly, as the population of our State continues to age and health care utilization continues to move upward.

Meanwhile, the demand for health professionals exceeds the number of new workers graduating from training programs each year. State budget constraints, outdated teaching facilities and aging faculty strain the ability of community colleges and State universities around the Nation to produce the volume of proficient pharmacists, dental and mental health providers, nurses of all levels, CNA, LPNs, RNs, advanced practice nurses, therapists and technicians to meet the growing needs of our health care system.

I have supported legislative initiatives that I hope will begin to address these various shortages, particularly in the areas of nursing and pharmacy.

We have all heard about the imminent shortage of nurses.

Many hospital administrators warn that the national nursing shortage will only grow worse in the coming years because of an aging population. Nationwide, hospitals have a shortfall of 126,000 nurses. The *Journal of the American Medical Association* says that could grow to 400,000 in the next decade.

While the nursing shortage problem is certainly acute in hospitals in Rhode Island, home health agencies and skilled nursing facilities are also feeling the painful pinch of these shortages. Interestingly, 21.8 percent of Rhode Island's health services workers were employed in nursing care facilities, while the State ranks ninth in the country in terms of employment in home health care.

I have co-sponsored legislation intended to enhance our ability to recruit and retain a new generation of nurses as well as legislation designed to improve the work environment of nurses currently on the job.

I have also been interested in the emerging shortage of pharmacists in this country. There were 6,500 openings for pharmacists at the 20,500 chain drugstores, and independents and hospital pharmacies are also recruiting.

The number of pharmacists is expected to only grow by 28,500 over the next 10 years—800 less than the 29,300 over the last decade. It is also reported that the number of applicants to pharmacy schools in 1999 was 33 percent lower than in 1994—the high point of enrollment during the 1990s. In an effort to address this problem, I have introduced bipartisan legislation, S. 1806, the Pharmacy Education Aid Act, will create scholarships for pharmacy students and provide loan repayment for those students who commit to teaching pharmacy for at least 2 years or those who practice pharmacy where there is a dire need—such as remote areas of the country.

Clearly, these are significant issues that have a direct impact on the ability of Rhode Islanders and all Americans to access health care services. Health profession shortages also have the effect of reducing quality of care and patient outcomes.

A recent *New England Journal of Medicine* study found that patient outcomes were directly correlated with nurse staffing ratios. The report, which examined the discharge records of 6 million patients at 799 hospitals in 11 States, found that in hospitals with higher numbers of registered nurses, patient stays were 3 percent to 5 percent shorter and complications were 2 percent to 9 percent lower than hospitals with fewer nurses.

The purpose of today's hearing is to explore the nature of these workforce shortages across the health care spectrum in Rhode Island, examine what steps are currently being taken at the State and Federal levels to address these issues, and ultimately gain a better understanding of the long-term solutions that will be necessary to tackle this looming crisis.

Before I close, there are a couple of administrative points I must take.

First, since there is a possibility of Senate votes this afternoon, Senator Chafee and I will have to leave here quickly at around 1:00, so we will shoot for a 1:00 p.m. termination of the hearing, and as such I would ask the witnesses to kindly respect a 5 minute limit on oral statements, with the understanding that your full written statement will be included in the record, we will have cards to assist you with the time.

We will also limit the questions of myself and my colleagues to 5 minutes each round.

For those interested in submitting written testimony, the record will be open for 14 days, so we will collect other reports that are not able to be presented orally today or in writing here today.

I want to thank you all for being here. One final set of thanks, to Ed Creole who is our media specialist, and Ed Maxum, who is our facilities director here, and to the Chief of Security, Jim Ellis, for their help in arranging this hearing this morning.

I will now ask for my colleague, Senator Lincoln Chafee, for opening remarks.

Senator Chafee.

OPENING STATEMENT OF SENATOR CHAFEE

Senator CHAFEE. It is a pleasure to be here. This is my first time in this new wing of the Community College of Rhode Island. Thank you, President Sepe, for hosting us here this morning. Thank you, Senator Reed, for again being a leader on an important issue.

As the Lieutenant Governor said, Rhode Island has an enormously high population of elderly, the highest in the Nation, as well as Florida, Arizona, I think West Virginia is in there, too, but we are right up there at the top. So this is an important issue for us, and as Senator Reed said, and, of course, Rhode Islanders have proved if we can get the leaders of an issue together, we can solve it, whether it is worker's comp or anything else, come together, and having management and representatives of labor here are so important to hammering out some kind of solution to this shortage which is reaching such crisis stages.

Senator Reed, once again, I have to thank you for your legislation. You mentioned your Pharmacist Education Aid Act, which I look forward to seeing passed, and also the Nurse Reinvestment Act. They are both good pieces of legislation, and we on the Federal side and on the State side are working very hard, Lt. Governor Fogarty, also. It is great to have everybody here, bringing their substantial brain power to work on this important issue.

Senator REED. Thank you, Senator.

Congressman Langevin.

OPENING STATEMENT OF HON. JAMES LANGEVIN

Mr. LANGEVIN. Thank you, Senator Reed, Senator Chafee, members of the panel, ladies and gentlemen. I, too, am pleased to be here in joining Senator Reed on this issue of critical importance, and I commend you, Senator Reed, for having the vision and foresight to address this workforce shortage now, and I hope we can potentially avoid the crisis in the future.

We recognize that increasing longevity of population, combined with the growing share of elderly persons has been adding pressure on the health care delivery system. Whether we are talking about providing better acute care or long-term care for our loved ones, whether it be grandparents, parents, or siblings or friends, we are going to have to act now. We are going to make sure they're getting good quality health care in the future, and I look forward to working with my colleagues both in the House and in the Senate to see what we can do to address this issue, but this hearing is important to take place when we start. I thank you.

Senator REED. Thank you very much, Congressman Langevin, for your statements, and also your great efforts in the House to help us with this issue.

Now let me introduce our first panel.

Joining us today is Dr. Roderick King of Boston, Massachusetts. Dr. King is the Director of Boston Field Office of the Health Resources and Services Administration in the United States Department of Health and Human Services. He is a Commander in the Commissioned Corps of the U.S. Public Health Service. Dr. King recently completed a 1-year appointment to the Boston field office as a Senior Health Policy Field Intern as part of a program by HRSA, Harvard University and the Commonwealth Fund to develop professional public health leadership. During his appointment, Dr. King examined workforce issues specific to Massachusetts and New England.

Dr. King was appointed as a senior lecturer in the Health Science Department of the University of Cape Coast in Ghana, West Africa. During his tenure, he was involved in a number of public health projects, including a sickle cell registry and information center, an AIDS awareness program, and the World Health Organization Polio Eradication Project.

Dr. King holds a faculty appointment at Harvard Medical School and continues to practice general pediatrics.

Thank you, Dr. King.

Next to Dr. King is Dr. Joseph Amaral.

Dr. Amaral is currently the President and Chief Executive Officer of Rhode Island Hospital and the Senior Vice President of Lifespan. He has been a Diplomat of the American Board of Surgery and a member of the Association for Patient-Oriented Research, the American College of Physician Executives. He has been the Chief of Surgery of Rhode Island Hospital and the Executive Chief of Surgery for Lifespan Affiliated Hospitals, as well as the Interim Chairman, Department of Surgery at Brown University. He has received numerous awards for clinical practice and scientific achievement. He serves on the Lifespan Academic Council and the Lifespan Teaching and Administration subcommittee, and has served on the Committee on Conflict of Interest.

In addition, he has conducted clinical research and has participated in the development of surgical devices.

I can say that he is a distinguished clinician here in the health care community. Thank you for joining us.

Next to Joe is Dr. Richard Besdine, who is currently the Interim Dean of the Brown Medical School in Providence, RI. He is also Professor of Medicine and Director of the Center for Gerontology and Health Care Research at Brown University and Director of the Division of Geriatrics in the Department of Medicine. He is the Chief of Geriatrics for Lifespan and the first Greer Professor of Geriatric Medicine.

The doctor has worked in gerontology and geriatrics for the last 30 years. He started very young. Before coming to Brown in 2000, he was, among other things, Director of the University of Connecticut Center on Aging and a principal investigator at the National Institutes of Health Claude Pepper Older Americans Independence

Center. He served for 15 years on the faculty of the Harvard Medical School and co-founded its Division on Aging.

He has a long list of academic and professional achievements.

He was the Director of the Health Care Financing Administration's Health Standards and Quality Bureau overseeing the quality of care for the Nation's 70 million Medicare and Medicaid recipients. He has been on numerous Federal task forces on aging and is on the boards of several organizations devoted to research on issues affecting the health of the elderly.

Next to Dr. Besdine is Nancy Roberts. Nancy is the President and Chief Executive Officer of Care New England Home Health, which represents the Visiting Nurses Association of Care New England, a Medicare certified, community-based home health agency, affiliated with Kent Hospital Home Care, the oldest hospital-based home care program in Rhode Island and HealthTouch, a private duty nursing agency, all located in Rhode Island. The organizations' 300 staff members visit over 10,000 patients annually.

Ms. Roberts has served as a consultant to the Rhode Island Department of Health, Division of Family Health, and has held several positions at Brigham & Women's Hospital in Boston. She volunteers her time and expertise to various boards and committees, including those of the Women & Infants Hospital, Butler Hospital, Newton Nurses Scholarship Committee, Rhode Island Public Health Foundation, the Children's Trust Fund Advisory Group, and the Visiting Nurses Associations of America, where she is Vice Chair.

Thank you very much, Nancy, for what you bring to the discussion.

Finally, our last panelist for the first panel is Dr. Norma J. Owens. Dr. Owens is a Professor of Pharmacy at the College of Pharmacy at the University of Rhode Island in Kingston. She is licensed as a registered pharmacist in Arizona, Connecticut and Rhode Island and is board certified in pharmacotherapy.

She has a clinical appointment as a Geriatric Clinical Pharmacy Consultant in the Rhode Island Hospital's Division of Geriatric Medicine and Department of Pharmacy.

She serves on the Pharmacy and Therapeutics Committee, the AIDS Steering Committee, the Research and Education Committee and the Antibiotic Use Committee at the Rhode Island Medical Center, and on the Curriculum Committee, the Admissions Committee, and the Committee for Prior Learning and as Faculty Marshall at the University of Rhode Island College of Pharmacy.

She has authored numerous scholarly articles and has conducted funded clinical research. Much of her writing and research has focused on pharmaceutical effects on the elderly in different clinical settings.

Thank you very much, Dr. Owens, for joining us today.

Now, let me turn it over to Dr. King, and with the only one further admonition, 5 minutes, please.

**STATEMENT OF RODERICK K. KING, DIRECTOR, BOSTON
FIELD OFFICE, REGION I (NEW ENGLAND), HEALTH
RESOURCES AND SERVICES ADMINISTRATION**

Mr. KING. Well, in the spirit of trying to stay on time and make sure you catch your airplane, I'll jump right into it.

The Health Resources and Services Administration appreciates this opportunity to testify before the Senate Health, Education, Labor and Pensions Committee on health professions workforce shortages.

Legislation authorizes HRSA to work to ensure that an adequate health care workforce is available to meet the health care needs of all Americans—regardless of their location and/or income. HRSA does this through a variety of programs, such as Titles VII and VIII of the Public Health Service Act, which created programs that fund the training of health professionals, including nurses. In addition, the National Health Service Corps, which provides scholarships and loan repayment for individuals willing to work in underserved areas, and this is similar to Nursing Education Loan Repayment Program under Title VIII.

Additionally, HRSA's National Center for Health Workforce Analysis, also under Title VII, provides data and analysis on workforce needs, which is essential for identifying shortages and to advise planners and policymakers.

I would like to review for the Committee two recent in-depth studies produced by HRSA's National Center for Health Workforce analysis which provide detailed information on workforce needs in two key areas of health professions whose services are well known to Americans on a daily basis.

The first, "Project Supply and Demand and Shortages of Registered Nurses: 2000-2020" examines data on the most commonly recognized health care shortage, that is for registered nurses. Registered nurses make up about a fifth of all health professionals and serve across the spectrum of medical specialties and services. Current data indicate that the demand for the registered nurses is expected to grow by 40 percent between 2000 and 2020. In contrast to this growth in need, the current projection for growth of this workforce during this same time period is only 6 percent. Two facts underlie this deficit: The registered nurse workforce is an aging population with more and more registered nurses approaching retirement age, while at the same time the number of entrants to that workforce is declining. Since 1995, the number of registered nurse graduates has declined by 31 percent nationally according to the National Council of State Boards of Nursing.

The study, "Projected Supply and Demand Shortages of Registered Nurses: 2000-2020" estimates a 6 percent national shortage of registered nurses in 2000, but by 2010 it projects the shortage at 12 percent and by 2015, 20 percent. If current trends continue, there will be a 29 percent shortage by 2020.

In 2000, 30 States and the District of Columbia were estimated by the National Workforce report to be experiencing shortages of registered nurses, shortages defined as shortages greater than 3 percent. By 2020, the number of States with shortages is projected to grow to 44. The national media recently widely reported a study which indicated that adequate ratios of registered nurses are a key

to a favorable patient outcome, as reports from around the Nation increasingly highlight the inability of medical facilities to adequately staff registered nurse positions.

Now, Rhode Island substantiates this national trend. Although the 2000 National Sample Survey from HRSA's Division of Nursing showed that Rhode Island had a little over 1,000 registered nurses per 100,000 population in 2000—significantly above the national average of 782 nurses per 100,000, it too is being affected by national trends. "Projected Supply and Demand and Shortages of Registered Nurses 2000-2020" estimated a 10 percent shortage in registered nurses in Rhode Island in 2000, a 16 percent shortage in 2005, a 26 percent shortage in 2010, a 38 percent shortage by 2015 and a 48 percent shortage by 2020.

In a national context, the report indicates that Rhode Island was one of 14 States in 2000 having a double-digit shortage in registered nurses, with most shortages in the 10 to 12 percent range. By 2020, report data estimate that Rhode Island will have the eighth highest shortage among States, with 13 States having shortages of 40 percent or higher.

In response to this critical shortage in nursing and its effect on our entire health care system, under this Administration, funding for the Nursing Education Loan Repayment Program has increased four-fold—from \$2.3 million to \$7.3 million for fiscal year 2001 and to \$10.3 million in fiscal year 2002. The President's fiscal year 2003 budget request is \$15 million, another 50 percent increase. This program is one of the most expeditious means of targeting nurses to underserved areas, with nurses who already have degrees, agreeing to serve a minimum of 2 years in a designated health shortage area in exchange for assistance with their educational loans.

The second, very briefly, is called, "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists" is an in-depth workforce study of pharmacists. The study details factors beyond population growth that are driving the demand in this workforce area.

Some of these factors include:

The fact that recent growth in the number of prescriptions has been four times that of the growth in the number of pharmacists.

The growing education and prevention role that pharmacists are now expected to play, especially in the context of an aging population of patients who have increasingly complex medication regimens.

The competition among retail pharmacies has resulted in expanded store hours and new store openings.

The increased insurance coverage for prescription drugs, resulting in increasing administrative demands on pharmacists' time.

The increasing role of pharmacists in preventing medication error.

The increasing entry of women into the pharmacist workforce, from 13 percent of that workforce in 1970 to 46 percent in 2000, has resulted in workforce participants desiring part-time and shorter hours, and the increased use of pharmacists in institutional settings and in research.

Rhode Island is fortunate, according to the HRSA State Health Workforce Profiles, that it had 95.2 pharmacists and 107.3 pharmacy technicians and aides per 100,000 population in 1998, ranking Rhode Island first and second respectively among the 50 States in 1998.

However, Rhode Island too is being affected by data reported by the National Center Report on pharmacists, that nationally the number of vacancies for pharmacists has doubled in the last 2 years. In 2000, "The Pharmacist Workforce" estimated that the United States needed 14 percent more pharmacists. By 2005, the estimated need will be 35 percent more. Report data indicate a decline in the late 1990s in the number of pharmacy graduates, with a corresponding decline in the number of applicants to pharmacy schools—the latter were 33 percent lower in 1999 than in 1994, the high point over the past decade.

The shortage of pharmacists, like that of registered nurses, crosses the entire spectrum of health care facilities, including the Federal service. Pharmacist vacancy rates in the Public Health Service are 11 percent, in the armed forces 15 to 18 percent, and the Department of Veterans Affairs and Native American health centers have some facilities with less than half of their pharmacist positions filled, according to "The Pharmacist Workforce." To ensure an adequate workforce, however, it is essential to realize that millions of Americans face barriers to quality health care because of the maldistribution of the health care workforce. Distribution of health care personnel is as important as the overall total of the workforce. In terms of health care, rural areas, inner city areas, and certain populations of Americans—most notably certain racial and ethnic populations—are underserved.

Statistics for HRSA's Shortage Designation Branch report that some 56 million people live in more than 3,100 health professional shortage areas; 33 million Americans are underserved, most of them in predominantly rural counties. To alleviate these gaps in access to basic health care, data estimate that an additional 15,000 primary care physicians would be required to fill this need. This is the equivalent of virtually an entire annual graduating class from U.S. medical schools according to figures of the Association of American Medical Colleges.

In 2001, the National Health Service Corps, which has about 2,400 clinicians serving nationwide, received more than 3,800 requests from underserved areas for assistance in recruiting National Health Service Corps clinicians to provide basic health care.

The President has made increasing health care services for the underserved a priority of his Administration. Health centers are a primary source of health services for the underserved. The President's Initiative for Health Centers plans a multi-year expansion to increase the number of Health Center access points by 1,200 and increase the number of patients served by 6.1 million.

Recognizing the key role of the HRSA's National Health Service Corps, the President has requested an increase of over \$44 million for Fiscal Year 2003 for the National Health Service Corps. As the budget notes, the National Health Service Corps has been a significant source of staffing support for the Health Center program, with 46 percent of the National Health Service Corps clinicians cur-

rently serving in Health Centers. In many cases, the National Health Service Corps is the only source of clinicians to care for racially and ethnically diverse communities that lack access to services and experience increased health disparities.

This increase of \$44 million for the National Health Service Corps program will support an additional 131 scholars who will be available for future service, an additional 454 National Health Service Corps Loan Repayment recipients who agree to serve in underserved areas in exchange for assistance with their educational training loans, and an additional 144 mental and behavioral health National Health Service Corps Loan Repayment professionals. These will provide needed services in underserved communities and help staff the growing Health Centers program.

In the end, the two HRSA reports I discussed on registered nurses and pharmacists, as well as a major HRSA report issued last December of State-by-State profiles of the Nation's health workforce, are available from HRSA, and further information regarding these and other reports is available at the HRSA website at www.hrsa.gov. The State-by-State profiles are the first such comprehensive detailed data on the supply and demand for physicians, nurses, dentists, and 20 other health care professionals in all 50 States and the District of Columbia.

Again, I thank you for HRSA's opportunity to testify regarding this important subject and I will be happy to answer any questions you might have.

[The prepared statement of Dr. Roderick K. King follows:]

PREPARED STATEMENT OF RODERICK K. KING

The Health Resources and Services Administration appreciates this opportunity to testify before the Senate Health, Education, Labor and Pensions Committee on health professions workforce shortages.

Legislation authorizes HRSA to work to ensure that an adequate health care workforce is available to meet the health care needs of all Americans—regardless of their location or income. HRSA does this through a variety of programs such as: Titles VII and VIII of the Public Health Service Act which created programs that fund the training of health professionals, including nurses; and the National Health Service Corps (NHSC) which provides scholarships and loan repayment for individuals willing to work in underserved areas (similar to the Nursing Education Loan Repayment Program under Title VIII). Additionally, HRSA's National Center for Health Workforce Analysis, also under Title VII, provides data and analysis on workforce needs which is essential for identifying shortages and to advise planners and policymakers.

I would like to review for the Committee two recent in-depth studies produced by HRSA's National Center for Health Workforce Analysis which provide detailed information on workforce needs in two key areas of health professions whose services are well known to Americans on a daily basis.

The first, "Projected Supply and Demand and Shortages of Registered Nurses: 2000-2020" examines data on the most commonly recognized health care shortage, that for registered nurses. Registered nurses make up about a fifth of all health care professionals and serve across the spectrum of medical specialties and services. Current data indicate that the demand for registered nurses is expected to grow by 40 percent between 2000 and 2020. In contrast to this growth in need, the current projection for growth of this workforce during this same period is only 6 percent. Two facts underlie this deficit: the registered nurse workforce is an aging population with more and more registered nurses approaching retirement age, while at the same time the number of entrants to that workforce is declining. Since 1995, the number of registered nurse graduates has declined by 31 percent nationally according to the National Council of State Boards of Nursing.

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projects the shortage at 12 percent and by 2015, 20 percent. If current trends continue, there will be a 29 percent shortage by 2020.

In 2000, thirty States and the District of Columbia were estimated by the National Workforce report to be experiencing shortages of registered nurses (shortages defined as shortages greater than 3 percent). By 2020, the number of States with shortages is projected to grow to 44. The national media recently widely reported a study which indicated that adequate ratios of registered nurses are a key to favorable patient outcomes, as reports from around the Nation increasingly highlight the inability of medical facilities to adequately staff registered nurse positions.

Rhode Island statistics substantiate this national trend. Although the 2000 National Sample Survey from HRSA's Division of Nursing showed that Rhode Island had 1,101 registered nurses per 100,000 population in 2000—significantly above the national average of 782 nurses per 100,000, it too is being affected by national trends. "Projected Supply and Demand and Shortages of Registered Nurses 2000-2020" estimated a 10 percent shortage in registered nurses in Rhode Island in 2000, a 16 percent shortage in 2005, a 26 percent shortage in 2010, a 38 percent shortage by 2015, and a 48 percent shortage by 2020.

In a national context, the report indicates that Rhode Island was one of 14 States in 2000 having a double-digit shortage in registered nurses, with most shortages in the 10 to 12 percent range. By 2020, report data estimate that Rhode Island will have the eighth highest shortage among States, with 13 States having shortages of 40 percent or higher.

In response to the critical shortage in nursing and its effects on our entire health care system, under this Administration, funding for the Nursing Education Loan Repayment Program has increased four-fold—from \$2.3 million to \$7.3 million for fiscal year 2001 and to \$10.3 million in fiscal year 2002. The President's fiscal year 2003 budget request is \$15 million, another 50 percent increase. This program is one of the most expeditious means of targeting nurses to underserved areas, with nurses who already have degrees agreeing to serve a minimum of 2 years in a designated health shortage area in exchange for assistance with their educational loans.

The second National Center recently completed report "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists" is an in-depth workforce study of pharmacists. The study details factors beyond population growth that are driving the demand in this workforce area. Some of these factors include:

- The fact that recent growth in the number of prescriptions has been four times that of the growth in the number of pharmacists;
- The growing education and prevention role that pharmacists are now expected to play, especially in the context of an aging population of patients who have increasingly complex medication regimens;
- The competition among retail pharmacies has resulted in expanded store hours and new store openings;
- The increased insurance coverage for prescription drugs, resulting in increasing administrative demands on pharmacists' time;
- The increasing role of pharmacists in preventing medication error; the increasing entry of women into the pharmacist workforce (from 13 percent of that workforce in 1970 to 46 percent in 2000) has resulted in workforce participants desiring part-time work and shorter hours; and
- The increased use of pharmacists in institutional settings and in research.

Rhode Island is fortunate, according to HRSA State Health Workforce Profiles in that it had 95.2 pharmacists and 107.3 pharmacy technicians and aides per 100,000 population in 1998, ranking Rhode Island first and second respectively among the 50 States in these areas.

However, Rhode Island too is being affected by data reported by the National Center Report on pharmacists showing that nationally the number of vacancies for pharmacists has doubled in the last 2 years. In 2000, "The Pharmacist Workforce" estimated that the United States needed 14 percent more pharmacists; by 2005, the estimated need will be 35 percent more. Report data indicate a decline in the late 1990s in the number of pharmacy graduates, with a corresponding decline in the number of applications to pharmacy schools—the latter were 33 percent lower in 1999 than in 1994, the high point over the past decade.

The shortage of pharmacists, like that of registered nurses, crosses the entire spectrum of health care facilities including the Federal service. Pharmacist vacancy rates in the Public Health Service are 11 percent; in the armed forces, 15 to 18 percent; and the Department of Veterans Affairs and Native American health centers have some facilities with less than half of their pharmacist positions filled, according to "The Pharmacist Workforce."

To ensure an adequate workforce, however, it is essential to realize that millions of Americans face barriers to quality health care because of the maldistribution of the health care workforce. Distribution of health care personnel is as important as the overall total of the workforce. In terms of health care, rural areas, inner city areas, and certain populations of Americans—most notably certain racial and ethnic populations—are underserved.

Statistics from HRSA's Shortage Designation Branch report that some 56 million people live in more than 3,100 health professional shortage areas; 33 million Americans are underserved, most of them in predominantly rural counties. To alleviate these gaps in access to basic health care, data estimate that an additional 15,000 primary care physicians would be required to fill this need. This is the equivalent of virtually an entire annual graduating class from U.S. medical schools according to figures of the Association of American Medical Colleges.

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Recognizing the key role of the HRSA's National Health Service Corps, the President has requested an increase of over \$44 million for FY2003 for the NHSC. As the budget notes, the NHSC has been a significant source of staffing support for the Health Center program, with 46 percent of the NHSC clinicians currently serving in Health Centers. In many cases, the NHSC is the only source of clinicians to care for racially and ethnically diverse communities that lack access to services and experience increased health disparities.

This increase of \$44 million for the NHSC program will support an additional 131 scholars who will be available for future service, an additional 454 NHSC Loan Repayment recipients who agree to serve in underserved areas in exchange for assistance with their educational training loans, and an additional 144 mental and behavioral health NHSC Loan Repayment professionals. These will provide needed services in underserved communities and help staff the growing Health Centers program.

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Again, I thank you for HRSA's opportunity to testify regarding this important subject and will be happy to answer any questions you might have.

Senator REED. Thank you, Dr. King, for your very excellent testimony.

I would like to call now Dr. Amaral, and note that Dr. Amaral and Dr. King have to leave at noon. So if we are still going throughout the questioning and we have questions, we'll submit to them to you in writing.

STATEMENT OF JOSEPH AMARAL, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, RHODE ISLAND HOSPITAL

Dr. AMARAL. Senator Reed, Senator Chafee, Representative Langevin and Governor Fogarty, it is a pleasure to be here with you this morning addressing such a vitally important project.

As a professor, and as a practicing surgeon, I have seen up close the impact of health care workforce shortages on my own ability to teach, to do research and to provide the highest quality medical care. As the president of a major teaching hospital, the third largest in New England, I struggle daily with the impact of these shortages, on our ability to care for our patients, on our employee

morale, on our labor relations, on our hospital costs, and ultimately on Rhode Island Hospital's ability to fulfill its mission.

There is a lot of discussion in the media about the nursing shortage, and I can tell you that shortage is real. It is a challenge we face every day. However, I am most grateful that this hearing is addressing the shortage in all health care professions, including radiology technicians, respiratory therapists, pharmacists, and all the other professionals along the health care continuum including non-direct care providers. Unless we address these shortages, this looming crisis will threaten the availability, quality and cost of health care in the years ahead.

I would like to begin this morning by discussing what I believe are the broader environmental shifts within health care that serve as the backdrop for today's health care professional shortages. I would like to then explain how a lack of available health care workers plays out at Rhode Island Hospital, and at hospitals everywhere. Finally, I would like to briefly mention what we are doing to tackle this challenge. While we need the help of you and your colleagues in Congress to support pipeline programs and reimbursement policies that make these professions attractive again, we in the health care industry need to do our part as well. I assure you, we are not standing still.

If I could you and your colleagues on a tour of our hospital to highlight the shortage of health care workers, I would take you first to our billing and coding department.

Why? Because reimbursement policies, from Medicare to Medicaid, as well as from private sector insurers, have created an environment for medical practice that makes providing care to patients a difficult and thankless job. The documentation-driven nature of modern health care also gives the perception to the caregiver that paperwork is more important than providing care. As any nurse, my wife, for example, she entered the profession to care for people, not paper.

It is also the case that, quite frankly, hospitals have had to ask more of nurses and other professionals as part of the institutions' efforts to control costs.

When hospitals are not paid enough to cover their costs, which in Rhode Island we are not, when we are also responsible for caring for the uninsured and the underinsured, which we are, when we also value teaching and research, which we do, even though it is costly, then cost cutting becomes an imperative just to survive.

Any comprehensive effort to reduce costs and manage the budget requires taking labor and efficiency into account. We work hard on that every day. Unfortunately, these measures often require a complete redesign of processes that in themselves are time consuming, costly and have unanticipated consequences. But this has in many cases translated to fewer caregivers caring for more patients. There are right ways and wrong ways to increase efficiency, however, as I will talk about it in a minute. Many early attempts at cost control wrongly focus on nurses and other allied health professionals as the problem, not the solution. The result is an environment of declining professional respect for all health members of the health care team. This must be reversed.

Work environment is not solely to blame. Demographic trends, increasing opportunities for women throughout the workforce and the nagging perception of jobs, like nursing as “woman’s professions” have dwindled the ranks in key health professions and have slowed the number of new applicants. I am sure we will hear more about that from other panelists.

What options do these shortages leave in a major teaching hospital? One is to close beds and services. Doing so affects how soon patients get the care they need and where they get that care. If hospitals reduce bed capacity because they simply don’t have the manpower to fully staff the hospital, it means patients wait longer in the emergency room before being admitted. Delays in length of stay are associated with increased costs and oftentimes with no increase in reimbursement. Moreover, these delays may make patients worse. And shortages outside the hospital can exacerbate the problem within it. If physician practices and clinics seeing patients are available few hours of the day, these patients end up in the emergency room. It is a game of health care musical chairs, and when the music stops, it is often the patient without a seat, or without a bed, or without the quality and continuity of care that we all aspire to, and the music usually stops in the emergency room.

Another scenario is to stretch your available workforce as far as possible through overtime, and to hire expensive contract labor from for-profit agencies. Neither practice leads to optimal care, and both are incredibly costly. Let me give you an example.

In fiscal year 2001, Rhode Island Hospital’s net operating loss was \$29 million on contract labor. That is contracting out to other companies for the shifts and jobs we couldn’t cover with our own employees. That figure does not include what we spend on overtime, what we spend on recruitment or what we spent for routine wages and benefits. I certainly would prefer to spend that money on professionals who are interested in building a career in our institution and in our State.

Hospital financing has always involved a certain amount of “robbing peter to pay Paul.” Well, due to the severe shortages we are facing, hospitals are paying Peter overtime, and we are also paying Paul.

OK. Enough hand wringing. What are we doing about it?

For one thing, we are getting smarter about the use of technology. For example, we have automated our laboratory services, allowing us to run the lab better and more efficiently with fewer people, and has benefited patients and physicians. The same can be said for investments in information technology, including order entry, nursing documentation and result tracking.

For another, we are turning our greatest assets, our own employees, into a recruiting force. On that same tour of Rhode Island Hospital, one of the first things you would see when you walked in the door is a sign promoting our recruitment bonus—we are offering \$5,000 to employees who recruit or refer new hires for key positions.

And, finally, we are investing in our employees so they feel better about their jobs and stay in them longer. Through employee forums, competitive compensation, new professional development op-

opportunities and commitment to continuing education, we are making clear to all our employees that we need them and that we value them. In fact, we have employed a chief retention officer—and yes, she is a nurse—whose full-time job is to keep our employees here and happy. I am proud to say that in the past 2 years we have reduced our turnover rate at Rhode Island Hospital by 34 percent and our current rate of 9 percent is both low for our State and low for our industry. We are also working to increase what I call the “cultural competency” of our workforce, with dedicated outreach efforts to communities under-represented in the health care profession, as well as language classes for our employees. The face of America is changing, and at some point the health care workforce will need to catch up.

What can you in the Congress do? Fund Title VII training programs that produce more nurses, recruit minorities into the profession, and increase the ranks of primary caregivers. Adequately fund and broaden medical education, so that teaching hospitals can continue to serve as classrooms for tomorrow’s nurses and technicians and pharmacists, as well as doctors, and continue to hold hearings like this one, raising important issues and bringing community voices before Congressional committees.

I am happy to take any questions, but I want to close, Senator Reed, by thanking you for your leadership on academic medicine and on health care in general. I have always been proud to call you my Senator. Thank you.

[The prepared statement of Joseph Amaral, M.D. follows:]

PREPARED STATEMENT OF JOSEPH F. AMARAL, M.D.

Senator Reed, fellow panelists, my name is Dr. Joseph Amaral, and I am President and CEO of Rhode Island Hospital and Professor of Surgery at Brown Medical School. It is a pleasure to be here this morning addressing such a vitally important topic.

As a professor, and as a practicing surgeon, I have seen up close the impact of health care workforce shortages on my own ability to teach, to do research, and to provide the highest quality medical care. As the president of a major teaching hospital, the third largest in New England, I struggle daily with the impact of these shortages: on our ability to care for our patients, on our employee morale, on our labor relations, on our hospital costs, and ultimately on Rhode Island Hospital’s ability to fulfill its mission.

There is a lot of discussion in the media about the “nursing shortage,” and I can tell you that shortage is real. It is a challenge we face every day. However, I am most grateful that this hearing is addressing the shortage in all health professions, including radiology technologists, respiratory therapists, pharmacists, and other professionals along the health care continuum including non-direct care providers. Unless we address these shortages, this looming crisis will threaten the availability, quality, and cost of health care in the years ahead.

I would like to begin this morning by discussing what I believe are the broader environmental shifts within health care that serve as the backdrop for today’s health care professional shortages. I’d like to then explain how a lack of available health care workers plays out at Rhode Island Hospital, and at hospitals everywhere. Finally, I’d like to briefly mention what we’re doing to tackle this challenge. While we need the help of you and your colleagues in Congress to support pipeline programs and reimbursement policies that make these professions attractive again, we in the health care industry need to do our part as well. I assure you, we are not standing still.

If I could take you and your colleagues on a tour of our hospital to highlight the shortage of health care workers, I’d take you first to our billing and coding department.

Why? Because reimbursement policies, from Medicare and Medicaid as well as from private sector insurers, have created an environment for medical practice that makes providing care to patients a difficult and thankless job. The documentation-

driven nature of modern health care also gives the perception to the caregiver that paperwork is more important than providing care. Ask any nurse, my wife for example: she entered the profession to care for people, not paper.

It is also the case that, quite frankly, hospitals have had to ask more of nurses and other professionals as part of the institutions' efforts to control costs.

When hospitals aren't paid enough to cover their costs—which in Rhode Island we are not—when we are also responsible for caring for the uninsured and the underinsured—which we are—when we also value teaching and research—which we do—even though it is costly, then cost cutting becomes an imperative just to survive.

Any comprehensive effort to reduce costs and manage the budget requires taking labor and efficiency into account. We work hard on that every day. Unfortunately, these measures often require a complete redesign of processes that in themselves are time consuming, costly and have unanticipated consequences. But this has in many cases translated to fewer caregivers caring for more patients. There are right ways and wrong ways to increase efficiency, however, as I'll talk about it a minute. Many early attempts at cost control wrongly focus on nurses and other allied health professionals as the problem, not as the solution. The result is an environment of declining professional respect for all health care professionals. This must be reversed.

Work environment isn't solely to blame. Demographic trends, increasing opportunities for women throughout the workforce, and the nagging perception of jobs like nursing as "woman's professions" have dwindled the ranks in key health professions, and have slowed the number of new applicants. I'm sure we'll hear more about that from other panelists.

What options do these shortages leave for in a major teaching hospital? One is to close beds and services. Doing so affects how soon patients get the care they need, and where they get that care. If hospitals reduce bed capacity because they simply don't have the manpower to fully staff the hospital, it means patients wait longer in the emergency room before being admitted. Delays in length of stay are associated with increased costs and often times with no increase in reimbursement.

Moreover, these delays may make patients worse. And shortages outside the hospital can exacerbate the problem within it—if physician practices and clinics seeing patients are available fewer hours of the day, these patients end up in the emergency room. It is a game of health care musical chairs, and when the music stops, it is often the patient without a seat, or without a bed, or without the quality and continuity of care that we all aspire to, and the music usually stops in the emergency room.

Another scenario is to stretch your available workforce as far as possible through overtime, and to hire expensive, contract labor from for-profit agencies. Neither practice leads to optimal care, and both are incredibly costly. Let me give you an example.

In fiscal year 2001, Rhode Island Hospital's net operating loss was \$26 million. In that same year, Rhode Island Hospital spent \$21 million on contract labor—that's contracting out to other companies for the shifts and jobs we couldn't cover with our own employees. That figure does not include what we spent on overtime, what we spent on recruitment, or what we spent for routine wages and benefits.

Hospital financing has always involved a certain amount of "robbing Peter to pay Paul." Well, due to the severe shortages we're facing, we're paying Peter overtime, and we're ALSO paying Paul.

OK, enough hand wringing. What are we doing about it?

For one thing, we are getting smarter about the use of technology. For example, we have automated our laboratory services, which has allowed us to run the lab better and more efficiently with fewer people, and has benefited patients and physicians. The same can be said for investments in information technology, including order entry, nursing documentation and result tracking.

For another, we are turning our greatest assets, our own employees, into a recruiting force. On that same tour of Rhode Island Hospital, one of the first things you'd see when you walked in the door is a sign promoting our recruitment bonus—we're offering \$5,000 to employees who recruit or refer new hires for key positions.

And finally, we are investing in our employees so they feel better about their jobs and stay in them longer. Through employee forums, competitive compensation, new professional development opportunities and commitment to continuing education, we are making clear to all our employees that we need them, and we value them. In fact, we have employed a chief retention officer—and yes, she's a nurse—whose full-time job is to keep our employees here and happy.

I am proud to say that in the past 2 years we have reduced our turnover rate at Rhode Island Hospital by 34 percent and our current rate of 9 percent is both low for our State and low for our industry. We are also working to increase what

I call the “cultural competency” of our workforce, with dedicated outreach efforts to communities under-represented in the health care profession, as well as language classes for our employees. The face of America is changing, and at some point the health care workforce will need to catch up.

What can you in the Congress do? Fund Title VII training programs that produce more nurses, recruit minorities into the profession, and increase the ranks of primary caregivers. Adequately fund and broaden medical education, so that teaching hospitals can continue to serve as classrooms for tomorrow’s nurses and technicians, as well as doctors. And continue to hold hearings like this one, raising important issues and bringing community voices before Congressional committees.

I am happy to take any questions, but I want to close, Senator Reed, by thanking you for your leadership on academic medicine, and on health care in general. I have always been proud to call you my Senator. Thank you.

Senator REED. Thank you very much for your testimony.
Dr. Besdine, please.

**STATEMENT OF RICHARD W. BESDINE, M.D., FACP, INTERIM
DEAN, BROWN MEDICAL SCHOOL**

Dr. BESDINE. Senator Reed, Lieutenant Governor Fogarty, I want to thank you for the opportunity to testify before the Committee, and for your leadership in directing Congress’s attention to such an important and pressing issue as the critical shortages in our Nation’s health care workforce.

In addition to serving as Interim Dean of the Medical School, a post I assumed earlier this month, I also come to this issue from my additional roles, as president-elect of the American Geriatrics Society, and as a physician who has worked in geriatric medicine, as a clinician, educator, scientist and administrator for more than 30 years. From each of these vantage points, I see a deeply troubling future for health care nationally and for future economic harm here in Rhode Island.

In deference to the expertise represented elsewhere on this panel, I would like to limit my brief remarks this morning to three topics:

First, a broad overview of the physician workforce trends and how they influence and are influenced by our health care system.

Second, the interconnection between physicians and other health care professionals, whose fields are suffering from shortages far more severe than we find in medicine, and how those shortages affect medical education and medical practice.

And, finally, as a geriatrician, I would like to share my serious concerns about the coming collision between our rapidly growing aging population and the paucity of physicians trained to adequately manage their care.

If there is any good news in physician workforce trends, it is that there is probably an adequate number of physicians practicing in the United States overall. The bad news, however, is that in more than half the country, these practitioners are working in the geographic area and have skills and training that are not matched to areas of need.

Imagine if the Red Sox had a lineup total of nine players in the dugout, but they were three first basemen, six catchers, and no one to play the outfield.

Here in Rhode Island, some of the most recent data available suggests that psychiatrists, certain pediatric specialists, geriatricians and primary care physicians are in critically short supply. In

many of these cases, managed care policies and Medicare reimbursement biases exacerbate or even drive these trends, particularly threatening access of our most disadvantaged, elderly citizens.

Even in practice areas not currently plagued by shortages, the undersupply of nurses and other health care professionals impairs the way physicians function, and the care they deliver at the bedside.

Increasingly, and this is especially true in my field of geriatrics, delivering quality health care competently and in high quality is a team effort, and nowhere is it more prudent than in geriatrics. Many factors, including increasing medical complexity, the growing role of medications in treating and managing disease, and the time-compressed nature of a doctor's practice mean that physicians rely more than ever on nurses, therapists, pharmacists and other health professionals to do things that previously have been done solo by doctors.

These non-physician health care professionals have received highly specialized training and can now perform these tasks more economically and just as effectively as most physicians. Nurse clinicians, for example, are far better equipped to prevent, detect and treat bed sores than most physicians. Pharmacists are more likely to notice potential drug-disease and drug-drug interactions and flag them before patient harm eventually occurs.

You will hear later from my fellow panelists about alarming workforce trends in nursing, pharmacy, and radiology technologists. I want to reiterate, as a physician, that every aspect of medical practice, as well as medical education and research, relies on a foundation of teaming with nurses and other professionals. When members of the team vanish, the foundation weakens, and eventually crumbles.

This is not the time to roll back support for vital Title VII and Title VIII programs, as has been proposed by President Bush. This funding supports a wide variety of training and scholarship programs in the State of Rhode Island. These programs are designed to increase the number of primary care providers, particularly in rural and other underserved areas, through training in multidisciplinary settings. Additionally, the grants seek to diversify the health professions workforce by recruiting and training under represented minorities. I applaud your efforts to restore these important funds, and I hope you will count on us as your partner in making that happen.

Finally, I would like to close by doing what all geriatricians are trained to do: Advocate for optimal care of elderly patients.

There is an acute and worsening shortage of geriatricians that threatens the well-being of older Americans, a group that will double in numbers in the next 30 years. National estimates project that we will be 25,000 geriatricians short by the year 2030 if current trends continue. In Rhode Island alone, we are 50 geriatricians short, relative to need. That is 5-0. And the problem is even bigger than that number suggests, since geriatricians not only care for elderly patients, but also they train other physicians how to best diagnose and treat the complex, multi-system diseases and conditions that most often beset our oldest citizens. In this case, as

with nursing, we are short on practitioners and we are short on teachers.

Ironically, Medicare, the very program created to serve older Americans' health care needs and to fund graduate medical education, often does not pay for the training of geriatricians.

Because of the residency caps imposed as part of the Balanced Budget Act of 1997, academic medical centers are not free to respond to the growing need for geriatricians by expanding their residency programs to include training of geriatricians. Because geriatrics was a new and emerging field when the caps were imposed, the training slots around the country were limited, and despite the increasing demand, Medicare support has been frozen in time through the BBA—funding no new residence slots unless teaching hospitals cut other residencies. Here in Rhode Island, one of the oldest and fastest aging States in the country, we were only able to launch our new geriatric fellowship program through the generosity of the Miriam Hospital Foundation and Brown's other affiliated hospitals.

I urge you and your Senate colleagues to consider, as part of this year's health care legislation, giving hospital-based teaching programs the necessary flexibility to increase their residency slots to meet the changing health care needs of a changing America.

Thank you for your time, and I would be happy to answer any questions.

[The prepared statement of Dr. Richard Besdine follows:]

PREPARED STATEMENT OF RICHARD W. BESDINE, M.D.

Senator Reed, distinguished guests, my name is Richard Besdine, and I am Interim Dean for the Brown Medical School.

I want to thank you for the opportunity to testify before this committee, and for your leadership in directing Congress' attention to such an important and pressing issue as the critical shortages in our Nation's health care workforce.

In addition to serving as Interim Dean of the Medical School, a post I assumed earlier this month, I also come to this issue from my additional roles: as president-elect of the American Geriatrics Society, and as a physician who has worked in geriatric medicine, as clinician, educator, scientist and administrator, for more than 30 years. From each of these vantage points, I see a deeply troubling future for health care of our citizens.

In deference to the expertise represented elsewhere on this panel, I'd like to limit my brief remarks this morning to three topics:

- First, a broad overview of the physician workforce trends, and how they influence and are influenced by our health care system;
- Second, the interconnection between physicians and other health care professionals, whose fields are suffering from shortages far more severe than in medicine, and how those shortages affect medical education and medical practice; and
- Finally, as a geriatrician, I'd like to share my serious concerns about the coming collision between our rapidly growing aging population and the paucity of doctors trained to adequately manage their care.

Physician Supply

If there is any good news in physician workforce trends, it is that there is probably an adequate number of physicians practicing in the United States overall. The bad news, however, is that in more than half the country, these practitioners are working in the wrong places and have skills and training that are not matched to areas of need.

Imagine if the Red Sox had a total of nine players in the dugout, but they were three first-basemen, six catchers, and no one to play the outfield.

Here in Rhode Island, some of the most recent data available suggests that psychiatrists, certain pediatric specialists, geriatricians and primary care physicians are in critically short supply. In many of these cases, managed care policies and

Medicare reimbursement biases exacerbate or drive these trends, particularly threatening access for our elderly citizens.

Interconnection of Professionals

Even in practice areas not currently plagued by shortages, the undersupply of nurses and other health care professionals impairs the way physicians function, and the care they deliver at the bedside.

Increasingly—and this is especially true in my field of geriatrics—delivering quality health care is a team effort. Many factors, including increasing medical complexity, the growing role of medications in treating and managing disease, and the time-compressed nature of a doctor's practice mean that physicians rely more than ever on nurses, therapists, pharmacists and other health professionals to do things that they historically have done alone.

These non-physician health care professionals have received more specialized training and can now perform these tasks more economically and just as effectively as most physicians. Nurse clinicians, for example, are far better equipped to prevent, detect, and treat bed sores. Pharmacists are more likely to notice potential drug-disease and drug-drug interactions and flag them before harm occurs.

You'll hear more specifics this morning from my fellow panelists about the alarming workforce trends in nursing, pharmacy, and radiology technologists. For my part, I want to reiterate, as a physician and an educator, that every aspect of medical practice, as well as medical education and medical research, relies on a foundation of teaming with nurses and allied health professionals. When members of the team vanish, the foundation weakens, and eventually crumbles.

This is not the time to roll back support of vital Title VII and Title VIII programs, as has been proposed by President Bush. This funding supports a variety of training and scholarship programs in the State of Rhode Island. These programs are designed to increase the number of primary care providers, particularly in rural and other underserved areas, through training in multidisciplinary settings. Additionally, the grants seek to diversify the health professions workforce by recruiting and training underrepresented minorities. I applaud your efforts to restore these important funds, and I hope you'll count on us as your partner in making that happen.

The Acute Shortage in Geriatrics

Finally, I'd like to close by doing what all geriatricians are trained to do: advocate for the optimal care of elderly patients.

There is an acute and worsening shortage of geriatricians that threatens the well-being of older Americans—a group that will double in numbers in the next 30 years. National estimates project that we'll be 25,000 geriatricians short by the year 2030 if current trends continue. In Rhode Island alone, we are 50 geriatricians short, relative to need. 5-0. And the problem is even bigger than that number suggests, since geriatricians not only care for elderly patients, but also they train other physicians how to best diagnose and treat the complex, multi-system diseases and conditions that most often beset our oldest citizens. In this case, as with nursing, we're short on doctors AND we're short on teachers.

Ironically, Medicare, the very program created to serve older Americans' health needs and to fund graduate medical education, does not pay for the training of geriatricians.

Because of the residency caps imposed as part of the Balanced Budget Act of 1997, academic medical centers are not free to respond to the growing need for geriatricians by expanding their residency programs to include training of geriatricians. Because geriatrics was a new and emerging field when the caps were imposed, the training slots around the country were limited, and despite the increasing demand, Medicare support has been frozen in time through the BBA—funding no new residency slots unless teaching hospitals cut other residencies. Here in Rhode Island, one of the oldest and fastest aging States in the country, we were only able to launch our new geriatric fellowship program through the generosity of the Miriam Hospital Foundation and Brown's other affiliated hospitals.

I urge you and your Senate colleagues to consider, as part of this year's health care legislation, giving hospital-based teaching programs the necessary flexibility to increase their residency slots to meet the changing health care needs of a changing America.

Thank you for your time, and I would be happy to answer any questions.

Senator REED. Thank you very much, Doctor, and let me now call upon the technician.

Nancy Roberts.

**STATEMENT OF NANCY ROBERTS, MSN, RN, PRESIDENT AND
CHIEF EXECUTIVE OFFICER, CARE NEW ENGLAND HOME
HEALTH**

Ms. ROBERTS. Good morning. It is both an honor and a privilege to be here and testify and have such distinguished panelists with me.

Thank you, Senator Reed, for holding this hearing.

We have come together today because nationwide we face a healthcare worker shortage of an unprecedented nature. Young men and women are choosing alternative career paths. Practicing nurses are leaving our profession in droves, due to the intense job dissatisfaction, the rigors and demands of documentation and paperwork.

Care New England Home Health staff visit each and every day 600 patients throughout Rhode Island, traveling quietly, providing care and compassion for patients and families. Plus in our State we estimate that over 3,000 patients each and every day receive home health visits. These patients encompass the entire lifespan, ranging from pre-natal mothers and the tiniest of infants to those individuals experiencing their final days.

While this estimate is at 3,000, there are probably another 300 to 400 patients in hospitals and long-term care facilities awaiting discharge. They struggle with meeting the demand upon the staffing capacity of home health agencies. Like hospitals, home health agencies are struggling each and every day. It is not uncommon to hear from hospital discharge planners that they have called eight to nine agencies trying to find a home for a home health patient.

In home health agencies, we employ a variety of professionals and para-professionals, including nurses, physical, occupational and speech therapists, social workers, family workers, childhood and administrative personnel. These group of individuals work together after the patient has been discharged from a hospital, from a skilled nursing facility or referred from the community, provide care in the comfort and privacy of their home.

While much of our media attention has focused on the nursing shortage in our acute care settings, as it should, based on the fact that that is where the majority of patients receive their care, clearly we are seeing the same struggle, the point of which is a patient is discharged from a hospital, return to their home to the community. It is there when a national crisis bumps up against home health care.

Leslie Jean Neal, respected home health author writes, and I'll quote: "Early hospital discharge and understaffing often preclude thorough teaching from occurring in the hospital. Even when the patient theoretically has been given sufficient teaching to understand the care that will be necessary at home, the patients and caregivers are often overwhelmed and stressed by the amount of information they received." It is lost for forgotten by the time the nurse arrives. To properly care for each and every patient, home health care reaches beyond book learning. To reach beyond book learning means that the nurse, the home health care nurse uses information and experiences that are necessarily derived from former schooling. Intuition, creativity, the ability to be innovative, interpersonal skills and the knowledge that comes through general life

experience, reaching once again beyond book learning. Clearly the demands that are on home health nurses go far beyond their traditional education.

In the interest of time, I will not relate specific stories in terms of what nurses encounter day in and day out, but suffice to say, that the challenge that a nurse has in providing care in the community without the needed resources, both in terms of family support and community resources, clearly strain and challenge the most creative and innovative nurse.

Survey after survey, points to increase job dissatisfaction by nurses and other health care workers, a recent report released by Robert Wood Johnson Foundation, written by Bobbi Kimball, and Edward O'Neill, and again I will quote: "This shortage, the shortage of today is unlike any of those in the past and requires bold new solution. It calls for re-envisioning the nursing profession itself so that we can emerge from this crisis and in equal partnership with the profession of medicine." The authors go on to say, "Work environments for nurses are more demanding, less fulfilling and more stressful. These circumstances have impeded many nurses for providing care that meets their competencies and their standards of professionals. The resulting dissatisfaction and disillusionment has led to difficulty in retaining and recruiting new nurses in many settings."

We must clearly provide unprecedented levels of education and to support to our existing staff. While home health is not an ideal match for many new graduates, and perhaps even some seasoned practitioners, our experience with recruitment requires us to be very different from the hospital approach, focusing on experienced personnel rather than those who are brand new graduates. Clearly a home health nurse or a home health professional needs to have a keen interest in caring for patients at home.

It is essential as an organization that we redefine our role of health care workers. Our organization needs to come together to create an image of health care workers through the use of media and public service announcements.

Specific to home health, we must reposition the practice to be fully recognized as the specialty it is. We must do a better job of telling our story, telling the story of the home health care worker and what that means to our patients in the community. Education is a key element to that.

To that end, the Senate Bill 1864, the Nurse Reinvestment Act, which is designed to educate our national and local communities and other nursing professions. Clearly, the story of home health must be told as we begin to roll out what it means to our community to be without the precious resources of nurses.

Finally, it is essential that we prepare our home health care workers with the necessary tools to work in the community, to meet the many demands upon them. The advanced skills, while they have not been in the area of technical competencies, they lie in the area of communication, negotiation, conflict management, innovate practice.

Finally, we must all continue together to work together, all areas of our health care continuum. This is not a crisis that effects only one area. We are all affected, and I call on each and every one of

us here today to think about recreating the image for them to work with quality of work life that they have within the community, both, as well as the major care setting.

Thank you, Senator Reed.

[The prepared statement of Nancy Roberts follows:]

PREPARED STATEMENT OF NANCY ROBERTS

Good afternoon. My name is Nancy Roberts and I am the President and Chief Executive Officer of Care New England Home Health. I would like to thank Senator Jack Reed and the Senate Committee on Health, Education, Labor and Pensions for holding this special field hearing, "Who Will Care for Us? The Looming Crisis of the Health Workforce Shortage." It is both an honor and privilege to be here today sharing the stage with distinguished colleagues who are also stakeholders in helping to solve this crisis. My comments today will focus on how this shortage is impacting the delivery of home health to patients and their families in Rhode Island and provide recommendations for change based on my experiences as a practicing nurse, educator and healthcare administrator for the past 25 years.

We have come together today because nationwide we face a healthcare worker shortage of an unprecedented nature. Young men and women are choosing alternative career paths, and practicing nurses are leaving the profession every day due to intense job dissatisfaction, and the rigors of expansive and extensive paperwork that takes time away from providing true nursing care.

Care New England Home Health is one of the largest home health organizations in the State, consisting of the VNA of Care New England, Kent Hospital Home Care and HealthTouch. On a daily basis, we visit over 600 patients, quietly traveling throughout Rhode Island, providing care and compassion for patients and their families within the comfort of their homes. Collectively, it is estimated that close to 3,000 individuals receive a home health visit each day. These patients encompass the entire life span, ranging from pre-natal mothers and the tiniest of infants to those individuals experiencing their final days.

While this estimate is at 3,000, there are probably another 300 to 400 patients held over in hospitals and nursing homes daily, because much the same way, the hospitals struggle with meeting the demands of nursing staff to meet patient care needs, home health agencies are also struggling. It is not uncommon to hear that hospital discharge planners may have to call nine or ten home health agencies before they can place a patient. We are also operating at peak capacities and attempting to meet massive needs with limited workforce resources.

In home health, on a national level, we saw 51,000 fewer nurses available to work in Medicare-certified home health agencies from 1996 through 1999. This trend has continued and worsened in many areas. Home health plays a vital role in the overall continuum of care. We employ a variety of professionals and para-professionals, including nurses, physical, occupational and speech therapists, home health aides, nutritionists, family workers, social workers, chaplains and administrative personnel. This collective group works together after an individual has been discharged from a hospital, skilled nursing facility or referred from the community, providing care to ensure that multiple needs are met and positive health outcomes obtained.

Much of the national attention and media has focused on the nursing shortage in our acute-care settings, our hospitals. This is logical, as this is where the majority of Americans receive their health care. However, there is a point, and it is at discharge from the hospital back to the patients home, where this national crisis, bumps up against home health. Patients are discharged following hospitalization with a myriad of medical and psychosocial needs.

Leslie Jean Neal, respected home health author writes, "Early hospital discharge and understaffing often preclude thorough teaching from occurring in the hospital. Even when the patient theoretically, has been given sufficient teaching to understand the care that will be necessary at home, the patient and caregivers are often so overwhelmed and stressed that the information is lost or forgotten by the time the home health nurse arrives. To properly care for the patient, the home health nurse reaches beyond book learning. To reach beyond book learning means that the home health nurse uses information and experience that are not necessarily derived from formal schooling. Intuition, creativity, the ability to be innovative, interpersonal skills, and the knowledge that comes through general life experience reach beyond book learning."

At this point, I would like to share a story that illustrates the complexity of caring for patients in their homes. Home health workers must possess a unique set of competencies including flexibility and persistence in order to meet multiple patient

needs and demands. They must effectively utilize technology, succinctly address multiple audiences using advanced interpersonal and communication proficiencies, and utilize advanced problem-solving and management expertise to access and implement community resources. Now, for my story.

In March, at 13 weeks pregnant, Mary (name has been changed), a young, very proud, uninsured Hispanic woman who spoke little English was rushed to the hospital. It was discovered that she had an ectopic tubular pregnancy that required immediate surgery due to severe complications. Without the surgery, Mary would die. After the surgery and following a very brief in-patient stay, she was discharged to home. It was then that the VNA of Care New England received the referral for twice a day wound care and dressing change for her surgical incision.

Mary's home consisted of one-room in a multi-family house on the south side of Providence. It is common knowledge that the crime rate exceeds the State average in this area and is generally regarded as unsafe to travel into after dark. Mary had few supports in place to help her during this difficult time. While her mother agreed to purchase and deliver the necessary wound care supplies to her home, she refused to participate in her care. Mary was forced to hide these supplies for she feared any number of individuals that frequented this multi-family home might steal them from her room.

After receiving Mary's referral from the hospital Discharge Planning Department early on a Tuesday morning, the VNA prepared to send a bi-lingual nurse to Mary's home for the evening wound care and dressing change. The VNA nurse, Susan, arrived at the home after dark at 7 pm to be greeted by a large pit bull standing inside the fence of this multi-family home.

Mary had no phone, so Susan was unable to call and ask that the pit bull be restrained. Caught between finding a way to care for Mary and her own safety, she returned to her car and placed a call to the evening manager. She ignored the unsafe nature of the neighborhood, locked her car doors and did what needed to be done.

Through thoughtful deliberations, Susan and her manager decided to contact Mary's mother, the only known support Mary had identified, who had refused to participate in her actual care. She agreed to reach someone within the home and ask that the pit bull be restrained so Susan could safely enter the home. Mary's mother refused to release this phone number or the name of the individual she had spoken with to any VNA personnel.

Upon entry, Susan went immediately to Mary's room, to find her with an elevated temperature and a surgical wound showing early signs of infection. The physician was called and a new antibiotic ordered. Susan began the process of caring for the wound and communicating what was happening to Mary. Susan placed a call to her manager who contacted Mary's mother asking that she go to the pharmacy to pick-up the medication. She agreed and ultimately brought it to Mary at 11 p.m. Susan stayed with Mary during this time as her temperature continued rising and she wanted to ensure that she understood how to take her new medication.

When Mary's mother did arrive, Susan thanked her for getting the medication, administered it and gave specific instructions on what to do should her condition worsen during the night. Susan asked to speak with Mary's mother outside of her room and explained the need for someone to monitor her condition throughout the evening. She refused and walked to the front door of the home. Looking out the small glass paned window of the locked door, both Susan and Mary's mother encountered the pit bull in the fenced in yard. Susan asked that Mary introduce her to the keeper of the dog, which she did after considerable protest.

Through expert negotiation skills with Mary's mother, Susan was able to get the phone number of the pit bull's keeper and left for home after a visit that should have been 1-hour turned into a 5-hour ordeal. However, the work was not over, Mary needed to be seen again tomorrow by 10 a.m., and this was Susan's planned day off. On her way home, Susan once again contacted her manager who agreed to communicate that evenings' events to the morning manager.

This story goes on with many twists and turns along the way. However, the end result was that Mary received the care she needed for almost 6 weeks and completely recovered. What it took to provide this care was considerable negotiations with Mary, her mother, all staff members involved in her care, communication skills that expanded well beyond the norm and an engagement of multiple community resources.

At this point you are probably thinking to yourself, "What does this story have to do with the healthcare worker shortage?" Before we can hope to have an impact on solving this huge challenge, we must recognize a common starting point. What is the common point? Where do all roads meet? Survey after survey points to increased job dissatisfaction by nurses and other healthcare workers. A recently re-

leased report commissioned by the Robert Wood Johnson foundation entitled, "The American Nursing Shortage" by Bobbi Kimball, RN, MBA and Edward O'Neill, Ph.D., MPA states, "This shortage is unlike any of those in the past and thus requires bold new solutions. It calls for a re-envisioning of the nursing profession itself, so that it can emerge from this crisis stronger and in equal partnership with the profession of medicine."

Kimball and O'Neill go on to further state, "Work environments for nurses are more demanding, less fulfilling and more stressful. These circumstances have impeded many nurses from providing care that meets their standards of competence and professionalism. The resulting dissatisfaction and disillusionment has led to difficulty in retaining and recruiting new nurses in many settings."

The story I just shared with you highlights the need for development of these advanced competencies. As Kimball and O'Neill stated, nursing work environments are more demanding, less fulfilling and more stressful. I propose that a well prepared nurse who has received adequate training and education to help diffuse situations akin to one I just related to you, will not only come away from these situations a winner, but will also develop her skills beyond the role of traditional nursing care. We must provide unprecedented levels of education and support to our existing staff. I see this as particularly important for home health. Today's home health workers are far more than nurses, therapists and aides, they are masters of skills that reach far beyond their traditional schooling.

Home health is not an ideal match for many new graduates and even some experienced practitioners because of the level of autonomy needed to practice independently in patient homes and fully engage in competencies that are learned and refined through practice. Therefore, our recruitment efforts and requirements tend to be much different than those of our hospital partners, focusing on experienced personnel and those with a keen interest in caring for patients within their homes.

It is because of these requirements that we face a disadvantage with nurses and other home health workers joining us later in their careers, leaving us with fewer productive working years and shortening our retention cycle by virtue of advanced age. According to the latest National Sample Survey of Registered Nurses, the average age of the working registered nurse population was 43.3 in March of 2000, up from 42.3 in 1996. The average age of registered nurses working in Rhode Island home health agencies is 46-years-old. We find recruitment extremely challenging as nurses at this age have been jaded by negative experiences in other institutions, the onerous paperwork associated with nursing and a general feeling that their efforts are not rewarded or recognized.

With all of this said, it is essential that we prepare our organizations to redefine the roles of our healthcare workers. It is logical to embrace Kimball and O'Neill's recommendation of increasing the supply and retention of nurses by regarding them as strategic assets and making positive changes in the work environment. This may be achieved in a number of different ways including addressing staffing levels, offering flexible scheduling, mentoring roles, promoting professional autonomy in clinical decisionmaking, building needed competencies and expertise in specialty nursing care and leadership; developing and testing new care delivery models, creating work options for aging nurses and making use of technology that saves time and money and speeds clinical decisionmaking.

Our organizations need to come together to create a new image of healthcare workers through the use of media and public service announcements and active engagement at both the national and State levels. We must enhance the image of the profession, promote diversity in the workforce, encourage people to enter the nursing profession, and encourage career development for nurses.

Specific to home health, we must reposition the practice to be fully recognized as the specialty that it is. We must do a better job of telling the story of the many merits of home health and the satisfaction that nurses, other healthcare professionals and para-professionals may ultimately have by joining this unique practice setting. It is unlike any other setting because each situation from home to home changes dramatically and oftentimes it is only the individual practitioner who has the power to make an immediate difference in the life of a patient.

In closing, I would like to provide recommendations specific to addressing this shortage as it relates to home health and the need for the ongoing provision of this vital element in the overall healthcare continuum.

Education appears to be a key element in all that I have discussed today. This education needs to span across our communities as suggested by Neal, Kimball and O'Neill as well as several other noted authors. Congress seeks to provide public awareness through authorization of \$10 million through Senate Bill 1864, the Nurse Reinvestment Act which would educate our national and local communities on the nursing profession. It is imperative that we include the home health story as we

face significant recruitment challenges when seeking nurse specialists. As I mentioned earlier, we care for the tiniest of infants to those experiencing their final days. There are tremendous opportunities for pediatric nurses; IV nurses, and those interested in gerontology or hospice to find fulfillment in the home health setting. However, we need to educate both our existing pool of potential candidates as well as novice nurses coming through the ranks that these opportunities are available to them. The need for home health care will only continue to grow, as our population ages, especially here in Rhode Island as we are home to one of the highest per capita percentages of those over the age of 65. Also, we are faced with patients being discharged from hospitals both quicker and sicker in desperate need of home healthcare.

Within the Nurse Reinvestment Act, there is a provision for the development of grants for nursing internships and residency programs. If these grants ultimately are awarded to our Rhode Island universities and colleges, I propose that a home health care specialty program be developed. I call on the educators here today to consider this and pledge to work with you to develop appropriate curricula to help train our healthcare workers of tomorrow.

I challenge my colleagues in home health to look at the hospital magnet facilities that have so successfully created institutions that attract and reward nurses. The success of these institutions recognizes that quality work life is important, ongoing learning and training is key and staff development must be ongoing.

This sort of certification is needed for home health. We must recognize that paradigm shifts in institutional and organizational cultures are necessary to facilitate the type of changes seen at these magnet institutions and work toward creating these shifts within our own organizations. It is essential that we provide our home healthcare workers with the necessary tools to meet the many demands put upon them in homes throughout our communities. We must recognize that it is no longer enough to be clinically advanced, but home healthcare workers must also possess skills that allow them to be conductors of all aspects of the care delivered in our patients' homes. They must be master communicators, organizers and jack-of-all-trades. We must give them the tools to complete their jobs successfully or we only set them up to fail and possibly leave the home health or healthcare profession in its entirety.

Finally, we must all continue to work together. This is not a crisis that impacts only one area of our healthcare continuum. We are all affected. I call on each one of us here today to think about recreating the image of healthcare workers, to think about recreating our own organizations and to embrace the challenge and know that our work can make a difference. Susan made a difference in Mary's life as she worked diligently and tirelessly to ensure that care was provided. We must attack this shortage with the same diligence and work toward creating responsive workplaces that create a quality of life for our employees that is satisfying.

I challenge us to be mindful in our preparations, to not be shortsighted in our implementation of programs that may seem right at the moment, but may not present a long-term viable solution. It is our ultimate responsibility to work toward making positive changes in our healthcare work environments if we hope to significantly impact and change cultures.

We need to focus on preparing the healthcare work force of the future. It is incumbent upon us as leaders to recognize that we must prepare now, to ensure that this crisis does not haunt the American healthcare system for a protracted period of time and continue to limit the care we are able to provide to those in need.

Once again, I would like to thank Senator Reed and the Senate Committee on Health, Education, Labor and Pensions for holding this special field hearing and allowing me the opportunity to share these recommendations for action with you.

Senator REED. Thank you very much.

Ms. Norma Owens.

**STATEMENT OF NORMA OWENS, PHARM.D., PROFESSOR OF
PHARMACY, DEPARTMENT OF PHARMACY PRACTICE,
UNIVERSITY OF RHODE ISLAND**

Ms. OWENS. Thank you, Senator Reed, for inviting me and the College of Pharmacy to speak on this critical topic. Dean Letendre and Associate Dean Lausier of the College of Pharmacy send their bests to you and this audience. They're in attendance at the annual meeting of the American Association of College of Pharmacy. This

is a premier professional group that deals with issues in pharmacy education, including the present shortage of pharmacists.

In December 1999, the Secretary of Health and Human Services conducted a national study to determine the extent of a pharmacist shortage. This report was provided to Congress 1 year later and provides much useful information.

Pharmacists are the third largest health professional group in the United States with approximately 196,000 active pharmacists in 2000. About two-thirds of these pharmacists work in the community for retail pharmacies; the remainder are employed by hospitals, long-term care, the pharmaceutical industry, manufacturing, managed care and insurance groups, home health and universities. Over the last 10 to 20 years employment opportunities for pharmacists have greatly expanded, while the supply of pharmacists has remained essentially even, roughly about 68 pharmacists per 100,000 citizens in 1991 to 71 pharmacists per 100,000 in 2000.

The increase in demand for pharmacist is related to many factors including:

A rapid rise in prescription growth, somewhere around 44 percent increase from 1.9 to 2.8 billion from 1992 to 1999.

Also, market growth and competition among retail pharmacies has lead to longer pharmacy store hours and new store openings.

There is an increase in professional practice opportunities.

There is an increase in access to health care that has impacted pharmacists in two ways. First, in the number and variety of professionals who are authorized to prescribe medications; and, second, in the insurance coverage for prescription drugs.

And I will say parenthetically here that I look forward to prescriptive rights, prescriptive privileges for Medicaid.

Also, there is an increase in the number of female graduates in pharmacy who work part time. In 1970, female pharmacists accounted for 13 percent of the pharmacist workforce. Today they account for greater than 46 percent of the pharmacist workforce.

Finally, there has been an increase in the number of years needed to graduate from a College of Pharmacy from 5 years to 6 years, as the profession has changed from requiring a Bachelor of Science to a Doctor of Pharmacy as the entry-level degree. At URI, we have phased in the Doctor of Pharmacy degree while phasing out the BS in Pharmacy over 3 to 4 years. Nonetheless, all schools in college and pharmacy will have a 1-year gap where only a few, or no pharmacists graduate.

As a result of these changes, pharmacists' salaries have greatly increased, vacancy rates are high, and successful employers offer economic incentives, such as sign-on bonuses, automobile leases and relocation funds. There is grave concern that pharmaceutical care services to the patient may be jeopardized by the pharmacist shortage leading HHS to define the shortage as both acute and severe.

On a personal note, the University, the College of Pharmacy and my department have been adversely affected by the change in the pharmacist workforce. Everyone in my Department of Pharmacy Practice is a pharmacist. In most academic circles, I would be regarded as a young-to-middle-aged faculty member, but in my department I am the oldest, and really ancient, faculty member. In

my 20 years of employment at URI, there has never, never, never, never been a year when a departmental member has not resigned. The faculty who have worked with me have been passionate and excellent practitioners who have changed the lives of many pharmacists and improved the health care of Rhode Islanders. They are now working in the pharmaceutical industry, in advanced practice positions, in a variety of settings, and for other academic institutions. For the past 2 years, a pharmacy practice faculty member has received the "Teacher of the Year" award at the College only to leave URI for employment elsewhere. In the past 2 weeks, another faculty member tendered her resignation. Our faculty leave URI with heartfelt regret, and for the same reasons one would expect given the economic and social issues at work.

I believe the administration at the College and University would very much like to increase student enrollment in Pharmacy. Faculty vacancies in my department is only one variable limiting our ability to graduate more pharmacists. I can see no quick or easy solution to the problem of the pharmacist shortage, but I am confident that URI and the College of Pharmacy are open and willing to try and address this problem. And thank you for inviting me.

[The prepared statement of Norma Owens follows:]

PREPARED STATEMENT OF NORMA J. OWENS

Thank you, Senator Reed, for inviting the College of Pharmacy to speak on this critical topic. Dean Letendre and Associate Dean Lausier of the College of Pharmacy send their regrets to you and this audience. They are in attendance at the Annual Meeting of the American Association of Colleges of Pharmacy—the premier professional group that deals with issues in pharmacy education including the present shortage of pharmacists.

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The increase in demand for pharmacists is related to many factors including:

- A rapid rise in prescription growth—a 44 percent increase from 1.9 to 2.8 billion from 1992 to 1999,
- Market growth and competition among retail pharmacies that has lead to longer pharmacy store hours and new store openings,
- An increase in professional practice opportunities,
- An increase in access to health care that has impacted pharmacists in two ways—first in the number and variety of professionals who are authorized to prescribe medications and second, in the insurance coverage for prescription drugs,
- An increase in the number of female graduates in pharmacy who work part time. In 1970, female pharmacists accounted for 13 percent of the pharmacist workforce, today they account for greater than 46 percent,
- An increase in the number of years needed to graduate from a College of Pharmacy from 5 to 6 as the profession has changed from requiring a Bachelor of Science to a Doctor of Pharmacy as the entry-level degree. At URI, we have phased in the Doctor of Pharmacy program while phasing out the BS in Pharmacy over 3-4 years. Nonetheless, all schools will have a 1 year gap where only a few, or no, pharmacists graduate.

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that pharmaceutical care services to the patient may be jeopardized by the pharmacist shortage leading HHS to define the shortage as both acute and severe.

On a personal note, the University, the College of Pharmacy, and my department have been adversely affected by the change in the pharmacist workforce. Everyone in the Department of Pharmacy Practice is a pharmacist. In most academic circles I would be regarded as a young- to middle-aged faculty member, but in my department I am the "oldest" faculty member. In my 20 years of employment at URI, there has NEVER been a year when a departmental member has not resigned. The faculty who have worked with me have been passionate and excellent practitioners who have changed the lives of many pharmacists and improved the health care of Rhode Islanders. They are now working in pharmaceutical industry, in advanced practice positions in a variety of settings, and for other academic institutions. For the past 2 years, a pharmacy practice faculty member has received the "Teacher of the Year" award at the College only to leave URI for employment elsewhere. In the past 2 weeks, another faculty member tendered her resignation. Our faculty leave URI with heartfelt regret and for the same reasons one would expect given the economic and social issues at work.

I believe the administration at the College and University would very much like to increase student enrollment in Pharmacy. Faculty vacancies in my department is one variable limiting our ability to graduate more pharmacists. I can see no quick or easy solution to the problem of a pharmacist shortage but I am confident that URI and the College of Pharmacy are open and willing to try and address this problem.

Senator REED. Thank you very much, Dr. Owens.

I want to thank all the panelists for their excellent testimony.

I will take my 5 minutes of questioning and then ask if the Lieutenant Governor may want to participate. Recognizing that Dr. Amaral and Dr. Besdine are getting ready to leave, let me direct questions to them first.

You both referred to in your testimony about the use of technology, and on two related questions, one, can technology be used to try to positively change the current paperwork-dominated environment that seems to be so much effecting the recruitment of nurses by a professional, and on the other side, are the schools, the professional schools preparing new pharmacists, new nurses, new radiologists, et cetera, technicians to be technologically sophisticated in order to participate in that workforce? If you can answer both those questions.

First, Dr. Amaral.

Dr. AMARAL. I do believe that technology can make the work life easier, but right now it carries the complex problem, that many people are not technologically literate enough and can actually increase the stress in their job. It is also true that the technology is scattered into different types that aren't very good industry standards, so it makes it a difficult process.

The future is bright, because I think it will, but in the short term I think there are major problems. And, in addition, it is the incredible cost associated with implementing this technology.

As far as training people in this, I really cannot speak well to that in terms of pharmacy or nursing. I think medical education, again, if you have it there, you can train people. If you don't have it, you cannot. I would assume it is going to be the same in other health care professions.

Dr. BESDINE. I don't disagree with anything that Joe said, which is difficult; however, I think we can only go so far with technology relieving the burden on clinical providers who are in short supply as the current regulatory environmental permit, and the regulatory environment for documentation, as well as for reimbursement is so

burdensome at this time that I see that as really the major impediment, and technology can really only alleviate a small portion of that.

Regarding the preparation of health professionals, ironically what I see is that our graduating physicians and other health professionals are actually better technologically prepared than some of their faculty, and they're ready in the workplace, which is widely variable in its ability to plug them into utile technologies.

Senator REED. Nancy and then Norma, Ms. Roberts, the Professor of the School of Pharmacy.

Ms. ROBERTS. Sure. I guess as we look ahead we do know that our nurses today are spending 60 percent of their time documenting and only 40 percent of their time in actual patient care. A striking statistic. You look at technology in our home health environment, our major plan is what you call a point-of-care system, where there would actually be documentation that will be done on a laptop computer in the home. That information will be translated with a directive from a physician's office. But, just as my colleagues have mentioned, we have some technologic challenges before us, in terms of our workforce and their preparation. I believe those will ultimately assist us, whether they will be time savings or the quality of our care really being enhanced, I think, is debatable at this point.

Senator REED. Dr. Owens.

Ms. OWENS. I think pharmacists have always embraced technology and utilize it to an above-average amount in the profession, including robotics, the vendor machines, like issues to dispense, or machines to dispense in locations, and our students are quite comfortable with technology.

I think one area where more effort could be spent would be in the education trained and pharmacy technician, which we don't have at the University of Rhode Island. I believe CCRI is to trying to implement a program, so maybe additional personnel, and I think we have done a job good, and our students are not scared of technology and neither are the pharmacists who practice. It has done a lot to help alleviate some of the pressures.

Senator REED. Before you leave, Dr. King, a follow-up on some of your responses. It seems that technology does offer some help going forward, but a critical issue of just the lack of skilled professionals is looming, and it seems to be a vicious circle. The harder it is to recruit new skilled professionals, the more difficult it is for existing professionals to do their job, they get frustrated, they leave, they go off. Is that a fair description of the process? Just a yes or no.

Dr. AMARAL. Yes.

Senator REED. The first rule in the Senate is I can make some rules, so I'm going to ask Dr. King some questions, because you were so kind to come here today, and your testimony was outstanding, Doctor. Thank you.

You've looked at this problem of health care professionals in Rhode Island and throughout New England. We seem in Rhode Island at this moment to be doing fairly well in terms on nursing and pharmacists relative to other States, but the future is bleak. What existing shortages do we have, or work shortages outside of phar-

macy and nursing in the State of Rhode Island? Do you have that there?

Mr. KING. I don't have that on the top of my head. I know, as was mentioned, radiology technicians is one area, but actually even the broader area, laboratory technicians is also another area that has popped up throughout New England. I haven't specifically looked at Rhode Island, but I know particularly in Massachusetts there's been an issue that has popped up at Beth Israel, at a couple of other hospitals.

I see one of my colleagues who is willing to chime in.

Ms. ROSS. Hi. I am Maureen Ross from the Department of Health. I would say that our two most critical shortage areas are mental, dental, and we see that in our health professional shortage area designations through the system.

Senator REED. Thank you.

Now, let me turn to the Lieutenant Governor for a question or comments he may have. So, thank you, Doctor.

Mr. FOGARTY. I know time is short. Are we doing anything to try to go to such areas, in terms of growth in terms of this profession and the specific programs that might help us in dealing with the shortages?

Dr. AMARAL. One area that I can speak to, there was a Robert Foundation Grant, in group health and health centers in a group of hospitals, allowing us to use those, which is a means to not only respond better to people in the community who do not have English as their primary language but also to turn health care workers in being able to communicate. I think that is a very important issue. The cultural competence of our work staff needs to change. It is not culturally competent. In States like Rhode Island, where it is changing very rapidly, it becomes more of a problem, so we needed to do more. I think that is an area to focus on.

Senator REED. Well, I want to thank the panelists for their excellent testimony. As I indicated, in the next 14 days if you have additional material that you would like to give to us or you prepared in response to our questions. Thank you very, very much. We would like to wish you well.

I would like to call the next panel forward. We will go ahead and change the name cards and the stenographer will change the paper.

[Recess.]

Senator REED. Let me, once again, call the hearing to order and introduce our second panel.

Joining us is William Lynn McKinney, Ph.D. Dr. McKinney is the Dean of the College of Human Science and Services at the University of Rhode Island. He has served the University in various roles as teacher or administrator for the last 30 years. He was recently named "Professor of the Year" by the University of Rhode Island Honors Program and was elected president of AIDS Care Ocean State. He is the former interim executive director of the Rhode Island Project AIDS, former volunteer member of Seniors Helping Others and Rhode Island Furniture Bank. He was the first man named to the Board of Directors of the Rhode Island Coalition Against Domestic Violence.

In part because of these activities he is keenly aware of the need for higher education, and particularly the role of his college to address the needs of children and also their families, especially those on the margins of society. Dr. McKinney is seeking a clearer vision for Children, Families and Communities Focus Area.

Maureen E. McGarry, Ph.D., R.N., N.C.C. Dr. McGarry is currently the Dean of the Community College of Rhode Island Nursing, Allied and Dental Health Programs. She has a doctorate from the University of Connecticut in Professional Higher Education Administration and has significant experience in various aspects of nursing education. She is, as well, a National Certified Counselor. She serves on the Governor's Advisory Council on Health and Health Career Programs. She is a member of the Health Membership Council, Hospital Association of Rhode Island and of the Warwick Career and Technical Center Advisory Board.

Her nursing career has included hospice care, drug evaluation and community mental health. She has served since 1996 as a Member of the Hospital Association of Rhode Island. She was a member of the Rhode Island Gerontology Exchange Committee in the Department of Elderly Affairs and a member and past president of the Rhode Island Board of Nurse Registration and Nursing Education.

Barbara Schepps, M.D. Dr. Schepps is a radiologist and Professor of Diagnostic Imaging in the Department of Diagnostic Imaging at Rhode Island Hospital in Providence. She holds faculty and hospital appointments at Rhode Island Hospital, Brown University and Medical School, Women & Infants Hospital and The Miriam Hospital. She has completed specialty training in ultrasonography and mammography.

Dr. Schepps has served on numerous hospital committees, including those in medical education, emergency medicine, radiation safety, marketing, strategic planning, breast health, elective admissions and credentials. She is the President of the Hospital Staff Association at Rhode Island Hospital.

She has been significantly involved in women's health screening, both in her faculty appointments and in her participation in the American College of Radiology and the Radiological Society of America.

In the last several years she has been named "Rhode Island Woman Physician of the Year" and has been awarded the "Excellence in Ambulatory Teaching Award" for Clinical Faculty at Brown University. This past spring she was listed in America's Top Doctors: The Best in American Medicine.

Thank you, Doctor, very much for joining us.

James P. McNulty. James McNulty of Bristol, Rhode Island is the President of the Manic Depressive and Depressive Association of Rhode Island and currently serves as the President of NAMI, formerly known as the National Alliance for the Mentally Ill. He serves on the board of the Mental Health Consumer Advocates of Rhode Island. In 2000, Donna Shalala, then Secretary of Health and Human Services, invited Mr. McNulty to serve on the National Advisory Mental Health Council, a body that advises the Directors of the National Institute of Mental Health, the Director of the National Institutes of Health and the Secretary of Health and Human

Services. In addition, he has been facilitating for the last 11 years peer education and support groups focused on recovery.

Mr. McNulty has been active in involving patient and family advocates in all aspects of treatment for mental illness. He is currently participating in a NAMI initiative to involve consumers and family members as members of institutional review boards. In addition, he is studying the use of discontinuation, challenge and placebo arms in psychiatric clinical trials and the use in the United States of the criminal justice and penal systems in the overall approach to mental illness.

Finally, we are joined by Wendy Laprade. Wendy is a staff registered nurse at Women & Infants Hospital in Providence. She served for several years in the women's in-patient surgical unit and has been for 17 years a nurse in the 21-bed tertiary care Labor/Delivery/Recovery Unit.

I am glad you are here, our stenographer is due in 2 minutes, Wendy, so it is nice to have a trained professional.

During those years, she also spent a year as a staff nurse in Rhode Island Hospital's six-bed Cardiovascular Thoracic Intensive Care Unit. She has had bedside nursing, charge, preceptor/training and critical care responsibilities. She served on the Quality Assurance Committee from 1991-1993 and the Partnership Liaison for Labor/Management Initiative Grant in 1994 and 1995. In 1995 and 1996 she was a maternal fetal medicine nurse clinician.

She is licensed in Rhode Island and in Massachusetts as a registered nurse and is a member of the Association of Women's Health, Obstetrical and Neonatal Nurses and of the Rhode Island State Commission chaired by Representative Elizabeth Dennigan to study Acute Care Facilities Nursing Staffing.

Thank you very, very much.

She is currently an executive board member of the New England Health Care Employees Union and a board member of the SEIU Nurse Alliance Board.

Thank you very much.

Thank you for joining us today.

Dr. McKinney, again, if you could abide by our 5-minute rule, which is violated only by the Chairman.

STATEMENT OF WILLIAM LYNN McKINNEY, DEAN, COLLEGE OF HUMAN SCIENCE AND SERVICES, UNIVERSITY OF RHODE ISLAND

Mr. McKINNEY. Thank you, Senator Reed. The College of Community Science and Services is the second on campus at the University of Rhode Island. It includes the School of Education, the Department of Textiles, Fashion Merchandising and Design and three departments that have health-related focus, Human Development and Family Studies, Communicative Disorders and Physical Education and Exercise Science.

Health-related programs at URI continue to experience unprecedented high rates of application at both the undergraduate and graduate levels. In speech pathology, in physical education and exercise science and in physical therapy, the demand far exceeds the available places. These high application rates reflect the real need

for highly trained health care professionals throughout Rhode Island and the region.

I could provide you seemingly endless statistics, but in the interest of brevity I will cite only the following:

The U.S. Department of Labor estimates a greater than 36 percent increase in the number of positions available for physical therapists in the next 8 years.

The American Hospital Association, Commission on Workforce for Hospital Based Therapists, including physical, occupational and speech therapists, says there is an 11 percent shortage at the present time.

Earlier intervention with children is a burgeoning field, and children in schools are expected to require a greater physical therapy and speech therapy services as more and more special education needs are identified.

Rhode Island, as you've heard earlier, has a high density elderly population that is expected to grow. With current uncertainty about the economy, we find many of these people will be in the workforce much longer than they have been in recent years, and in many cases much longer than they have anticipated being. This, of course, may result in increased workplace injury and the resulting need for physical therapy services.

These statistics are among many that are alarming. Joining them in raising my concern is increasing knowledge that we need new types of professionals, particularly individuals whose work is much more preventive as it is diagnostic and focusing on treatment. But, our first inclination to focus our attention on graduate level therapy programs, we must concomitantly enhance our undergraduate programs in such areas as exercise, science and nutrition and community health. In short, we need to consider preventive measures as we also enhance our other programs.

At the graduate level, accrediting bodies are responding to changing needs across the Nation by changing expectations of us at the university.

For example, in audiology, the required professional entry degree will soon be a clinical doctorate. That will be true of physical therapy in the near future as well.

As we respond at the University to our accrediting bodies and plan the resulting changes that we must make on the campus, we confront the realities of 2002. We would close programs only when all other options were exhausted, but closures are a real possibility. At the University and within the College we face budget issues that reduce our flexibility and hiring educators to supplement our schedule faculty, that prevent us being fully competitive and offering undergraduate scholarships and graduate fellowships and that diminish our confidence in having a steady flow of capital for equipment and supplies.

To respond quickly and vigorously to the looming crisis of health workforce shortages, we need, at a minimum, a 10-year, \$4-million program that would support the College of Human Science and Services with flexibility in hiring faculty and expand a base for undergraduate and graduate student support and updated equipment and buildings.

As a result of this 10-year plan we can focus training as market needs shift, we can create 3-year professorships in high need areas, for example. We can increase the number of graduate and undergraduate students in our programs, thus increasing the number of trained professionals. We can attract stronger applicants and thus stronger graduates. We can enhance our relationships with community agencies and with schools, providing more and more services that they require. We can expand our capacity to work with employers, to enhance worker safety and comfort and thus reduce workplace stress and injury, and we can consolidate health-related professional training, working toward creating a cohesive entity that would foster multi-discipline clinical training, better patient care and more efficient operation.

The problem confronting us will require increased collaboration across all institutions, higher education and with health care agencies throughout the State. As we in the College of Human Science and Service at URI, I commit to that collaboration and to a sustained focus on increasing the supply of highly trained health care professionals.

As we respond to the impending crisis, I urge us all to include preventive services.

We know that prevention is considerably less expensive than commitment and remediation. I thank you.

[The prepared statement of William L. McKinney follows:]

PREPARED STATEMENT OF WILLIAM L. MCKINNEY

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- The American Hospital Association's Commission on Workforce for hospital-based therapists including physical, occupational, and speech therapists.
- Early intervention with children is a burgeoning field, and children in schools are expected to require greater physical therapy and speech therapy services as more special education needs are identified.
- Rhode Island has a high-density elderly population that is expected to grow. With uncertainty about the economy, many of these people will be in the workforce longer than they have been in recent years. This may result increased workplace injury and resulting need for physical therapy services.

These statistics are among many that are alarming. Joining them in raising my concern is increasing knowledge that we need new types of professionals, particularly individuals whose work is as much preventive as it is diagnostic and treatment. While our first inclination is to focus our attention on graduate level therapy programs, we must concomitantly enhance our undergraduate programs in such areas as exercise science, in nutrition, and in community health.

At the graduate level, accrediting bodies are responding to changing needs by changing expectations of us at the University. For example, in Audiology, the required terminal degree is no longer a Master's, but a clinical doctorate. A clinical doctorate in Physical Therapy will soon be required as well.

As we respond to our accrediting bodies and plan the resulting changes that we must make on the campus, we confront the realities of 2002. We would close programs only when all other options were exhausted, but closures are a real possibility. At the University and within the College, we face budget issues that

- Reduce our flexibility in hiring educators to supplement our skeletal faculty.
- Prevent our being fully competitive in offering undergraduate scholarships and graduate fellowships.

- Diminish confidence in a steady flow of capital.

To respond quickly and vigorously to the looming crisis of health workforce shortages, I propose a 10-year, \$4,000,000 program with Federal funding that would support the College of Human Science and Services with flexibility in hiring faculty, an expanded base for undergraduate and graduate student support, and updated equipment and buildings.

As a result of this 10-year plan, we could

- Focus training as market needs shift; we could create 3-year professorships in high need areas, for example

- Increase the number of graduate and undergraduate students in our programs, thus increasing the number of trained professionals.

- Attract stronger applicant pools and thus stronger graduates.

- Enhance our relationships with community agencies and with schools, providing more and better services that they require.

- Expand our capacity to work with employers to enhance worker safety and comfort and thus reduce work-place stress and injury.

- Consolidate health related professional training, working toward creating a cohesive entity that would foster multi-discipline clinical training, better patient care, and more efficient operation.

The problem confronting us will require increased collaboration across all institutions of higher education and with health care agencies in Rhode Island. As Dean of the College of Human Science and Services at the University of Rhode Island, I commit to that collaboration and to a sustained focus on increasing the supply of highly trained health care professionals.

Senator REED. Thank you very much, Dr. McKinney.

Dr. McGarry.

STATEMENT OF MAUREEN E. McGARRY, RN, Ph.D., NCC, DEAN OF HEALTH AND REHABILITATIVE SCIENCES, CCRI-FLANAGAN CAMPUS

Ms. MCGARRY. Thank you for this opportunity. One of the areas that I wanted to mention is that I've been in health care in one way or another for 36 years, and I certainly have seen tremendous changes, but none quite like the changes that are currently underway.

Here at the Community College of Rhode Island we have always prided ourselves in being able to respond immediately to the needs of the health care community, and it has only been recently that we have been unable to do this.

Just taking you back to the 1960s, we had the initial associate's degree nursing program that was developed, and it stands today as the only associate degree nursing program offered in the State, and it has also the distinction of being the largest in the New England area, with graduates that remain in Rhode Island and have excelled on the national licensing examination consistently.

We also know that because of the issues that are occurring right now, we are not going to be able to continue to respond the way we have done in the past. I won't bore you with the 16 health career programs that are currently under my responsibility, but I did want to identify others that are only one of their kind here in Rhode Island that we offer. We have a practical nursing program, and there is a renewed need for practical nurses within the State. We have an associate degree program in dental hygiene, a physical

therapist assistant associate degree program, as well as a certificate in renal technology. These all came about because of responses to the health care community.

Recently, due to the drastically reduced 2000-2003 budget cut, which our institution, as well as the other higher ed institutions within Rhode Island suffered, the cost of equipment and staffing needs and the accommodation of the continued request will have to be foregone. For instance, histology technology, pharmacy technology, emergency management and optician technicians are naming a few of the current requests that we cannot respond to.

The health career programs in allied health, dental health, nursing, rehabilitative health, with few exceptions, have continued to have more applicants than we can accommodate. This places the student in the unnecessary and unfulfilling position of being in a holding pattern until a space becomes available.

For the health care provider seeking to hire even more graduates, this becomes another source of frustration.

It is the college's awareness that we have a number of first generation college students. Many of these students seek an education for one of our health careers. The vast majority of these individuals are adult learners, some whose native language is other than English. A recent survey of 153 nursing students, for instance, really reveals some very interesting findings. We have about 46 percent that indicate that their primary language is not English and that between 36 to 77 percent identify that they were of minority heritage.

That is increasing, when you compare it the current nursing population, there were fewer that had that distinction.

I wanted to say a little bit about the aging workforce, that was mentioned before. We also have an aging workforce within our faculty. We are anticipating over 50 percent of our nursing faculty will be anticipating retirement within the next 5 years. Fewer individuals are seeking to take on the career as a nursing educator, with the advance credentials of a master's in nursing at a regulatory requirement.

We need to continue to strive to encourage people to continue to go on and receive their advanced education so that they will be able to replace those folks who are seeking retirement.

One of the issues that we have before us is that it is well known that a new inexperienced graduate is offered a salary similar to that offered an individual with advanced credentials for a faculty position. This provides little incentive for an individual to pursue a faculty position, other than a desire to facilitate student learning.

Collective resources of health care facilities and colleges have created innovative strategies to respond to the increased shortage.

We have Colleagues in Caring-Rhode Island, which has worked toward tremendous efforts, but we need to continue that vital role.

Also, the Health Partnership Council of the Hospital Association of Rhode Island is attempting to respond in a collective way to these issues.

We also have some of the Black Nurses Association, the Hispanic Nurses Association that has assisted in terms of tutoring. These are just to name a few of the innovative approaches that have recently occurred, as well as the radiography issues and the dental

hygiene issues in terms of the supply and the demand not being met by our college. We stand ready to receive whatever additional funding can be forwarded our way with which to respond to these. Thank you.

[The prepared statement of Maureen E. McGarry follows:]

PREPARED STATEMENT OF MAUREEN E. MCGARRY

I have been a nurse and nursing educator for 37 years. In that capacity my current role as Dean of Health and Rehabilitative Sciences, as well as a member of a number of local, regional and national organizations, I am keenly aware of the looming crisis that is bearing down on the health care community. This crisis is also impacting colleges and other institutions that have the responsibility of educating the health care workforce. The change is unlike earlier shortfalls experienced by health care is not only the expanding number of employees needed, but also the broad spectrum of positions where there are current and anticipated vacancies.

While nursing is not the only profession experiencing a reduction in the number of individuals seeking or remaining in the health field, the number of nurses needed to care for the complex needs of our population in acute care, home care and long term care settings far surpasses the number required for other health care professions.

In the academic institutions this is also a critical factor as there are small faculty to student ratios required to provide maximum monitoring of students caring for patients and provide sufficient learning opportunities.

Through my role in the National League for Nursing Accrediting Commission as a program evaluator and panel review member I am aware of the rigor necessary for nursing programs to achieve and maintain NLNAC accreditation. One major thrust of the NLNAC has been to examine program outcomes such as graduate achievement licensure results. These outcomes are closely monitored, also on the State level, to determine the ability of programs to supply competent safe practitioners.

In Rhode Island the Board of Nurse Registration and Nursing Education monitors nursing practice and nursing education through the regulatory requirements. I have had an opportunity to serve on the board twice during my career. During both of these appointments, the serious role of protecting consumers was emphasized as a paramount function of the board members.

As Dean for over 16-credit bearing health programs, I know students receive quality education at a reasonable cost, leading them with the ability to seek employment within a wide range of healthcare facilities. Unfortunately, the recent critical budget issues within the State have necessitated that the college raise tuition and fees. This was deemed necessary as the General Assembly drastically cut the appropriation for higher education.

Since the inception of the Community College of Rhode Island in the 1960s, there has been a continued effort on the part of the college to respond to the manpower needs of health care facilities. The College initially responded by developing an associate degree program in nursing. The graduates take the licensure examination to become registered nurses. These graduates have continued to surpass the State average on the licensure examination. Further, the graduates' success rate has been over 92 percent. This provides the health care communities with a steady supply of individuals capable of becoming credentialed and, therefore, maintain employment. By and large, the graduates remain in Rhode Island following graduation, further providing a steady work force for employers.

A review of recent career placement surveys indicate well over 90 percent of our graduates are employed in the career of their choice, with employers indicating satisfaction with the caliber of their knowledge and skills. This has been a consistent outcome across all of the health career program graduate and employer surveys.

At the present time, the College offers a broad array of certificate and degree programs for a variety of healthcare careers. These programs were created, without exception, due to the community's need for this level health care employee.

Degree Programs

Clinical Laboratory Technician
Dental Hygiene
Therapeutic Massage
Associate Degree Nurse (RN)
Occupational Therapy Assistant
Physical Therapist Assistant

Radiologic Technologist
 Cardio Respiratory Therapist

Certificate Programs

Dental Assistant
 Emergency Medical Technician (EMT)
 Practical Nurse (LPN)
 Phlebotomist
 Renal Dialysis Technician (Hemodialysis Technician)
 Magnetic Resonance Imaging Technician
 Sonographer
 Therapeutic Massage

The College also maintains a Training Center for the American Heart Association offering Basic Life Support, First Aid and AED certification. This is one of the ten (10) largest centers in Rhode Island.

Community Services also offers an opportunity for students to receive nursing assistant education. The successful candidate can then take the certification examination and become registered within Rhode Island as a nursing assistant.

The RI Department of Labor and Training certifies a number of these programs as options for displaced workers through the Workforce Investment Act of 1998 (WIA).

Due to the cost of equipment and staffing needs, the College has been unable to accommodate several recent requests such as: histology technology (associate degree), pharmacy technology (certificate and associate degree), and emergency management (certificate and associate degree). Recently, the College has also been asked to consider an optician technology associate degree program due to recent changes in the statutory requirements.

The Allied Health, Dental Health, Nursing and Rehabilitative Health programs have far more applicants than can be admitted. Many of these programs have one or two semester waiting lists.

The College serves a number of first-generation college students. Many of these individuals seek an education in one of the health careers. The vast majority of these students are adult learners, individuals whose native language is other than English.

A recent survey of 154 pre-nursing students revealed over 30 percent receive financial aid, up to 46 percent indicated their primary language is not English and between 36 percent and 77 percent indicated being of minority heritage.

Three hundred (300) current nursing students were also surveyed. The first year students indicated that 20 percent classify themselves as minority and second year students represent 16 percent minorities within the cohort.

Individuals seek to become healthcare employees for a variety of reasons: the most common being the desire to care for an individual who is seeking health care. Many come from varied backgrounds, life experiences and other careers; banking, fire services, business, etc. Some come directly from high school and Career and Technical Centers; some individuals return to college having spent time raising their families or caring for aging parents.

Each comes with a richness of experiences, which must be capitalized on as they gain their new knowledge and skills necessary to become a successful healthcare employee. The diversity of gender, ethnicity, talents and skills provide excellent opportunities for the college and healthcare facilities.

The College can no longer respond to health care staff shortages by expanding student enrollment. There are a number of reasons this is no longer feasible without significant infusion of resources, mainly fiscal, capital and credentialed faculty. The State fiscal constraints has impacted the college budget by significantly reducing the anticipated 2002-2003 budget by \$2.7 million.

Projections

The Rhode Island Employment projections web site indicates through 2006 estimates of 12,000 vacancies in health services. For Registered Nurses, 366 annual openings exist. The Hospital Association of Rhode Island has estimated over 600 vacancies currently exist. Annual estimates of position vacancies are expected through 2020. For Licensed Practical Nurses, 91 annual openings were identified. The total growth in Rhode Island for the 50 top occupations lists Registered Nurses as the second group with the largest expected growth with 2,273 positions and Licensed Practical Nurses with 421 positions.

Rhode Island projections indicate the demand for registered nurses will continue beyond 2020. Approximately 12 percent of the workforce in Rhode Island is employed in health care. The Rhode Island Department of Labor has projected 10,000

new jobs in health care through 2006. Five thousand of these are projected to be in nursing.

Projections also are high for Dental Hygienists, Pharmacy technicians and Radiologic technologists.

Barriers

- The aging work force, in particular, that of nursing faculty, presents a major barrier that must be addressed. Fewer individuals are seeking a career as a nursing educator, yet within the next 5 years over 50 percent of the current nursing faculty anticipate retiring.

- The resource acquisition (financial and manpower) has substantially decreased, yet the demand for increasing enrollment continues to increase. The college has responded to the continued need of the community by efficiently delivering education, even offering courses onsite for health care facilities when requested.

- Collective resources for hospitals and colleges must be infused with additional funds to prepare for the ever-increasing needs of qualified professional staff. This will ensure meeting the health care demands.

- Even with continued collaboration with health care facilities and colleges it is imperative that additional funds be provided, for example, to the Clinical facilities. A consideration would be to reexamine the Medicare pass-thru option for facilities that are assisting colleges with faculty and other resources.

- Students find it necessary to continue employment throughout pursuit of their health education. A recent survey revealed that 90-98 percent work part-time or full-time while a student. It must be noted each of the health programs are rigorous and accelerated, as they must be completed within a 2- or 2½-year time period. This is stipulated by a number of specialty accreditation requirements.

- The public colleges and university have a cap on the number full-time positions permitted. This places undo limits to adequately respond to the academic needs of the community.

- Increased need for day-care services at each campus has continued to be expressed by students.

- Student stipends could help to decrease the need for extensive hours of employment and improve success in this rigorous program. Suggestions students have made regarding this would be to provide living expense monies as a stipend for students achieving a solid/high GPA.

- Tuition scholarship availability to help decrease the number of hours that students work has been suggested.

- There is an increased need for remediation required by students applying for admission to the health career programs. This places an additional strain on the college to provide expanded resources in developmental education.

- State budget constraints have curtailed forward movement on program expansion particularly with respect to nursing.

- Applications have recently increased in nursing (1,700), radiography (300) and dental hygiene (240). Individuals are placed on waiting lists, as there is limited ability on the part of the college to respond to the requests for expansion. As the current time resource utilization has been maximized.

- Most health programs rely upon technology and therefore, incur additional capital expenses necessary to provide students with contemporary learning opportunities. Equipment-intensive program laboratories periodically need to be updated. In addition, high capacity computers and software is also necessary.

- Support courses from a variety of disciplines are required for each of the health programs. Entering students, at the present time, need remediation prior to enrolling in the required program courses. This places additional strain on the colleges lean resources as courses sections and faculty resources are needed to respond to this developmental education requirement. This also prolongs the time needed for the student to complete all program requirements as well as certification/licensure requirements.

- Thirty-six students are currently admitted to the Dental Hygiene program. There is significant demand within the Dental Community to increase this enrollment to 45 or more to meet the current and projected requirements. This is an expensive program, which requires additional student costs including textbooks and equipment. A dental kit alone costs approximately \$1,200. At the completion of the program students have additional expenses due to the certification and license requirements. These students must hire a client for the North East Regional Board Examination. Expenses for this include: travel cost to the testing site, hotel costs for student and client as well as payment to client for loss of wages.

- For the college, with very few exceptions, health programs are expensive. Student tuition and fees do not cover the program costs. For example, for each nursing

student the college admits, there is a deficit due to program expenses of \$1,000. It can be easily identified that the college would incur the expense of \$50,000 per semester if there is an addition of fifty (50) students admitted in response to the nursing shortage.

- This is also similar to what other programs experience, but slightly less, as faculty are not in the clinical areas for 15 (15) hours per week with small faculty to student ratios.

- Faculty salaries are low compared to the salaries offered within the health care community. In addition, Rhode Island Statute requires advanced academic preparation and yet the new inexperienced graduate may receive an initial salary offers very similar to the salary offered for an initial faculty position. This makes it very difficult to recruit faculty for the health programs.

- There is a recent practice of sign-on bonuses in the community to attract individuals. The experienced staff nurse has few opportunities for salary incentives, however, unless they receive compensation for mentoring or precepting new graduates.

- Salary compression has recently been identified as a discouraging factor for faculty in the health programs when compared to new hires in other academic departments. Salary compression has also been identified as an issue within the health care facilities.

- This frustration, as well as additional employment demands, can serve as negative factors if individuals are about to pursue a health care career and have discussions with frustrated and discouraged employees.

- Colleges must continue to be proactive in increasing faculty salary opportunities through the State fiscal offices to provide a consistent supply of qualified faculty.

Strategies to Help Resolve the Critical Shortage

- Continue to collaborate with the dental community to reduce program and student costs.

- Continue the activities of Colleagues in Caring-Rhode Island. This group consists of representatives from the Hospital Association of Rhode Island, nursing practice, nursing administration representing a variety of settings, such as: nursing homes, home care, nursing educators as well as Rhode Island State Nurses Association, Rhode Island Department of Health and the Rhode Island General Assembly, organized labor and other interested parties. A number of vital areas have been examined through the task force committees and CIC-RI mission: recruitment and retention of students and staff, creation of the Nursing Career Information Center of Rhode Island through Ambassadors for Nursing, workforce data collection, short-term staffing strategies and sustainability. The vital role of the project director needs to be financially sustained.

- Continue active participation in the Health Partnership Council of the Hospital Association of Rhode Island. I am currently serving a 2-year term as co-chair of this council. This provides an opportunity for the council to focus on the vital needs of the health care work force and the role of the academic institutions.

- Continue to strengthen partnerships within the health care community and colleges to develop innovative approaches to deal with the health care staff shortage including recruitment activities.

- Examine potential of "joint appointments" of Masters in Nursing prepared staff interested in retaining their clinical connection, yet, also facilitate learning for nursing students.

- Encourage assistance from the State professional association members to mentor and tutor students. Members of the Black Nurses Association and the Hispanic Nurses Association have been serving as volunteers.

- Continue to develop articulations with High Schools and Career and Technical Centers to attract individuals to pursue a career in the health field.

- A partnership with a community hospital has recently been developed to respond to a new effort by the hospital to provide RN-Refresher programs.

- Provide a wide array of non-credit remediation courses to avoid students maximizing the use of financial aid and then be unable to continue due to financial constraints.

- Nursing faculty be more directly involved with counseling/advising regarding career choices and course selection. Reducing faculty load to provide collaboration opportunities with student support services would be one approach.

- Through collaborative effort by State representatives, seek bank leniency for loans for nursing students, particularly minority students. If the College has evidence students are participating in reinforcement sessions etc., have excellent class attendance; prior poor academic performance may be viewed in a different light.

- Students need remediation in a number of basic skill areas: Math, English, written and verbal communication. Develop a “Caring Group Network” prior to nursing program admission. The small group of 8 or 9 students with a nursing faculty facilitator could begin weekly sessions, for 1 hour a week, about a month before classes are in session and then continue to meet as a team throughout the program.

Anecdotal Information

- One of the largest Rhode Island health care facilities has indicated that the Community College of Rhode Island has educated 65 percent of the hospital staff.
- Recently, a student spoke of a strong desire to enter the nursing program, however, having incurred over \$10,000,000 in loans from a previous educational pursuit, she is reluctant to have additional financial responsibilities. While there are a number of recent legislative initiatives, such as, interest free loan assistance and nursing education scholarships, students would need to still need to make an initial investment.
- The Health Resources and Services Administration Scholarships for Disadvantaged Students (SDS) have continued to award CCRI with monies. The stipulations have prevented the college from awarding the scholarships for the following reasons: requirement that students be full-time (12 or more credits) and the need for parent income tax information. The student population we have served, by in large, are well over 30 years of age. This becomes an unnecessary hardship for these students to comply with these requirements.

Senator REED. Thank you very much, Dr. McGarry.
Dr. Schepps.

STATEMENT OF BARBARA SCHEPPS, M.D., DIRECTOR, ANNE C. PAPPAS CENTER FOR BREAST IMAGING, RHODE ISLAND HOSPITAL, PROFESSOR (CLINICAL) BROWN UNIVERSITY MEDICAL SCHOOL

Dr. SCHEPPS. Thank you for the opportunity to address this committee. I appreciate being able to testify on behalf of the 228,000 radiologic technologists in the United States and the 1,100 who are registered here and licensed here in Rhode Island. They're an integral part of the health care team who are often forgotten.

As already noted, there is a severe shortage of these individuals. The cause is multifactorial. Over the past 30 years, new imaging modalities have become not only part of the physician's vocabulary, but they are daily words in the public's honormantarium.

CT is now discussed to diagnose appendicitis. Before going to the operating room instead of just physical examination alone. With MRI, an interventional radiology, we can diagnose abnormalities, such as blood vessel aneurysms, and treat them without taking the patient to the operating room, but merely to the radiology suite.

The number of imaging procedures for 100 people in 1960 was 36. In 2000, 130 procedures for 100 people were performed. Screening tests, such as mammography, have allowed the diagnosis with merely a needle and an x-ray and mortality of breast cancer has directly been improved, and we have allowed the patients to have more conservative therapy based on early diagnosis by screening.

In addition to these improvements, increasing numbers have been based also because of defensive medicines being practiced. Doctors are ordering more and more imaging tests to cover themselves against the threat of malpractice.

Another problem that is causing an increase in the number of imaging tests performed is the number of Baby Boomers and older people. We have talked about this earlier, and by the year 2030 it is projected that the number of people who are 65 and older will double and those 85 and older will triple.

The workforce technology is also aging. It is interesting to note that 70 percent of the radiological technologist workforce is over the age of 35.

There is also a decrease in the number of people entering the field. Women have other options. They don't all choose to go into the hospital-based professions. There are decreasing number of schools of radiological technology. In Rhode Island there are two, in CCRI there's one and Rhode Island Hospital has one, but it is interesting the applications are limited and the number of graduates that actually matriculate is probably about half of those that matriculate, and this has been a trend.

In 1994 there were 10,629 graduates of technology programs in the United States. In the year 2000 there were merely 749 graduates. There are many other schools for radiation therapy technologists in Rhode Island, the nearest being in Worcester, being in Boston. Now technologists are also leaving the field. They are leaving it because of burnout, they work nights, they work weekends. It is a 24-hour-a-day, 7-day-a-week job, they have holidays, and a new graduate can be assured that he or she will be working Christmas and New Year's for the next 5 years.

There are better jobs. Technologists are leaving Rhode Island in particular for other jobs. There are better paying jobs just across the border at some of the hospitals previously mentioned, and people are leaving to take these jobs. They're being offered three times the salary they can make here. They also are going in other fields. Many of them are choosing to teach, they're doing academics and they're also working in research positions.

The workforce is also a part-time workforce. Say we have 1,100 registered technologists—licensed technologists in Rhode Island, but most of those people are either part time, and many of them don't work at all. In radiologic technology in the United States there was a 15.3 percent vacancy rate, and one out of seven can be filled.

What are the consequences? The consequences include closing shifts, decreasing accessibility, increasing length of stay, decreasing emergency room throughput and increased waits for screening tests.

What are the strategies that might help improve the shortage. One might be so we can decrease the number of having less defensive medicine. Others might be soliciting students at younger ages, in junior high school and high school and creating interest in these jobs. Subsidizing their education would be helpful. Most currently these schools cost between \$4- and \$5,000 for a 2-year program, and that is prohibitive for some of these young people.

Looking at minorities and people returning to the workforce in other areas. The technologists with whom I speak say that they would like to have respect and a career ladder, a way to go from just being a staff technologist and improve. They would also like to get a degree, an associate's degree for their 2 years of training. They do that at CCRI, but in many other programs they don't get them. And, of course, they all like increased remuneration.

[The prepared statement of Dr. Barbara Schepps follows:]

PREPARED STATEMENT OF BARBARA SCHEPPS, M.D.

My name is Barbara Schepps and I am a practicing board certified radiologist. I am on the active staff of Rhode Island Hospital, Women and Infants Hospital and the Miriam Hospital. I am employed by Rhode Island Medical Imaging, am an owner of this radiology practice and have served as its president for the past 12 years. I am a past president of the Rhode Island Medical Society. Currently I am chairperson of the American College of Radiology's (ACR) Radiologist Resources (Manpower) Committee and the ACR's Commission on Human Resources. I have co-authored a number of papers on the national shortage of radiologists. From each of these perspectives, as a practicing radiologist in a hospital setting, part owner of a large diagnostic imaging practice, and chairperson of the ACR's manpower committee and past president of the State's medical society, I have a unique perspective on the current crisis caused by the shortage of radiologic technologists and the potential for even far more dramatic consequences if this local and national crisis is not addressed.

Background

Over the last 30 years, radiology has changed how medicine is practiced. When I began my career in radiology there was x-ray and the beginnings of modern day radiation therapy and nuclear medicine. Today, part of most laypersons vocabulary are words like CT scan, MRI, and PET scans. Doctors are referring their patients for such things as non-invasive cardiac nuclear scans, ultrasound studies of unborn babies and granny's carotid arteries, and for some patients, radiation therapy to treat prostate cancer, all unheard of when my career began.

Radiology can now reduce unnecessary surgery by looking inside the body without a scalpel, but with a CT scan. In the hospital of the 21st century, prior to a patient being rushed to the operating room for an appendectomy, a CT scan is obtained to be certain if the diagnosis is indeed appendicitis. In the radiology suite of this century radiologists are diagnosing tumors with needles guided by CT, ultrasound, MRI or x-ray without the need for exploratory surgery. Vascular radiologists are opening clogged blood vessels with catheters and stents (tubes) inserted with only a nick in the skin.

Radiology is truly a burgeoning field and is the lynchpin in most of the recent advances in the diagnosis and treatment of disease. Effective treatments rely on accurate diagnosis. For instance, radiology has directly contributed to the reduction in the mortality from certain diseases, such as breast cancer, by screening women with mammography who have no symptoms to find unsuspected disease. When a mammogram shows a suspicious area, the radiologist can diagnose breast cancer with a needle without a trip to the operating room. Not only has the mortality reduced, but also women who are diagnosed with breast cancer may be candidates for a more minimal surgical procedure because tumors are found at an earlier stage. Over the span of my practice the radiologist had gone from only interpreting simple x-rays to being a diagnostician performing minimally invasive procedures to treat many with minimally invasive techniques.

The field of radiation oncology has grown by leaps and bounds. Over the years, the radiation oncologist (a physician) and the radiation therapist (a technologist), have worked hand-in-hand to both cure many cancer victims and reduce the suffering of others. For some, radiation therapy may replace more invasive surgery entirely. An integral part of the practice of radiology is the radiologic technologist. Radiologic technologists are part of a team. The radiologic technologist actually takes the x-rays and the images for CT, MR, PET and ultrasound. In the radiology suite of today, much of the work of a technologist involves the use of computers. The radiation therapist delivers the radiation for therapy treatments. The nuclear technologist measures and delivers doses of radioisotopes and takes the images for the radiologist to interpret. All technologists are versed in radiation protection practices.

To become a radiologic technologist most individuals attend a full 2-year accredited school. There are two such schools in Rhode Island, one at Rhode Island Hospital (RIH) and the other at the Community College of Rhode Island (CCRI). The requirements for admission to the RIH program are a high school diploma or GED, necessary health requirements, a C or better average in algebra or higher, a course in human anatomy, and a basic computer course. Throughout the program the student is given written examinations, clinical evaluations, and competency evaluations. Upon completing training at the program at RIH, a graduate earns a Certificate in Radiologic Technology that entitles them to take the American Registry for Radiologic Technologist (AART) exam to become a Registered Radiologic Technologist (RRT). Students graduating from CCRI also receive an Associates Degree.

The cost for the entire 2 year program at Rhode Island Hospital is \$4,000 and at CCRI, \$5,000. RIH is licensed for a class of 15 students per year; CCRI, 46.

There is a new 4-year program at Quinnipiac University in Connecticut. In this program a student qualifies to sit for the ARRT examination after the first 2 years. In the subsequent time they may go on for advanced certification such as in ultrasound and are then able to take that advanced registry. They receive a BS degree at the end of 4 years.

The Problem

The need for diagnostic imaging services is burgeoning. Utilization is driven by an aging population, new and better equipment, patients demands for tests they have read about on the internet or seen advertised, and physicians seeking quicker, more accurate and less invasive means of obtaining diagnoses. While the number of radiologic technologist remains stagnant or is decreasing, the demand for diagnostic imaging services has grown by 3 to 4 percent annually. Since the 1960s, the use of imaging resources has increased from about 36 procedures per 100 people to 130 procedures per person in the 1990s. It is projected that there will be a 140 percent increase in imaging procedures by 2020. More than 30 million radiographic procedures are performed in the United States each year. For the radiologic technologist this translates into longer working hours and increased number of studies performed per hour. An American Healthcare Radiologist survey showed that the average hospital-based radiographer performed 3,308 examinations in 2000, an increase of almost 550 over 1995 numbers. The average interventional technologist workload increased 95 percent over the same 5-year period.

As the population ages, there is and will be an increasing need for imaging services. The oldest of the Baby Boom Generation, approximately 78 million Americans, are now in their mid-50s. It is estimated that by 2030 the population over age 65 will double and the population over 85 will triple. Clearly the demand for imaging will skyrocket. Seniors utilize 3 to 4 times more health care resources than younger adults.

Another compounding factor is the aging technologist workforce. The average age of a radiologic technologist is 41, one of the oldest averages in the allied health care field. Unfortunately, many of these very necessary workers are part of the Baby Boom Generation and will be retiring just as the need for radiologic technologists is soaring. In a study by the ASRT, only 14.5 percent of radiologic technologists were younger than 30 and only 30 percent were under 35 years of age.

Further contributing to the workforce shortage is the fact that fewer people are entering the field. Nationally, the number of people taking the ARRT radiologic technology registry declined between 1994 and 2000 from 10,629 to 7,149. For radiation oncology, the drop was even more dramatic, from 1,046 in 1994 to 399 in 2000. A slight upturn was noted in 2001 with 7,434 and 579 in diagnostic radiology and radiation oncology respectively.

Additionally, there are fewer places to study radiologic technology. Because of cut-back in reimbursement and decreasing applications, many hospitals have been forced to abandon their programs. In 1994 there were 692 JRCERT-accredited educational programs for radiography, in 2001, only 583. For radiation therapy the numbers are even more dismal: 125 programs in 1994 and 69 in 2001. The schools nearest Rhode Island are in Worcester, Boston and Hartford. Fourteen States have no radiation therapy programs at all.

Many of those applying to programs do not meet the qualifications. Of those accepted, some pay the initial deposit and never matriculate. Many do not complete the program. For the class of 2001 at RIH, there were 26 individuals applied, 12 accepted, 8 matriculated and 5 graduated. In 2002, 32 applied, 13 accepted, 11 matriculated and 7 completed the program. At CCRI in 2001, the class began with 32 individuals and graduated 16; in 2002, 40 matriculated and 24 graduated.

Why are people not choosing to enter this field? One reason is that traditionally women comprised much of the workforce and today women have many other career opportunities open to them. Another reason is that careers in health care have lost their appeal. Relatively low wages combined with high stress, the 24/7 nature of the job, and the increasing healthcare bureaucracy contribute to the lack of interest in the field. High school students are not encouraged to attend 2-year programs, but are enjoined to strive for a traditional 4-year college degree. Today's youth who do attend 2-year and some 4-year programs, choose jobs in the computer industry that are higher paying and more "fun." Ads for airport screeners this week were advertised at \$20,000 to \$40,000 without the 2- to 4 years of additional education.

Why do people leave the field? Many burn out from job-related stress. Others see better paying opportunities. In speaking with technologists, the single greatest reason for seeking other work is salary. As rewarding as the technologist's life may be,

it may also be quite demanding. Working with the sick, the well and the worried can be a strain.

Others seek jobs with no call, nights or obligatory weekends and shift work. Hospitals are particularly vulnerable because of the 24/7 nature of their service needs. A few cite the lack of a career ladder for radiographers. Some seek less demanding and more financially rewarding careers with or without the need for additional education. Why do technologists leave Rhode Island? Some leave for better paying jobs, frequently just across the border in neighboring Massachusetts or Connecticut. Certain hospitals in Boston, so desperate for technologists, pay salaries that can be 3 to 5 times those in Rhode Island. Others will relocate further for even higher salaries.

In the United States there are currently 227,863 ARRT certified technologists. Many of these individuals are certified in more than a single area. Areas of certification include: nuclear medicine, cardiovascular, mammography, CT, MRI, sonography, vascular, and quality assurance. Rhode Island has 1,078 registered technologists. Since 1995, State licensure is required in Rhode Island. There are 1,232 licensed radiologic technologists in Rhode Island (may not live or work in the State or may be contract employees brought to the State for unfilled vacancies). While these numbers may seem reasonable they do not tell the whole story. Many technologists keep up their registry and licensure but do not work in the field. Many, many others work less than the 40-hour week. Of those who work, some hold administrative, supervisory, or research positions and do no clinical work. While a vast majority of technologists are radiographers (x-ray technologists), many hold additional certification(s) and only work in a sub-specialty.

In November 2001, the U.S. Bureau of Labor Statistics projected the need for 75,000 more radiologic technologists in 2010 than it did for 2000 along with the need for 22,000 more cardiovascular technologists, 16,000 more sonographers, 8,000 more nuclear medicine technologists, and 7,000 more radiation therapists. These numbers reflect both growth within the specialty and vacancies left by those retiring or changing careers. It is interesting to note that a January 2002 survey of the American Hospital Association and three other hospital organizations reported a 15.3 percent vacancy rate for radiologic technologists, meaning that 1 of every 7 jobs for radiologic technologists cannot be filled. This vacancy rate is higher than the reported 13 percent vacancy rate for nurses and 12.7 percent vacancy rate for pharmacists. It is interesting to note that starting salaries for both pharmacy technicians are double to triple that of an entry-level technologist.

Consequences of the Shortage

The shortage of radiology technologists affects everyone. As an employer of more than 100 technologists, a vast amount of resources are expended recruiting and retaining our technologist workforce. Our practice offers flexible hours, generous benefits and a comfortable work environment. There is no mandatory overtime or night work. The office practice of radiology is frequently less demanding than the hospital setting. Patients walk and talk. All of these factors contribute to the increased cost of running a radiology practice in a day of decreasing reimbursement. Over the past 2 years, however, despite our favorable salaries and working conditions, we have had increasing difficulty filling our positions. We vie with other practices and hospitals for the same limited workforce. This translates into curtailing some non-emergent services and sharply reducing others. One that has been a trigger point with both patients and referring physicians has been our need to decrease our mammography services. We no longer offer evening and Saturday appointments. Patients have to wait as long as 5 months to obtain routine mammographic screening. This translates into decreased patient and physician satisfaction. This problem is nationwide. Due in part to the technologist shortage, practices are choosing to stop performing mammography altogether. The FDA website shows that in March of 2001 there were 9,873 MQSA mammography practices, in July of 2002, only 9,349. While some of this might be due to consolidation, with reported waits for screening mammography as high as 6 months, at least part of the facility closings can be directly attributed to the shortage of mammography technologists. Furthermore, if, as it has been shown, early detection of breast cancer is dependant upon finding tumors early, the decrease in access will have a direct impact on the lives of American women.

Other services are being limited. At Rhode Island Hospital we have been forced to close some of our CT scanners from time to time because there are no technologists to work. Around the country, practices are being forced to limit or eliminate critical services.

Another consequence that must never occur is the use of unqualified personnel to fill the need. The use of ionizing radiation is a serious matter. A significant por-

tion of the radiologic technologist's education centers around the safe use of x-rays. Conjure the image of untrained personnel misusing this precious resource!

In the hospital setting this can impact directly on length of stay, emergency department throughput and operating room schedules and all of these have a direct effect on the cost of healthcare. Morale of the working technologist is affected. This coupled with similar shortages in other allied health fields affect the workplace and make recruiting and retention of healthcare workers more difficult.

Possible Solutions

While it is not possible to change some of the factors leading to the impending crisis such as the aging population or the increasing indications for the use of imaging and image-guided interventions and therapies, attention must be focused to recruiting and retaining young people. We must pique their interest. An interesting anecdote relayed to me is that no student entering the CCRI program this year is under 20. High school counselors do not encourage students to enter these fields. This may stem from their personal lack of knowledge of the rewards and benefits of the technical areas of imaging. One strategy is try to attract students is to talk to students as early as middle school and educate them about this career opportunity. Another might be offering the free education with a concomitant means of earning income. The granting of an associate degree from all 2-year programs would also be attractive.

Other individuals to target might be minorities who traditionally have been locked in dead-end low-paying jobs. This can be accomplished with outreach programs and career days. Single parent families are another excellent target audience; the parent could benefit from a job with flexible hours.

Perhaps another source to be tapped are those seeking a career changes. Schools of technology should attend job fairs to create awareness.

Finally, perhaps the development of a career ladder with increasing rewards with such advancement might help to retain those in the field. The development of a program such as an R.T. Clinical Specialist could help the beleaguered radiologists and serve as a means of both attracting new technologists and facilitating upward mobility among the current technologists.

Thank you for allowing me to speak to you today on this very important topic.

Senator REED. Thank you.

Jim McNulty.

STATEMENT OF JAMES McNULTY, PRESIDENT, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. McNULTY. Thank you, Senator Reed, Governor Fogarty for being here, for the opportunity to speak today.

It has been an interesting hour and a bit listening to all of the testimony. You have my written testimony. I am going to try and give you some insight into some of the things that helped form some of that testimony.

I spent the last year traveling in the United States. I was elected President of the NAMI a year ago and I have since put on 130,000 miles, visited 20 States and about 13 major metropolitan areas, and things aren't very good anywhere. Some are a little better than others, but most are in pretty dismal straits. The system delivering our health care services is on the edge of total breakdown. I am not an alarmist. You have known me for several years. I don't say things like that lightly, but it is true. It is not far different than that in other areas of medicine, but I think mental health has been sort of the leading edge, and it is one of the major brunts and the cost containment efforts have been represented most by the managed care organizations in this country.

I am not here to beat on the managed care organizations, because that is futile. They have to run what they are doing simply because we as a Nation have refused to make the right decisions on health care. We have made no policy. We have chosen to sit by

and let things evolve into chaos. Those of you in leadership that have shown us so many different things, Senator, I am asking you, and, Governor Fogarty, asking you as well, to continue showing me leadership. You are in a unique position to implement policy.

One of the things that occurred to me while I was listening to everybody, there are many problems here. There is a mind numbing level of detail to the problems that you heard today. What we need to do is put the patient in the proper place, which is first. It is my belief that if you put a patient at the center of the health care system and work from there, you will have a health care system that not only takes care of the patient, the caregiver, but the professionals that work in the system and the institutions that care for patients. What I have seen for years is the fact that we have sort of robbed Peter to pay Paul, put fingers on various dikes, we have used duct tape to an extraordinary degree to try and keep the system together, and I think one of the ironies to me is that we have such extraordinarily good and dedicated health care professionals, that these people have done a superb job of just keeping things together, but it is reaching the state where they are not going to be able to keep things together, and I think we need to recognize that, and we need our Government at this time, as in no time without calling the past to take the lead back on health care. This is not something that one group, one guild can lead on. It has to be everybody involved in it, and, frankly, based on what my observation of the last several administrations in Washington has been, I don't hold great hopes that the administrations are going to be able to solve that. I think it is going to take the legislative representatives of people to address some of these issues.

Obviously, we stand ready to help you in any way and to advise you. It is a big job, I am not going to minimize the fact that it is, but what I would like to tell you about is a couple of stories of how patients are impacted.

One of my very best friends and colleagues in Rhode Island, Mickey Siline, who is the Executive Director of NAMI in Rhode Island, has a son with major mental illness, and he has suffered from this since he was a teenager and he is now in his mid-30s, and one of the things that works well for people with mental illness is to have case managers. People who help them with the activities of daily living, it is helping them deal with the things that caregivers cannot do all the time because of the caregiver burnout, and we have a very good, very good public mental health system here in Rhode Island, which is in danger of falling to pieces, as are all other health care systems. The tragic thing was that Jimmy had a wonderful care manager, an individual left working for the public mental health system to take a job as a commercial office cleaner because it was more pay, and I think that that, that is just horrible to think that that is how we reimburse our health care professional. I have to tell you that the consequence of not treating people's health problems is not just a—it is sick, stay sick, but it is often death.

One of my very best friends, someone whom I knew years from the days that I started, is an advocate in running support groups, committed suicide 2 years ago because of the lack of health care, people that could help him and reach out to him.

There is a real consequence, a very real consequence to the fact that we as a Nation have not addressed our health care needs. Thank you.

[The prepared statement of James McNulty follows:]

PREPARED STATEMENT OF JAMES McNULTY

Senator Reed, I want to thank you for the opportunity to present oral and written testimony at this Senate field hearing, which you are so graciously and capably chairing.

My name is Jim McNulty, of Bristol, RI. I am the President of the National Alliance for the Mentally Ill. Today, NAMI has more than 220,000 consumer and family members nationwide dedicated to improving the lives of persons with severe mental illnesses. As a person diagnosed with bipolar disorder (manic-depressive illness), I am proud to serve as NAMI's President and proud that NAMI is the Nation's "voice on mental illness" representing both consumers and family members.

I am also president of the Manic Depressive and Depressive Association of Rhode Island, a support and advocacy organization. I serve as a member of the board of directors of the National Alliance for the Mentally Ill of Rhode Island, and Mental Health Consumers of Rhode Island.

I am a member of the Governor's Council on Behavioral Health, and was appointed to a 4-year term, in January 2001, on the National Advisory Mental Health Council, which advises the administration, specifically NIH Director Dr. Elias Zerhouni and Secretary of HHS Tommy Thompson on issues of policy on mental health research and service delivery.

I am an advisor on numerous research studies, and grants at academic medical centers around the United States—I will forebear citing the entire list here. I serve on an Institute of Medicine panel studying protection of human subjects in research.

Of more immediate significance, I have traveled over 130,000 miles since being elected president of NAMI in July, 2001. In this capacity I have visited 20 States, and numerous large metropolitan centers in the U.S.—New Orleans; Washington, DC; New York; Los Angeles; Minneapolis; Seattle; Dallas; Houston; Chicago—and I must tell you that what I have observed is very alarming.

The system of delivering mental health care services in this country is teetering on the edge of irreversible breakdown. There are still bright spots, but not many. And all of the bright spots are in danger of dissolution, too. This is as true in Rhode Island, an area of major concern for most of us here today, as in all other areas of the country.

In my career as an advocate for mental health services, I have eschewed being an alarmist and shouting continually that the mental health system is broken, since it wasn't until very recently. I have spoken about this with Paul Appelbaum, M.D., president of the American Psychiatric Association, staff of the American Psychiatric Nursing Association, members of the American Psychological Association—and many, many others. Looking back 2 years, Felice Freyer of the *Providence Journal* asked me for my assessment of the state of mental health care in our State. I told her then that we were watching a train wreck in slow motion. That was true then, and it is truer today.

I keep my fingers on the pulse of what happens in our community by spending time conducting support groups for family members and consumers, and answering calls for help by people seeking emergency mental health care.

In fact, the system for providing outpatient mental health care here in Rhode Island is so bad in the adult system that those without an attending psychiatrist when admitted to a hospital must wait weeks—8 to 12 weeks is not an uncommon wait—for outpatient follow-up care with a psychiatrist. Accordingly, internists, primary care physicians, family practitioners, pediatricians, nurse practitioners, gastroenterologists and other non-psychiatrically trained specialists are forced to provide mental health services. These specialists, well-intentioned and devoted to caring for their patients, are performing services that they have insufficient training for, and are not equipped to provide in any reasonable way.

Managed care has decimated the ranks of all mental health clinicians, not psychiatrists alone. The claim is made that we have the same number of mental health providers as we have had for the last 12 years. Real-life patients and advocates will tell you that there is a phenomenon called the "phantom network": all of these providers may exist on paper, at the offices of managed care organizations and at the RI Department of Health, but God help you in trying to obtain an appointment.

This dire situation is worse still in the areas of treating children's mental health. The Center for Mental Health Services, an agency of DHHS, estimates that 20 per-

cent or 13,700,000 of the Nation's children and adolescents have a diagnosable mental disorder, and about two-thirds of these children and adolescents do not receive mental health care. We have about 8,000 boarded child and adolescent psychiatrists—and we need more like 30,000. We cannot even begin to assess the need for counselors—school and family, alike, or residential treatment facilities nationally. And we a faithful image of the national picture here in RI.

We have appallingly few resources for the elderly mental ill, many of whom would benefit from appropriate and timely services, which would decrease the costs associated with putting many seniors in nursing homes and hospitals.

Our Veterans Administration mental health care networks are staggering under the burden of an unanticipated influx of new patients, refugees from the private sector, many of whom lost their retirement healthcare coverage.

The public mental health system, in most States also a phantom network, is struggling after years of funding neglect and insufficient attention from State administrators. It is no different here in Rhode Island, despite heroic efforts from the Community Mental Health Centers and the department of MHRH.

I could enumerate problems for several more pages, but I want to ask you as my Senator, and the Committee, to focus on several things:

Rep. Patrick Kennedy, D-RI, has introduced H.R. 5078, the Child Mental Health Service Expansion Act; I ask you to consider sponsoring a companion bill in the Senate.

Introduce legislation to end the blatantly discriminatory treatment of mental illness under Medicare (and keep up the pressure for insurance parity in the private sector).

Keeping this Administration honest on mental health issues—to the extent feasible, participating in the President's Commission on Mental Health

Continue providing national leadership on healthcare—many of the problems we have in healthcare today exist because Presidents have not had a vision of what a national health policy should be. As a Nation, we made a decision by agreeing not to make a decision, and we have chaos instead.

Last, we need our leaders to communicate to the professional societies—guilds, if you will, and health care providers and insurers that they must focus on taking care of their patients. If our goal is to provide appropriate, effective care to those who need it, we will build a good system. If we continue to allow various constituencies to use their narrow concerns as a proxy for good health care any system we try to build will fail.

NAMI, nationally and locally, stands ready to assist and advise in any way you ask, to avert tragedy in our health care system, and especially in our mental health care delivery. We are conducting a survey of all the States to help understand the problems, and work toward solutions.

Senator Reed, thank you for this opportunity to testify before the Committee.

Senator REED. Thank you very much, Jim.

Wendy Laprade.

STATEMENT OF WENDY LAPRADE, RNC, STAFF NURSE, WOMEN AND INFANTS HOSPITAL

Ms. LAPRADE. Thank you, Senator Reed, for inviting me today.

Nineteen years ago, when I started my nursing career as a staff nurse I knew that certain inconveniences came with the profession.

Providing care for patients in the acute care required me working evenings, nights, weekends and holidays. I did not, however, anticipate unsafe staffing problems, mandatory overtime, floating to unfamiliar areas of the facility, the ergonomic strain, safety and health issues. I never imagined that my nursing time would be occupied with non-nursing duties, counting drugs and supplies, checking equipment, transporting, as well as typing, ordering, cleaning and justifying. We must fix the underlying problems, not just whitewash the nursing picture, for as fast as the educators can help to produce new nurses, they will be leaving the bedside for more acceptable opportunities.

But there is a step we can take today, immediately, to stop the hemorrhaging, and that is to put a ban on mandatory overtime.

Senate Bill 1686, "Safe Nursing and Patient Care Act" introduced by Senators Kennedy and Kerry would do this. Limiting forced overtime will ease the impact of the shrinking supply of nurses by encouraging more nurses to stay in the profession. It will protect countless patients in the same way that limits on mandatory overtime for trained engineers, air traffic controllers, truck drivers and other occupations where public safety is at risk.

With the rise of managed care in the 1980s, long before a nursing shortage began to emerge, hospital administrators moved to cut costs by cutting expenses, particularly by laying off and decreasing hours for huge numbers of registered nurses across the country, the industry reduced staffing levels to the point where nurses, increasingly unable to provide our patients with the care we were trained to give, began to leave hospitals for more rewarding and less physically and emotionally taxing jobs.

Nurses in hospitals and related facilities are caring for more patients today than we did a decade ago. Because of restrictions on hospital admissions and lengths of stay imposed by managed care, the patients in hospitals are more acutely ill and in need of greater care.

The result is that hospitals are having increasing difficulties filling vacancies for RNs. This is confirmed by our SEIU Nurse Alliance Survey, where:

Nurses reported that on average it took nearly 11 weeks (10.77) to fill a nursing vacancy in their unit, and 52 percent of the nurses believed that it takes longer to fill vacancies today than 3 years ago.

This doesn't show nurses' job dissatisfaction; it signals a real problem for patients. When staff is less experienced and unstable, it is more likely that patient care will suffer.

The hospital industry cites many of these statistics to point to a nationwide "nursing shortage." But a closer look at the data suggests that the real problem is a shortage of nurses willing to work in hospitals under current working conditions. This opinion was also shared by the General Accounting Office in their recent report. "Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors." Many view the situation as a staffing crisis rather than a nursing shortage; system understaffing brought on by the restructuring of the industry under managed care has led to dramatically deteriorating working conditions and increasing concern about the quality of patient care which is causing nurses to leave hospitals. This is confirmed in a survey of health care human resource managers conducted by the William M. Mercer Consulting Company who found two important factors affecting turnover:

"Dissatisfaction with the job itself, working conditions, the relationship with the supervisor, or career opportunities;" "Workload and staffing," noting that "a reduction in RN resources has increased the job demands of those remaining in the workforce." In the report, the consulting company suggests that the employers concerned about turnover "should examine their own practices and work environment." It cannot be stressed enough that when our nursing profession is in crisis, our Nation's health care system is in crisis.

Inadequate staffing has given rise to increased numbers of medical errors. In 1999, the Institute of Medicine found that between 44,000 and 98,000 Americans die every year in hospitals due to medical errors; more people die of medical errors than from motor vehicle accidents, breast cancer or AIDS. While the IOM report exposed a national crisis, it did not explore one of the primary causes of it: Understaffing. However, this issue was comprehensively assessed by a research team from the Harvard School of Public Health led by Professor Jack Needleman, which found that higher RN staffing was nursing, in particular urinary tract infections, pneumonia, length of stay, upper gastrointestinal bleeding and shock.

A majority of nurses in our SEIU Nurse Alliance Survey identified understaffing as a cause of medical errors. The situation, they say, is not improving.

Fifty-four percent of nurses say that half or more of the errors they report are the direct result of inadequate staffing.

Despite the growing attention focused on medical errors, most nurses say the rate of incidents has remained unchanged over the last year—while fully 30 percent of nurses say the errors have actually increased.

We also should keep in mind that there are many more medical errors that go unreported for fear of retaliation. Most health care workers who blow the whistle on short staffing and poor patient care have no legal protections against retaliation. Federal whistleblower laws are narrow in coverage and do not apply specifically to the health care industry.

The staffing crisis and the deteriorating conditions it has created has compromised quality care for people in our communities. According to the Maryland Hospital Association, “over half the hospitals throughout Maryland report they have had to close beds, delay and cancel surgeries, disrupt scheduled procedures, and ‘re-route’ ambulances to other facilities for emergency patient care.” The MHA says that is increasingly common for patients arriving in an emergency department “to be held there until adequate staffing becomes available on a patient unit.” These situations are not unique to the State of Maryland.

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Nurses are often mandated to work back-to-back 8-hour shifts or 4 extra hours on top of a 12-hour shift to fill gaps in staffing. Of course this threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also places an incredible stress on family life, particularly when last minute changes have to be made to find childcare or care for elderly parents.

According to our survey, nurses in acute care hospitals work an additional 340 hours of overtime on average every year. Nurses are not only being increasingly required to work excessive amounts of mandatory overtime, but also routinely are required to “float” or be reassigned to units where they lack the experience and training. Nurses are being stretched to the limit, experiencing high levels of stress, chronic fatigue and work-related injuries. These intolerable

work practices lead to further burnout, undermine nurses' sense of professionalism and drive nurses from hospitals.

Nineteen years ago when I started my practice most hospitals provided new employees with a fairly extensive initial training and continuing education program. In 1995, an average initial training lasted 3 months. In 2000, that was decreased to 30 days.

Nurses want to provide safe and efficient care for our patients. We need appropriate nursing education to keep up the ever-expanding technology.

Correcting these issues, I believe, will help restore a sense of value back in the nursing profession. Workers stay when they feel a sense of value and pride in their work.

According to the SEIU Nurse Alliance Survey:

Only 55 percent of acute nurses plan to stay in hospitals until they retire.

And only 43 percent of nurses under 35 plan to stay in hospitals until retirement.

But 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

These statistics show a little discussed fact about today's shortage. In reality, the current supply of nurses far exceeds demand. The proportion of RNs employed in hospitals has decreased substantially and consistently from 69 percent in 1988 to 59 percent in 2000. Our current crisis is not a shortage of nurses, it is a shortage of nurses working at the bedside. Nationwide there are approximately 2.7 million registered nurses, however, 500,000 of those RNs are not working in nursing. According to The American Hospital Association statistics, nationwide there is a 12 percent vacancy rate in nursing. This translates to 126,000 nursing vacancies. It is easy to see that we have the nurses, but they are not working in nursing positions.

Deteriorating staffing and working conditions have led many nurses to leave the profession all together and fewer young people are entering it: Nursing school enrollment has declined in each of the last 6 years. According to Dr. Dennis O'Leary, President of the Joint Commission on the Accreditation of Healthcare Organizations, (JCAHO) in the May 2000 report "Framing the Issues: In pursuit of solutions to the National Nurses Workforce Dilemma," there are 21,000 fewer nursing students in 2000 than in 1995. As a result, the average age of working RNs has increased 7.8 years since 1983 to 45.2 years. As these trends continue, there is likely to be a severe nursing shortage in the future. By 2020, we expect that will be a shortage of 400,000 nurses, when the majority of the Baby Boomers will be seeking care.

Many nurses wish to remain in hospital work, and would do so if staffing and working conditions improve. If these conditions are not improved, nurses' flight from hospital care will intensify and in the near future we will face a true shortage. The fact that younger nurses are even less likely to stay in acute care than their older colleagues is a warning sign.

The American Hospital Association reported in its report "Commission on Workforce for Hospitals and Health Systems," many hospital workers do not feel valued and discourage others from entering health care.

I have focused my remarks principally on hospitals, since that is where my practice is and where I believe the nursing crisis is most severe. There is however, a related and equally serious problem in nursing homes. While RNs make up a small proportion of the nursing home workforce, and are largely in managerial positions, most of the staff in nursing homes are certified nurse assistants, and to a lesser extent, licensed practical nurses or licensed vocational nurses.

SEIU members include more than 120,000 nursing home employees, the vast majority of whom are CNAs and a large number of whom are LPNs/LVNs. Similar to administrators in the hospital industry, nursing home owners have argued that they are facing a shortage of nurses and nurse aides. For this reason they have asked for increased Medicare and Medicaid reimbursement and have resisted the setting of minimum staffing standards.

But just like in hospitals, the real problem isn't finding people to work in nursing homes, it is keeping them there. Turnover rates for direct care workers in nursing homes are nearly 100 percent, creating a revolving door of caregivers that renders continuity of care impossible. Workers are leaving due to heavy workloads. They simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt and burnout.

Moreover, low wages, lack of health insurance coverage, pensions and high injury rates also make nursing home work unsustainable for many workers.

Nurses across America are sounding the alarm: Staffing levels are too low to provide the quality of care their patients need. In many States, nurses who are in unions have turned to the bargaining table to change their working conditions in order to ensure safer staffing and better patient care. Eliminating mandatory overtime, establishing safe staffing standards and improving recruitment and retention by increasing pay have been the primary issues in nurse contract negotiations from coast to coast.

Many members of SEIU's Nurse Alliance have been able to negotiate limits, if not outright prohibitions, on mandatory overtime. At the Dimensions Health Care, in Maryland, the nurses, through their union contract, have ensured that their hospital's past practice of not requiring mandatory overtime is followed, a practice that is an incentive for many nurses to stay on at that hospital. Earlier this year, SEIU nurses at Aliquippa Community Hospital in Philadelphia became the first in their State to win an agreement in their contract eliminating mandatory overtime. Their hospital CEO, Fred Hyde, recently joined nurses in pressing for State law in Pennsylvania to protect patients and nurses from mandatory overtime, calling it "involuntary servitude." SEIU nurses at Kaiser Permanente, the League of Voluntary Hospitals in New York, Swedish Medical Center in Washington State, and many other hospitals have negotiated contracts with breakthrough agreements that give bedside nurses a voice in getting safer staffing levels through labor-management committees. But, while we have made some progress, this issue is too big and too important to the health of our profession, our hospitals and our communities to address hospital-by-hospital and contract-by-contract nurses working together with SEIU, unions and the American Nurses Association

have introduced legislation on the State level to establish safe staffing standards, ban mandatory overtime, provide whistleblower protection for nurses when they speak out on understaffing that jeopardizes good patient care, and provide for involvement of direct care nurses in the development of staffing policies.

California was the first State, in 1999, to pass legislation to require fixed minimum staff-to-patient ratios in hospitals. Proposed ratios were issued earlier this year, with hearings planned. Legislation has now been passed and signed into law in a total of 7 States while legislators in 16 additional States have considered elements of safer staffing, primarily banning mandatory overtime.

The State-based impetus to ban or to limit mandatory overtime has given rise to Federal legislation, The Safe Nursing and Patient Care Act, now with 93 co-sponsors in the House and 12 in the Senate. Addressing the problem of mandatory overtime creates a significant improvement in the nurses' working conditions. A significant majority of nurses surveyed by SEIU in February and March of 2002 state that they would be more likely to stay in hospital nursing if mandatory overtime were eliminated.

Comprehensive safe staffing legislation should contain all the elements of the SEIU model-legislation, including:

- Minimum staffing requirements set by the legislation.

- Submission of annual staffing plans that includes a system for determining staffing levels based on acuity.

- Maintenance of daily staffing records.

- Prohibition of mandatory overtime.

- Maximum number of working hours for nurses.

- Protection for whistleblowers.

- Public disclosure of mandated and actual staffing levels.

- Unannounced inspections.

On the Federal level, legislation has been introduced designed to attract new people into the nursing profession by making it easier to access educational and training resources. Continued support for education is essential. Your continued support for education through The Nursing Reinvestment Act and entry-level nursing programs is essential.

Additionally, on the education front, I would encourage this Committee to explore support for the establishment of public-private partnerships that would provide educational programs that establish career ladders for nursing assistants to become licensed practical nurses and for licensed practical nurses to become registered nurses. These workers who are currently working in related fields, have a more realistic idea of the work. Providing these workers, as well as clerical workers, dietary and housekeeping workers with educational opportunities through progressive steps toward employment in professions that demonstrate the greatest need. There are tens of thousands of dedicated health care workers in our country's hospitals, nursing homes and in-home care, who leave health care employment because of intolerable working conditions, poor pay and benefits. They could be a valuable resource to address our future shortage needs. These programs should be worker friendly, crediting the student for prior learning and experience, perhaps through the use of online distance learning with a clinical component based in the workplace. This would enable them to complete

the course work in as expeditious a manner as possible and move them into the workplace where their services are so desperately needed. Obviously, these programs would have to be fully credentialed, and the providers must be reputable institutions of higher education.

While these efforts are to be applauded, this will not address the fundamental problems facing our profession and our patients. America's hospitals are in a state of emergency. And it is one that will only grow worse as the nursing shortage grows more severe. Forcing more mandatory overtime or simply relying on new nurse recruitment programs won't solve the problem either. Likewise, easing immigration rules to attract more foreign workers or expanding the number of visas allowed for nurses and nursing home workers will only push more caregivers through the revolving doors of our Nation's hospitals and nursing homes. All of these measures will only treat the symptoms, not cure the disease. Unless and until we address the understaffing and poor working and patient care conditions that plague nurses, we will never solve the shortage.

In order to address the crisis that exists in our hospitals and nursing homes, we must discuss what is being done to change these conditions and what can Congress do to stop the nursing profession from bleeding to death.

Fundamentally, the solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals and extended care facilities.

We also need staffing standards that will change the culture of care in nursing homes to one which ends the assembly line and instead truly values residents and their lives. And we need adequate reimbursement with built-in accountability to ensure that taxpayer dollars are spent on resident care instead of profits.

In hospitals, we must set enforceable minimum staffing standards linked to the acuity of patients, skill of the staff, and skill mix to ensure good quality care in hospitals, emergency rooms and outpatient facilities. But we must make sure that such minimums do not become the maximums.

We must make safe staffing a requirement for all hospitals receiving Federal money taxpayer dollars.

We must make sure the Federal Government provides adequate oversight of our hospitals, and that the industry's self-monitoring system under the Joint Commission of the Accreditation of Healthcare Organizations be reformed.

And we must protect the rights of patients and the rights of health care workers who blow the whistle on staffing problems that jeopardize the quality of care.

To be sure, it will take time to enact and implement staffing standards. The understaffing problem did not develop overnight, and neither will the solution. Again, I would request the immediate support of Congress for The Safe Nursing and Patient Care Act. While this certainly will not end the crisis, it will hopefully begin the healing process.

At the same time, we cannot lose sight of the fact that the system needs a fix. We must find ways to set meaningful standards for staffing in the health care industry. Understaffing in our Na-

tion's hospitals is a serious health problem. It is a problem that will only be solved through the joint efforts of public officials, nurses and hospital administrators. And it is a problem that must be solved if we are to guarantee quality care for patients—and keep skilled nurses in our hospitals and at the bedside.

I would like to thank you, Senator Reed, for your co-sponsoring of the Safe Nursing and Patient Care Act. My thanks to the entire Committee for allowing us to speak about these issues that are so close to my heart.

[The prepared statement of Wendy Laprade follows:]

PREPARED STATEMENT OF WENDY LAPRADE

Thank you, Senator Reed for inviting me to testify at this hearing on the current nursing crisis in this country.

My name is Wendy Laprade. I am a registered nurse. I am a staff nurse. I work at the bedside giving patient care. I have worked at Women and Infants Hospital for the last 18 years. I am a member of District 1199, New England Health Care Employees Union and a member of the Service Employees International Union Nurse Alliance. While I have contact with representatives of over 110,000 nurses through the SEIU Nurse Alliance, my comments today will be primarily from a more personal prospective.

Nineteen years ago when I started my nursing career, I knew that certain inconveniences came with the profession. Providing care for patients in the acute care setting requires working evenings, nights, weekends and holidays. I did not anticipate unsafe staffing levels, mandatory overtime, floating to other unfamiliar areas of the facility, ergonomic strains, safety and health issues. I never imagined my nursing time would be occupied with non-nursing duties—counting drugs and supplies, checking equipment, transporting, having to speak on the telephone constantly and being put on hold for long periods of time with doctors and other departments, typing, ordering, cleaning and justifying. We must fix the underlying problems, not just whitewash the nursing picture, for as fast as educators can help to produce new nurses, they will be leaving the bedside for more acceptable opportunities.

But there is a step we can take today, immediately, to stop the hemorrhaging—and that's to put a ban on mandatory overtime. Senate Bill 1686, Safe Nursing and Patient Care Act, introduced by Senators Kennedy and Kerry would do this. Limiting forced overtime will ease the impact of the shrinking supply of nurses by encouraging more nurses to stay in the profession. It will protect countless patients in the same way that limits on mandatory overtime for train engineers, air traffic controllers, truck drivers and other occupations where public safety is at risk.

With the rise of managed care in the 1980s, long before a nursing shortage began to emerge, hospital administrators moved to cut costs by cutting expenses, particularly by laying off and decreasing hours for huge numbers of registered nurses. Across the country, the industry reduced staffing levels to the point where nurses—increasingly unable to provide our patients with the care we were trained to give—began to leave hospitals for more rewarding and less physically and emotionally taxing jobs.

Nurses in hospitals and related facilities are caring for more patients today than we did a decade ago. Because of restrictions on hospital admissions and lengths of stay imposed by managed care, the patients in hospitals are more acutely ill and in need of greater care.

The result is that hospitals are having increasing difficulties filling vacancies for RNs. This is confirmed by our SERJ Nurse Alliance Survey, where:

Nurses reported that on average it took nearly 11 weeks (10.77) to fill a nursing vacancy in their unit, and 52 percent of the nurses believed that it takes longer to fill vacancies today than 3 years ago.

This doesn't just show nurses' job dissatisfaction; it signals a real problem for patients. When staff is less experienced and unstable, it is more likely that patient care will suffer.

The hospital industry cites many of these statistics to point to a nationwide "nursing shortage." But a closer look at the data suggests that the real problem is a shortage of nurses willing to work in hospitals under current working conditions. This opinion was also shared by the General Accounting Office in their recent report, "Nursing Workforce: Emerging Nurse Shortages Due To Multiple Factors." Many view the situation as a staffing crisis rather than a nursing shortage; sys-

temic understaffing brought on by the restructuring of the industry under managed care has led to dramatically deteriorating working conditions and increasing concern about the quality of patient care which is causing nurses to leave hospitals. This is confirmed in a survey of health care human resource managers conducted by the William M. Mercer Consulting Company, who found two important factors affecting turnover:

"Dissatisfaction with the job itself, working conditions, the relationship with the supervisor, or career opportunities;"

"Workload and staffing," noting that "a reduction in RN resources has increased the job demands of those remaining in the workforce."

In the report, the consulting company suggests that the employers concerned about turnover "should examine their own practices and work environment." It cannot be stressed enough that when our nursing profession is in crisis, our Nation's health care system is in crisis.

Inadequate staffing has given rise to increased numbers of medical errors. In 1999, the Institute of Medicine found that between 44,000 and 98,000 Americans die every year in hospitals due to medical errors; more people die of medical errors than from motor vehicle accidents, breast cancer, or AIDS. While the IOM report exposed a national crisis, it did not explore one of the primary causes of it: understaffing. However this issue was comprehensively assessed by a research team from the Harvard School of Public Health led by Professor Jack Needleman, which found that higher RN staffing was associated with a 3 to 12 percent reduction in the rates of patient outcomes sensitive to nursing—in particular urinary tract infections, pneumonia, length of stay, upper gastrointestinal bleeding, and shock.

A majority of nurses in our SEW Nurse Alliance survey identified understaffing as a cause of medical errors. The situation, they say, is not improving.

Fifty-four percent of nurses say that half or more of the errors they report are the direct result of inadequate staffing.

Despite the growing attention focused on medical errors, most nurses say the rate of incidents has remained unchanged over the last year—while fully 30 percent of nurses say the errors have actually increased.

We also should keep in mind that there are many more medical errors that go unreported for fear of retaliation. Most health care workers who blow the whistle on short staffing and poor patient care have no legal protections against retaliation. Federal whistleblower laws are narrow in coverage and do not apply specifically to the health care industry.

The staffing crisis and the deteriorating conditions it has created has compromised quality care for people in our communities. According to the Maryland Hospital Association, "over half the hospitals throughout Maryland report they have had to close beds, delay and cancel surgeries, disrupt scheduled procedures, and 're-route' ambulances to other facilities for emergency patient care." The MHA says that it is increasingly common for patients arriving in an emergency department "to be held there until adequate staffing becomes available on a patient unit." These situations are not unique to the State of Maryland.

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Nurses are often mandated to work back-to-back 8-hour shifts, or 4 extra hours on top of a 12-hour shift to fill gaps in staffing. Of course, this threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also places an incredible stress on family life, particularly when last-minute changes have to be made to find childcare or care for elderly parents.

According to our survey, nurses in acute care hospitals work an additional 340 hours of overtime on average every year. Nurses are not only being increasingly required to work excessive amounts of mandatory overtime, but also routinely are required to "float" or be reassigned to units where they lack the experience and training. Nurses are being stretched to the limit, experiencing high levels of stress, chronic fatigue, and work-related injuries. These intolerable work practices lead to further "burnout," undermine nurses' sense of professionalism, drive nurses from hospitals.

Nineteen years ago when I started my practice, most hospitals provided new employees with a fairly extensive initial training and continuing education program. In 1995, an average initial training lasted 3 months. In 2000, that was decreased to 30 days.

Nurses want to provide safe and effective care for our patients. We need appropriate nursing education to keep up with the ever-expanding technology.

Correcting these issues, I believe, will help restore a sense of value back in the nursing profession. Workers stay when they feel a sense of value and pride in their work.

According to the SEIU Nurse Alliance survey: Only 55 percent of acute care nurses plan to stay in hospitals until they retire. And only 43 percent of nurses under 35 plan to stay in hospitals until retirement. But 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

These statistics show a little-discussed fact about today's "shortage." In reality, the current supply of nurses far exceeds demand. The proportion of RNs employed in hospitals has decreased substantially and consistently from 68 percent in 1988 to 59 percent in 2000. Our current crisis is not a shortage of nurses—it is a shortage of nurses working at the bedside. Nationwide there are approximately 2.7 million Registered Nurses, however, 500,000 of those RNs are not working in nursing. According to The American Hospital Association statistics, nationwide there is a 12 percent vacancy rate in nursing. This translates to 126,000 nursing vacancies. It is easy to see that we have the nurses, but they are not working in nursing positions.

Deteriorating staffing and working conditions have led many nurses to leave the profession altogether and fewer young people are entering it: nursing school enrollment has declined in each of the last 6 years. According to Dr. Dennis O'Leary, President of Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in the May 2000 report *Framing the Issues: In pursuit of solutions to the National Nurses Workforce Dilemma*, there are 21,000 fewer nursing students in 2000 than in 1995. As a result, the average age of working RNs has increased 7.8 years since 1983 to 45.2 years. As these trends continue, there is likely to be a severe nursing shortage in the future. By 2020, we expect that will be a shortage of 400,000 nurses, when the majority of the baby boomers will be seeking care.

Many nurses wish to remain in hospital work, and would do so if staffing and working conditions improve. If these conditions are not improved, nurses' flight from hospital care will intensify and in the near future we will face a true shortage. The fact that younger nurses are even less likely to stay in acute care than their older colleagues is a warning sign.

The American Hospital Association reported in its report "Commission on Workforce for Hospitals and Health Systems," many hospital workers do not feel valued and discourage others from entering health care.

I have focused my remarks principally on hospitals, since that is where my practice is and where I believe the nursing crisis is most severe. There is, however, a related and equally serious problem in nursing homes. While RNs make up a small proportion of the nursing home workforce, and are largely in managerial positions, most of the staff in nursing homes are certified nurse assistants (CNAs) and, to a lesser extent, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs).

SEW members include more than 120,000 nursing home employees, the vast majority of whom are CNAs and a large number of whom are LPNs/LVNs. Similar to administrators in the hospital industry, nursing home owners have argued that they are facing a shortage of nurses and nurse aides. For this reason they have asked for increased Medicare and Medicaid reimbursement and have resisted the setting of minimum staffing standards.

But just like in hospitals, the real problem isn't finding people to work in nursing homes, it is keeping them there. Turnover rates for direct care workers in nursing homes are nearly 100 percent, creating a revolving door of caregivers that renders continuity of care impossible. Workers are leaving due to heavy workloads. They simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt and burnout.

Moreover, low wages, lack of health insurance coverage, pensions and high injury rates also make nursing home work unsustainable for many workers.

Nurses across America are sounding the alarm: staffing levels are too low to provide the quality of care their patients need. In many States, nurses who are in unions have turned to the bargaining table to change their working conditions in order to ensure safer staffing and better patient care. Eliminating mandatory overtime, establishing safe staffing standards and improving recruitment and retention by increasing pay have been the primary issues in nurse contract negotiations from coast to coast.

Many members of SEIU's Nurse Alliance have been able to negotiate limits—if not outright prohibitions—on mandatory overtime. At the Dimensions Health Care, in Maryland, the nurses through their union contract have ensured that their hospital's past practice of not requiring mandatory overtime is followed, a practice that is an incentive for many nurses to stay on at that hospital. Earlier this year, SEIU nurses at Aliquippa Community Hospital in Pennsylvania became the first in their

State to win an agreement in their contract eliminating mandatory overtime. Their hospital CEO, Fred Hyde, recently joined nurses in pressing for State law in Pennsylvania to protect patients and nurses from mandatory overtime, calling it "involuntary servitude."

SEIU nurses at Kaiser Permanente, the League of Voluntary Hospitals in New York, Swedish Medical Center in Washington State, and many other hospitals have negotiated contracts with breakthrough agreements that give bedside nurses a voice in getting safer staffing levels through labor-management committees. But, while we have made some progress, this issue is too big and too important to the health of our profession, our hospitals and our communities to address hospital-by-hospital and contract-by-contract.

Nurses working together with SEW, unions and the American Nurses Association have introduced legislation on the State level to establish safe staffing standards, ban mandatory overtime, provide whistleblower protection for nurses when they speak out on understaffing that jeopardizes good patient care, and provide for involvement of direct care nurses in the development of staffing policies.

California was the first State, in 1999, to pass legislation to require fixed minimum staff-to-patient ratios in hospitals. Proposed ratios were issued earlier this year, with hearings planned. Legislation has now been passed and signed into law in a total of 7 States while legislators in 16 additional States have considered elements of safer staffing, primarily banning mandatory overtime.

The State-based impetus to ban or to limit mandatory overtime has given rise to Federal legislation, The Safe Nursing and Patient Care Act (HR 3238/S 1686), now with 93 co-sponsors in the House and 12 in the Senate. Addressing the problem of mandatory overtime creates a significant improvement in the nurses' working conditions. A significant majority of nurses surveyed by SEIU in February and March of 2002 state that they would be more likely to stay in hospital nursing if mandatory overtime were eliminated.

Comprehensive safe staffing legislation should contain all the elements of the SEIU model-legislation, including:

Minimum staffing requirements set by the legislation; Submission of annual staffing plans that includes a system for determining staffing levels based on acuity (severity of illness or injury); Maintenance of daily staffing records; Prohibition on mandatory overtime; Maximum number of working hours for nurses; Protection for whistleblowers; Public disclosure of mandated and actual staffing levels; Unannounced inspections.

On the Federal level, legislation has been introduced designed to attract new people into the nursing profession by making it easier to access educational and training resources. Continued support for education is essential. Your continued support for education through the Nursing Reinvestment Act and entry-level nursing programs is essential.

Additionally, on the education front, I would encourage this Committee to explore support for the establishment of public-private partnerships that would provide educational programs that establish career ladders for nursing assistants to become licensed practical nurses and for licensed practical nurses to become registered nurses. These workers who are currently working in related fields, have a more realistic idea of the work. Providing these workers as well as, clerical workers, dietary and housekeeping workers with educational opportunities through progressive steps toward employment in professions that demonstrate the greatest need. There are tens of thousands of dedicated health care workers in our country's hospitals, nursing homes and in home care, who leave healthcare employment because of intolerable working conditions, poor pay and benefits. They could be a valuable resource to address our future shortage needs. These programs should be worker-friendly, crediting the student for prior learning and experience, perhaps through the use of online distance learning with a clinical component based in the workplace. This would enable them to complete the course work in as expeditious a manner as possible and move them into the workplace where their services are so desperately needed. Obviously, these programs would have to be fully credentialed, and the providers must be reputable institutions of higher education.

While these efforts are to be applauded, this will not address the fundamental problems facing our profession and our patients. America's hospitals are in a state of emergency. And it's one that will only grow worse as the nursing shortage grows more severe. Forcing more mandatory overtime or simply relying on new nurse recruitment programs won't solve the problem either. Likewise, easing immigration rules to attract more foreign workers or expanding the number of visas allowed for nurses and nursing home workers will only push more caregivers through the revolving doors of our Nation's hospitals and nursing homes. All of these measures will only treat the symptoms, not cure the disease. Unless and until we address the

understaffing and poor working and patient care conditions that plague nurses, we will never solve the shortage.

In order to address the crisis that exists in our hospitals and nursing homes, we must discuss what is being done to change these conditions and what can Congress do to stop the nursing profession from bleeding to death.

Fundamentally, the solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals and extended care facilities.

We also need staffing standards that will change the culture of care in nursing homes to one which ends the assembly line and instead truly values residents and their lives. And we need adequate reimbursement with built-in accountability to ensure that taxpayer dollars are spent on resident care instead of profits.

In hospitals, we must set enforceable minimum staffing standards linked to the acuity of patients, skill of the staff, and skill mix to ensure good quality care in hospitals, emergency rooms and outpatient facilities. But we must make sure that such minimums do not become the maximums.

We must make safe staffing a requirement for all hospitals receiving Federal taxpayer dollars.

We must make sure the Federal Government provides adequate oversight of our hospitals, and that the industry's self-monitoring system under the Joint Commission on the Accreditation of Healthcare Organizations be reformed.

And we must protect the rights of patients and the rights of health care workers who blow the whistle on staffing problems that jeopardize the quality of care.

To be sure, it will take time to enact and implement staffing standards. The understaffing problem didn't develop overnight, and neither will the solution. Again I would request the immediate support of Congress for the Safe Nursing and Patient Care Act. While this will certainly not end the crisis, it will, hopefully, begin the healing process.

At the same time, we cannot lose sight of the fact that the system needs a fix. We must find ways to set meaningful standards for staffing in the health care industry. Understaffing in our Nation's hospitals is a serious health problem. It's a problem that will only be solved through the joint efforts of public officials, nurses and hospital administrators. And it's a problem that must be solved if we are to guarantee quality care for patients—and keep skilled nurses in our hospitals and at the bedside.

I would like to thank you again, Senator Reed, and the Committee for allowing me to speak about these issues that are close to my heart. I look forward to working with you in the future.

Senator REED. Well, thank you very much.

My thanks to all the panel for their excellent testimony. Let me take my round and then turn to the Lieutenant Governor.

One of the things that is just persistent in all the comments this morning is the frustration of the workplace as a major source or cause which drives the nurses away, the radiologists away, acts as an inhibition for students to go into nursing.

Again, Wendy, you seem to be suggesting this is really the principal issue in terms of the frustration of the workplace. What more can we do, besides the measures you have pointed out, and I'm going to ask all the panel to just think about the Federal and State level, because without dealing with this issue, even increased remuneration, as Dr. Schepps suggested, is not going to really cure the problem.

Ms. LAPRADE. Boy, am I sorry you're asking me first.

Senator REED. Well, I will ask Dr. McKinney first his theory.

Mr. MCKINNEY. I think the distance between the practitioner and where important decisions are being made is the biggest factor, and those decisions, it seems to me, have to be the prerogative of those people who are actually providing the care, and that is not the case these days.

Senator REED. So that would suggest a new way to operate, not so much that there's technology, just decisionmaking as having smaller feedback.

Dr. McGarry.

Ms. MCGARRY. It also strikes me from some of the reports that I've seen, even in terms of all of the surveys, that certainly increasing salary is one aspect, but the more important is respect, is the recognition of the critical thinking and decisionmaking that goes on on a day-in/day-out basis, and also one the anecdotes that I had supplied for you in my testimony had to do with a person who left after about 18 years being in the health care community because she did not feel that there was any recognition for the increased responsibility of even tutoring or mentoring or being a preceptor for some of the newer or even more inexperienced staff. I think those are the other types of things that need to have that recognition, in addition to the Nurses' Week, that fully recognizes nurses, et cetera, but have something that is more pervasive, 365 days, all through the hours of the shift, et cetera.

Senator REED. As far as you responded and others, is this perception of the need to show appreciation for these medical professionals, is this increasing? Are we getting the message?

Dr. SCHEPPS. No, I really don't think that, particularly radiologic technologists who are basically, for the most part, a non-degree program graduate, they feel that they're kind of second class citizens in health care, and they really would like to have, not just respect 1 week a year, but all the year, and I think that what they do, what they do is quite different from what they did 30 years ago, and perhaps their education of 2 years is not long enough, and perhaps it should be a 4-year program, and we need to look to change those kinds of things, but who is going to support them. The people who go into this field generally cannot afford a 4-year college or cannot even afford a 2-year college, and this is a way for them—many of them are immigrants, they're minority, they are people that have no other way to become upwardly mobile and they need to have some infrastructure there for them to gain this respect, this daily respect, not just recognition once a year.

Senator REED. Jim, your perception on the mental health care.

Mr. McNULTY. Well, again, I agree with everything that my fellow panelists have said. A quick anecdote to sort of illustrate. I mean, we have very highly trained people in mental health that give front line care, not just psychiatrists or psychologists, social workers, mental health workers. I have a friend who is a nurse, a mental health clinician, and she told me that she had an interaction with a managed care organization. She had interviewed a patient who was very suicidal, who had attempted to jump up out of a car while she was being transported to this facility for an interview, and the managed care staffer said, "Well, gee, how fast was the car traveling?" And she said, "Gee, I don't know." Turned around and asked the patient's husband, and the husband said, "Well, about 25 miles an hour." "25 miles an hour? Oh, well you cannot get killed jumping out of a car going that speed." This illustrates exactly what it is. That is the respect issue. You have highly trained clinicians who know what the hell they're doing and they're not allowed to do their jobs at any level. It is your secondguess by people who have a pressure on them to keep costs down, and that is what I said in my testimony, I don't know how we are going to

address that balance, but we have to. If we don't do that, then the system is not going to get better.

Senator REED. Wendy, any further comments? If you want to supplement your testimony.

Ms. LAPRADE. Well, as Dr. McGarry said, the issue of respect is huge in nursing. The majority of my peers are all saying the same thing, whether they are nursing peers, radiology peers, med techs, they are all saying the same thing, it comes down to a system where our education within the hospitals has been decimated. With managed care coming in, costs had to be cut, and the education department, at least for nursing, was a huge hit. Initial training for nurses coming in has decreased. You're sending brand new grads in that don't have the bases. They're trying to be trained and they're being overwhelmed and then put right onto the floors, and they're leaving. Continuing education for the nurses that are currently there has decreased, which shows us less value, and that is a huge issue for us. The non-nursing issues, as I had spoken about before, is also something. When we are spending our time with different regulations that come out, a lot of times related to JCAHO, which says that I cannot dipstick a urine because I might be color blind, when I have been dip sticking urines for 19 years. You know, it is just some of the basic—pardon me—foolishness that goes on.

Senator REED. I am just glad that I have never heard those terms in the same sentence.

[Laughter.]

Mr. FOGARTY. Just maybe a question or comment to Jim McNulty.

Based on the work of the our task force last year, the thing that most concerned me about crisis in the children's mental health services in our State where, I mean, families have to be beyond crisis asks to get help. Do you see any change in the foreseeable future on that? Because I just don't know what parents do when their kids are in a situation, and if we cannot take care of their problems early on, but it is, obviously, much more costly to them as a whole, the whole health care system?

Mr. McNULTY. Yes. Representative Kennedy has, in fact, introduced a bill in the House, H.R. 5078. One of the things I asked Senator Reed to do was to consider passing a similar bill in the Senate, of the Childhood Mental Health Services Management Act, and it has many of the elements in it that help, and I think it is a good start. It is a good place to start. To illustrate the problem, we have 8,000 child and adolescent psychologists in the United States. The need right now is for 30,000, and it is going to get worse, and the same thing prevails at the geriatric end of the scale, as one of the earlier panelists mentioned. Government is so frightening that I can almost barely bring myself to think about it, because we are so short of resources. Our two psychiatric hospitals in the State have done a great job. We cannot get paid. Psychologists don't get paid enough anyway, psychiatrists don't get paid enough anyway, but what happens is the children in particular have collateral times. Collateral times means time you spend working on a patient, but you cannot bill for that. With children and adolescents, that ends up being sometimes two or three times the hour that you might spend face to face with the child or adolescent.

So you are essentially working for half or one-third of your pay. No one can do that for very long. You cannot ask the mental health professional to think about poverty in addition to all the other things that they have to put up with.

Senator REED. Let me ask one final question. That is, we focused in on practitioners. Turning to the students, are you saying, and it might refresh your testimony, both Mr. McKinney and Dr. McGarry, by your physical facilities or your staff in terms of training all the young people who come to the University of Rhode Island or the Community College of Rhode Island who say, I want to be a health care professional, is that a real concern to you? We are talking now about a problem of years of shortage and facing the daunting challenge, that all the panelists expressed so well, the many different factors that are contributing to it, but if we have a show point at the very beginning of the system where young people walk up and say, I would like to be a nurse, I would like to be a physical therapist, I would like to be a mental health professional and our schools say, that is nice, but come back in years from now when the waiting list has gone down.

Mr. MCKINNEY. Yes. It is a serious difficulty. Until very recently in our physical therapy master's program, we had 24 seats and in excess of 500 applications. Now that has dwindled a bit, but it is starting to build again. The competition in the speech pathology and audiology is as about as high as it is for any graduate program at the university.

Senator REED. Dr. McGarry.

Ms. MCGARRY. Actually, we have had significant increases in particularly our nursing application pool, and we think that this is being in response to the media, as have been going on both nationally as well as locally. Seventeen-hundred applications for 250 spots. We have enriched the flexibility opportunities. We have day programs, we have evening and weekend programs. However, the most striking problem that has just occurred is the closing of all of our satellites. One of our satellites houses four programs. Four health programs, I might add. These folks are all going to be displaced into the some, or one or three of the main campuses, depending upon where these can be housed. These all have critical accreditation requirements, one of which is being written as we are sitting before us today, and those things have to be addressed, because there are some vital issues that will not be answered and we are not going to continue to respond to the needs, the health care force needs. So, those are the kinds of things that we are struggling with. We know those decisions, in terms of the satellites, did not come easy. There seems to be no other way, short of reducing our intake of students, and that was not a viable or pallial decision. So, it is coupled by many things, but that to me is the most striking concern that is before us.

Senator REED. Thank you very much. I want to thank all of the witnesses this morning. It was an excellent series of panels. We face an extraordinarily daunting challenge. There are shortages today that they can grow to be critical in the not-too-distant future, that will be parallel with quality and the affordability of the health care system, and so we have to act today.

One of the comforting aspects, though, that has been demonstrated this morning, we have so many very talented, very skilled professionals here in Rhode Island who are committed to working with the problem. That is the problem before us, and we have to act now so we don't end up one day wondering what happened to our health care system.

Let me thank all the witnesses. Let me thank the Lieutenant Governor particularly. He has to respond this morning to his outstanding leadership on all these issues in the State of Rhode Island, and my colleagues, Senator Chafee and Congressman Langevin. The hearing is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR REED

Good morning. Thank you all for taking time out of your schedules to be here today to attend this official field hearing of the Senate Health, Education, Labor and Pensions Committee. I would like to thank Dr. Tom Sepe for his warm welcome and our Lieutenant Governor for his opening remarks and for his strong leadership on the health workforce shortage issue here in Rhode Island. I would also like to take a moment to give a special thank you to all of our witnesses here today. I appreciate your willingness to come here on relatively short notice and share your thoughts and perspectives on this critical issue.

The Health Care Workforce in Rhode Island

Over the past decade, health care has become an increasing portion of our overall Gross Domestic Product (GDP), as well as a growing percentage of our Nation's expenditures. It is estimated that the United States spends more on health care than any other Nation in the world and we as Americans expect to have access to the best and latest treatments and we expect high quality of care.

Health professionals make up roughly 10.5 percent of the Nation's total workforce. In Rhode Island, that figure is 11.8 percent—or 53,000 people—who are employed in the health sector. Amazingly, our small State ranks third in the Nation in per capita health services employment. Health services employment in Rhode Island grew 30 percent between 1988 and 1998, compared to 23 percent nationally. These figures are only expected to continue to grow robustly, as the population of our State continues to age and health care utilization continues to move upward.

Our Educational System Struggles to Keep Up with the Need

Meanwhile, the demand for health professionals exceeds the number of new workers graduating from training programs each year. Budget constraints, outdated teaching facilities and aging faculty strain the ability of community colleges and State universities around the Nation to produce the volume of proficient pharmacists, dental and mental health providers, nurses of all levels (CNA, LPNs, RNs, Advanced Practice Nurses), therapists and technicians to meet the growing needs of our health care system.

In the U.S. Senate, I have supported legislative initiatives that I hope will begin to address these various shortages, particularly in the areas of nursing and pharmacy. We have all heard about the imminent shortage of nurses, not only in Rhode Island, but around the Nation. Many hospital administrators warn that the national nursing shortage will only grow worse in the coming years because of an aging population. Nationwide, hospitals have a shortfall of 126,000 nurses. The *Journal of the American Medical Association* says that could grow to 400,000 in the next decade.

While the nursing shortage problem is certainly acute in hospitals in Rhode Island, home health agencies and skilled nursing facilities are also feeling the painful pinch of these shortages. Interestingly, 21.8 percent of Rhode Island's health services workers were employed in nursing care facilities, while the State ranks ninth in the country in terms of employment in home health care.

I have co-sponsored legislation intended to enhance our ability to recruit and retain a new generation of nurses as well as legislation designed to improve the work environment for nurses currently on the job.

I have also been interested in the emerging shortage of pharmacists in this country. There were 6,500 openings for pharmacists at the 20,500 chain drugstores, and independents and hospital pharmacies are also recruiting. The number of pharmacists is expected to only grow by 28,500 over the next 10 years—800 less than the 29,300 over the last decade. It is also reported that the number of applicants to pharmacy schools in 1999 was 33 percent lower than in 1994—the high point of enrollment during the 1990s. In an effort to address this problem, I have introduced bipartisan legislation to increase financial assistance to students, faculty and schools of pharmacy in order to encourage more students to pursue careers in pharmacy and provide pharmacists to underserved areas of the country.

S. 1806, the Pharmacy Education Aid Act, will create scholarships for pharmacy students and provide loan repayment for those students who commit to teaching pharmacy for at least 2 years or those who practice pharmacy where there is a dire need—such as remote areas of the country.

The Impact of Workforce Shortages on Care

Clearly, these are significant issues that have a direct impact on the ability of Rhode Islanders and all Americans to access health care services. Health professions shortages also have the effect of reducing quality of care and patient outcomes.

Specifically, a recent *New England Journal of Medicine* study found that patient outcomes were directly correlated with nurse staffing ratios. The report, which examined the discharge records of six million patients at 799 hospitals in 11 States, found that in hospitals with higher numbers of registered nurses, patient stays were 3 percent to 5 percent shorter and complications were 2 percent to 9 percent lower than hospitals with fewer nurses.

The purpose of today's hearing is to explore the nature of these workforce shortages across the health care spectrum in Rhode Island, examine what steps are currently being taken at the State and Federal levels to address these issues, and ultimately, gain a better understanding of the long-term solutions that will be necessary to tackling this looming crisis.

Thank you all for being here and I look forward to the testimony of the distinguished panelists who have graciously agreed to take time out of their busy schedules to be here with us today.

WASHINGTON POST HIGHLIGHTS CRITICAL SHORTAGE OF PHARMACISTS

Reed Legislation Would Provide Financial Assistance to Encourage Students to Become Pharmacists

A June 21, 2002 *Washington Post* story highlighted the critical shortage of qualified pharmacists currently facing the health care system.

U.S. Senator Jack Reed has introduced legislation to increase financial assistance to students, faculty and schools of pharmacy in order to encourage more students to pursue careers in pharmacy and provide pharmacists to under served areas of the country.

In the *Washington Post* story, David A. Knapp, dean of the University of Maryland's pharmacy school describes the shortage as "[t]he ticking time bomb."

According to the story, he warns of "stressed out" pharmacy staffers—many working 12-hour shifts—miscounting pills and "grabbing the wrong bottle off the shelf." He added: "With the elderly population increasing, the extent of those problems is going to increase as well."

According to the Health Resources and Services Administration (HRSA), the number of pharmacists is expected to only grow by 28,500 over the next 10 years—800 less than the 29,300 over the last decade. HRSA also reported that the number of applicants to pharmacy schools in 1999 was 33 percent lower than 1994—the high point of enrollment during the 1990s.

The *Washington Post* story stated, "The 56,000 retail and mail-order pharmacies in the United States filled 3 billion prescriptions last year, up from 1.9 billion in 1992. The number will soar to 4 billion by 2005, according to industry estimates. At last count, there were 6,500 openings for pharmacists at the 20,500 chain drug-stores, and independents and hospital pharmacies are also recruiting."

Reed's legislation, S. 1806, the Pharmacy Education Aid Act, will create scholarships for pharmacy students and provide loan repayment for those students who commit to teaching pharmacy for at least 2 years or those who practice pharmacy where there is a dire need—such as remote areas of the country.

The bill modifies a law that created the highly successful National Health Service Corps (NHSC), a Federal program that has helped fund the education of 20,000 primary care professionals, in exchange for their commitment to serve in traditionally under served rural and urban areas.

The Reed bill will allow students entering pharmacy school and students who have graduated with a pharmacy degree to apply for NHSC Scholarship and Loan Repayment funds. In return, the students would commit to practicing in an area of the country in need of pharmacists for a least 2 years. It would also allow students or practicing pharmacists who teach full-time for 2 years at a school of pharmacy to apply for loan repayment assistance. This loan repayment assistance will be funded by both the school of pharmacy and the Federal Government. In addition, the bill provides schools of pharmacy access to grants to help defray the cost of classroom and facilities construction and expansion.

Last year, an amendment authored by Reed created a 4-year pilot program to make pharmacy students eligible for loan repayments in exchange for a 2-year commitment to serve in areas of the country where significant shortages of medical professionals persist, was included in the Safety Net Amendment Act of 2001.

Congressmen Jim McGovern (D-MA) and Mike Simpson (R-ID) have sponsored similar legislation in the House of Representatives.

[The Washington Post]

BUSINESS

FRIDAY, JUNE 21, 2002



Pharmacy student Bell Dwin watches Barbara Kirby measure medicinal powder for a customer of the Safeway in Georgetown.

Prescription for Trouble

Shortage of Pharmacists
Raises Risk of Errors,
Poor Customer Service

By BILL BRUBAKER
Washington Post Staff Writer

While many new college graduates are facing a tough job market, Mariel Sinkov, fresh out of the University of Maryland pharmacy school, has had a mailbox full of opportunities.

Long before she picked up her diploma last month, Sinkov said, she was offered \$75,000 or more to work for CVS, Safeway, Walgreens, Kmart, Rite Aid and Giant Food.

Hospital recruiters were also on her trail. And CVS offered a \$15,000 signing bonus if she would work for the chain in Washington.

"I feel blessed," said Sinkov, 25, who joined Rite Aid for a salary she declined to disclose, citing a confidentiality agreement the company required her to sign.

Cities and towns across the United



Nakita Cropper, a recent Howard University pharmacy graduate, will study further in Atlanta. She said she dislikes the financial focus of many retail pharmacies.

States face a pharmacist shortage—severe in some locations, such as the Washington area—as baby boomers take more medications and retail chains open more drugstores.

While this is good news for new pharmacy school grads—offers of leased BMWs and \$100,000-plus salaries have

been reported in some hard-to-staff regions—it has meant poorer customer service and an increased risk of errors by overworked pharmacists, some experts warn.

The 56,000 retail and mail-order

See PHARMACIST, E4, Col. 1

Shortage Adds To Competition For Students

PHARMACIST, From E1

pharmacies in the United States filled 3 billion prescriptions last year, up from 1.9 billion in 1992. The number will soar to 4 billion by 2005, according to industry estimates. At last count, there were 8,500 openings for pharmacists at the 20,500 chain drugstores, and independents and hospital pharmacies are also recruiting.

The ticking time bomb is how the shortage is described by the dean of the University of Maryland's pharmacy school, David A. Knapp. He warns of "stressed out" pharmacy staffers—many working 12-hour shifts—miscounting pills and "grabbing the wrong bottle off the shelf."

He added: "With the elderly population increasing... the extent of those problems is going to increase as well."

A spring 2001 survey of 500 pharmacists found that nine out of 10 were aware of a "medication error" in their own pharmacies in the previous 12 months. The most common error was dispensing the wrong dosage or the wrong drug.

Pharmacists attributed the errors most often to "work overload" and "inadequate staffing," according to the survey by two industry publications: *Drug Topics* and *Hospital Pharmacist Report*.

The National Association of Chain Drug Stores (NACDS) recently asked its members to rate the severity of the pharmacist shortage in the 50 states and the District from one to five, with five being the most severe.

The District had the 45th-highest grade, indicating the shortage is worse only in Arkansas (which ranked last), California, Maine, Minnesota, Wisconsin and Massachusetts. Virginia ranked 39th and Maryland 36th.

Safeway's eastern regional pharmacy director, Murd Flowers, said the shortage has had a "detrimental effect" on customer service at some of the chain's 104 pharmacies in the Washington-Baltimore area.

In some instances it's simply because of the increased volume," he said. "In other instances it's because of a diminished quality of pharmacists."

When you need a pharmacist—or any employee—you take the best of whatever is available. That doesn't mean they are the highest quality. Sometimes, for example, a store will hire someone who has problems communicating with customers, he said.

CVS disclosed in its 2001 annual report, published in April, that it was forced to cut pharmacy hours last year at stores in the District and other cities. "In D.C., there were situations where pharmacies would close early—unexpectedly—because someone had called in sick and there wasn't a replacement," said Todd Andrews, a CVS spokesman.

Andrews said CVS hired 2,000 pharmacists last year and has about 100 openings at its more than 4,000 stores. *Rite Aid* did not say how many pharmacists it needs. "It's an industry-wide shortage," *Rite Aid* recruiter Michele Belsey said.

Safeway executives said they have five openings at the chain's 10 stores in the District alone. One position—at Hochinger Mall in Northeast—



Barbara Kirby checks a prescription while Joanie Wright sorts orders at the Safeway pharmacy in Georgetown. "Ten years ago, I was busy but at least I had more time to... talk to patients," Kirby says.

has been vacant since last summer. Jerry Rhodes, a Safeway recruiter, said many pharmacists do not want to work in inner-city neighborhoods.

Concerns about traffic and security, especially since Sept. 11, have made it harder to attract pharmacists to the District, some executives say.

"When we interview new pharmacists they say, 'Gee, why do I want to go down there, fighting the traffic and the hassle and security and all that stuff when I can stay closer to my home and get a job making the same amount of money?'" Flowers said.

The shortage was created, in part, by tougher academic standards that are being phased in at the 83 U.S. pharmacy schools, some chain executives say. Students generally must complete at least two years of undergraduate work before they can enter pharmacy school. In the early 1990s, many pharmacy schools began lengthening their programs from three years to four so that students would graduate with doctor of pharmacy degrees.

Several store chains have begun offering financial assistance to encourage students to attend pharmacy school. Recent Howard University pharmacy school graduate Kathleen Hershey, from a Baltimore family of 12 children, said she accepted \$16,000 in aid from Gant Food with no strings attached.

CVS requires its "scholarship of excellence" recipients to work a full year as a CVS pharmacist for every \$5,000 in aid they accept.

Some retail pharmacists complain they cannot use the skills they acquired in school. Rather than counseling patients on drug side effects or how medications interact with each other, they are increasingly sorting out customer complaints—about HMOs, for example.

"The worst thing is a patient—especially a senior citizen—who's just found out that they have cancer," said Barbara Kirby, the longtime pharmacy manager of the Safeway in upper Georgetown. "They come in to you with a lot of prescriptions. They want to talk to someone. They want to talk about the medicine and how they feel. Sometimes they cry."

But with other customers waiting, Kirby often must counsel these patients over the phone. "Ten years ago, I was busy but at least I had more time to sit down and talk to patients," she said. "Now

it's really difficult."

While salaries have grown in recent years, so has on-the-job stress, pharmacists and industry executives agree.

"I've worked in pharmacies where you didn't have time for a restroom break, let alone a lunch break," said Douglas Hoy, a vice president of the National Community Pharmacists Association, a trade group.

"I've lost probably 15 pounds working here," said Bill Ranker, 24, pharmacy manager of the Safeway in Chester, Md.

Ranker joined Safeway as an \$81,000-a-year "floater" pharmacist last summer, straight out of the University of Maryland's pharmacy school. Within months, he was promoted to pharmacy manager—a job that pays about \$95,000, he said.

While starting salaries are high, they don't grow much. "Unfortunately... a new hire is going to make the same salary... no matter whether they've worked 30 years or are a new grad," Safeway's Rhodes said. "That's just the way pharmacy traditionally has been."

Retail pharmacies generally pay more than hospitals, which also are facing a shortage. Six out of 10 new graduates elect to work in retail settings, according to NACDS data.

"One problem I have with retail is, quite often they are looking at the bottom line," said recent Howard graduate Nakita Cropper, who is entering an advanced studies program at an Atlanta hospital. "I can't say they're not patient-focused. But the financial aspect is the most important to them."

Inova Health Systems, which operates five hospitals in northern Virginia, pays new pharmacists \$65,000 to \$70,000 a year, spokeswoman Kathleen Thomas said. Senior pharmacists earn \$80,000 and up.

"I prefer a hospital setting where I can interact more with patients," said Michelle Le, a pharmacist at Inova Alexandria Hospital. "It's more satisfying."

To most new graduates, though, retail is the way to go.

"It's just kind of handy being there for grabbing hot food and for your shopping," said Cheryl Walker, a recent Maryland graduate who plans to work for a supermarket chain. "I don't like hospitals because the atmosphere is maybe just too heavy."

THE PHARMACIST EDUCATION AID ACT OF 2001

I. Overview

Pharmacists are the third largest health professional group in the U.S. and play a key role in the healthcare delivery system. Today's pharmacist receives an education that broadens the traditional dispensing activities to focus on improved compliance and health status of individuals. However, a December 2000 report released by the Secretary of Health and Human Services (HHS) concluded that "there has been an unprecedented demand for pharmacists and for pharmaceutical care services, which has not been met by the currently available supply." Specifically, "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists" documented the critical role that pharmacists play in our health delivery system and concluded that there is a shortage of these critical health providers that will continue to grow increasingly worse unless significant changes are made.

Factors influencing the demand for pharmacists include the growth in the elderly population, increased use of complex prescription medications and improved insurance coverage of prescription drugs. The growing pharmacist shortage has been well documented:

- The HHS study found that the number of unfilled full-time and part-time pharmacist positions increased from 2,700 to 7,000 between 1998 and 2000;
- A survey by the National Association of Chain Drug stores found that the number of vacancies among member companies had increased by 1,000 positions in the last 6 months;
- A November 2001 GAO report found that, on average, hospitals report 21 percent of their pharmacist positions are currently unfilled. Vacancy rates are even higher in Federal systems, such as the Department of Veterans Affairs, the Department of Defense and the Indian Health Service.

1. Legislation Summary

The Pharmacist Education Aid Act, or PharmEd, addresses the current shortage of pharmacists in the U.S. by increasing the chance an individual will pursue an education as a pharmacist and the schools will have the capacity to provide them with a high quality education.

Aid to Students

PharmEd allows students entering pharmacy school and students who have graduated with a PharmD degree to apply for National Health Service Corps (NHSC) Scholarship and Loan Repayment funds. It also provides new funds for students who demonstrate financial need to apply for scholarships to qualifying schools of pharmacy.

To attract more pharmacists to become faculty, students or practicing pharmacists who contract to teach full time at qualifying schools of pharmacy for at least 2 years will also be eligible for educational loan repayment.

Aid to Schools

The practice environment for which schools of pharmacy must prepare their students is changing rapidly. Schools of pharmacy need to install and upgrade their information technology systems so that their students get the best possible training for a career practicing in today's pharmacies. Information technology improvements also allow schools to increase their educational capacity through the creation or expansion of distance learning programs. PharmEd authorizes competitive grants for information technology systems improvements to qualifying schools.

Many schools of pharmacy currently educate the pharmacist of tomorrow in the buildings of yesterday. Many schools lack building capacity and need help to renovate, and in some cases expand, their buildings and teaching facilities. PharmEd provides competitive grants for construction to qualifying schools of pharmacy in particular need.

An important feature of PharmEd is its commitment to improving the health status of populations served by many Federal supported health programs, including those programs and institutions that are currently operating with high vacancy rates for pharmacists. Schools of pharmacy are considered "qualifying" if they require their students to perform at least one of their clinical rotations in one of the types of facilities having the hardest time recruiting pharmacists into permanent positions. These facilities include, but are not limited to, disproportionate share hospitals, facilities in rural and inner city areas with medically underserved client populations, facilities run by the Armed Forces of the United States, the Veteran's Administration, the Bureau of Prisons and the Indian Health Service.

Groups that endorse the bill include the American Association of Colleges of Pharmacy, American Pharmaceutical Association (APHA), National Association of Chain

Drug Stores, National Community Pharmacists Association, American College of Clinical Pharmacy and American Society of Health-System Pharmacists.

III. Other Resources

- (1) HHS study—<http://www.bhpr.hrsa.gov/healthworkforce/pharmacist.html>
- (2) GAO report—<http://www.gao.gov/> (GAO-02-137R—November 13, 2001)

PREPARED STATEMENT OF BARBARA A. RAYNER

It is with pleasure that I convey to you some thoughts and observations relative to the health care workforce shortage issues being examined in this Senate Field Hearing.

The State Department of Elderly Affairs is responsible for the management of a host of direct service programs which benefit frail, at-risk elders in their quest to remain living independently and in their home environment.

These include: the Homemaker/Home Health Aide Program; Adult Day Services Programs; Respite Services; Alzheimer Support Programs; Caregiver Support Programs; Protective Services including abuse, neglect and self-neglect; and, Case Management Services.

While these services, in combination with our community-based system of care are available and accessible through Senior Centers, the reality is that because of the workforce shortages, economic constraints of retirement incomes and their inability to navigate and access services, care plans are not adequately activated by elders and their families.

I believe these points have been adequately addressed at the hearing, and provide this brief statement only as a reinforcement of testimony.

I believe Rhode Island, and the country as a whole, needs to approach the provision of health care and the related staffing, goods, and services as an economic development opportunity, rather than the current prevailing view of a financial burden to taxpayers. This philosophical difference has long been evidenced in the efforts of such countries as Japan. Because of the elevated status of the aged of Japan, and the corresponding cultural attitudes, Japan has been working since the early 1980s in developing products, which preserve dignity, yet compensate for physiological losses. I clearly recall learning of these projects through my work with the National Council on Aging's International Affairs Committee, and my exposure to actual products being developed and shared with other scientists interested in this work. The simplest example I recall was a beautiful tapestry bib, which could be worn by a frail elder experiencing drooling, and inability to control food in their mouths. A more elaborate example was wheelchairs, which could fold down into an economy size car. In summary, elders and family caregivers need to be thought of as consumers of services and purchasers of goods and equipment, which promotes the independence of elders and their families.

We have come to depend on volunteerism as a resource to support the care of frail elders: I feel we need to be cautious in recognizing the limitations and appropriate placement of this workforce.

The population we are focusing on in this discussion is typically very compromised and complex: therefore, the role of the volunteer as a friendly visitor is certainly appropriate with the understanding that this function is the limit. Volunteerism, while critically important to the services we provide, should be designed to support, not supplant, the provision of direct care.

Cash and counseling programs have a long and successful history in a number of European countries as well as the United States. These programs epitomize the strength of families in managing the care of their frail loved one and, further, they can provide financial support to primary caregivers who must also be earning a living. This approach to providing services has been demonstrated within the disability community here in Rhode Island with great success.

Demonstrated outcomes not only illustrate expanded and individualized services, but also experience one of the lowest incidences of fraud and abuse. Overarching the outcomes of this approach is the reality that the family caregivers have been, and remain, the most preferred level of advocate by the elders themselves.

Closely connected to issues related to successful independent aging-in-place is the matter of medication management for and by the frail elder. DEA instituted a pharmacy counseling program that matches high-risk elders with pharmacy counseling provided at a local pharmacy. Through our RIPAE program this intervention identifies diabetics and high-end consumers of medications who are offered this service. This approach represents optimal utilization of our pharmacists, offers targeted edu-

cation, reduces unnecessary emergency room visits, and, most importantly, supports the elder and the family through direct training and family support.

While this does not directly address the shortage of pharmacists in our country, programs of this sort ensure optimal and appropriate utilization of this limited resource.

A declining economy and increased unemployment rate typically generates more citizens interested in training, education, certification and licensing in the health care field. On the other hand, a strengthening and strong economy moves these same workers out of the health care field. I fully support any and all measures, which can be taken to strengthen this workforce through incentives, higher wages, and overall image enhancing of these valuable and honorable professions, which provide the link to independence for our elders. I encourage expansion of workforce training of older persons age 55 and older to enter this field and any other innovative approaches, which encourage retention, recruitment, expansion, and legitimization of this para-professional workforce. Further, we must review our training or re-training requirements to customize and better meet the interest and needs of older workers.

PREPARED STATEMENT OF PATRICIA RYAN RECUPERO, JD, M.D.

I applaud Senator Jack Reed for directing the public's attention to the important issue of the growing shortage of trained health care professionals. Certainly, the shortage in pharmacists, nurses and others that he highlighted is one that deserves quick and decisive action to correct.

I would like to take this opportunity to call attention to another shortage that is already having a severe and devastating impact on families and communities throughout Rhode Island and around the country. The mental health field at all levels—patients, providers, educators, and researchers—suffers from a major lack of financial support from the insurance industry, Federal and State governments, and businesses that continue to ignore the needs of the mentally ill because of stigma or a lack of information.

I do not wish to blame or condemn any group or individuals for this situation. In fact, there are signs that we may see “a light at the end of the tunnel.” Senator Reed and a number of his colleagues in Washington, including Rep. Patrick Kennedy, D-RI, as well as Lt. Governor Fogarty in Rhode Island, and President Bush have been instrumental in spotlighting the need for parity of benefits covered by insurance companies. Great progress has been made on this front. Organizations such as the National Alliance for the Mentally Ill and the Mental Health Association are beginning to bear fruit.

Equally important, and so badly needed, is parity in reimbursement. I know the Senator is familiar with recent national and international studies documenting the effects mental disorders have on individuals, families, businesses and communities around the world. Suffice to say that study after study points to the undeniable fact that serious, chronic diseases of the brain are no less debilitating—no less fatal—than diseases of the kidney, heart and other organs. A report in the July issue of the *American Journal of Preventive Medicine* indicated that people with depression are 1.5 to 4 times more at risk of heart disease. There can be no doubt of the existence of a “mind/body connection” that can be studied and measured.

Those of us in the field are hopeful that this trend of recognizing mental illness as a treatable disorder of the brain will begin to bring relief for patients and health care professionals who for many years have faced difficult and unfair restrictions. However, it needs to be stated that the process of making improvements has been all too slow.

There are a number of factors contributing to the problem of access to appropriate and timely psychiatric care, but there is one crucial and overriding cause—reimbursement for behavioral medicine (mental health and substance abuse) has been consistently set at a lower level than reimbursement for other types of medical care. For Butler Hospital, and others like us, that means we cannot maintain any reserve capacity and our beds are almost always full. The situation is even worse on the outpatient side, where more providers are opting-out of insurance panels, resulting in drastically reduced access to care. This was dramatically brought to the public's attention last year in Rhode Island, when the State's Eleanor Slater Hospital was overwhelmed on several occasions with emergency weekend admissions because of a lack of available services at local community mental health centers.

Nowhere do we see more graphic evidence of these problems than in child psychiatry. The pool of child psychiatrists in Rhode Island has been seriously depleted over the past 10 years. The primary reason for this is, once again, a reimbursement

structure not based in reality. The result is that facilities like Butler Hospital, which trains many of the residents in Brown Medical School, cannot retain these professionals upon graduation.

Another problem area exists in psychiatric nursing. In simple terms, mental health care providers are discriminated against. We must pay our nurses less than at general hospitals because we are reimbursed less. Forced to operate on this "uneven playing field," our ability to find and retain psychiatric nurses has been eroded over the past decade.

These are but two critical areas in need of immediate attention. This mental health crisis exists against a backdrop of a growing body of scientific evidence pointing to the direct impact that a person's mental health can have on other major organs in the body. Studies in this country and around the world confirm that the brain, the most complex organ in the body, can cause incalculable human tragedy and cost business and society billions in lost productivity and accidents. For example, a 1999 study of an employer with over 20,000 employees found that when mental health spending was cut, general health costs and sick days went up.¹

In closing, I again want to commend Senator Reed for his efforts on behalf of the people and families struggling with mental disorders or substance abuse. Also, let the record show that Butler Hospital endorses and supports the five points that were presented by Mr. James McNulty, president of the National Alliance for the Mentally Ill (NAMI). In particular, we support his request to Senator Reed to sponsor a companion bill in the Senate similar to the one introduced by Rep. Patrick Kennedy, D-RI, H.R. 5078. I am optimistic that working with Senator Reed, NAMI, and others, we can look forward to a new era when mental illness will no longer be looked on as just a minor problem that only affects a small percent of the population.

PREPARED STATEMENT OF JANE WILLIAMS

Thank you for conducting the Senate Health, Education, Labor, and Pensions Committee field hearing, "Who will care for us?" on health workforce shortages earlier this month. At the hearing you invited written testimony and I respectfully submit the following comments.

As Chair of the Department of Nursing at Rhode Island College, I have over 300 enrolled nursing majors with 100 students graduating each year, making us the largest baccalaureate program in Rhode Island. I represent a perspective that was not specifically presented at the hearing.

In answer to your question, "What can the Federal Government do?" increased Federal support is needed. Specific strategies I would suggest include:

- Increase financial support for baccalaureate nursing students. Provide scholarships and stipends for basic students and for registered nurses with associate degrees and hospital diplomas who want to earn bachelor's degrees. There is a need to increase the number of bachelor's degree nurses educated each year. With patient care growing more complex, ensuring a sufficient RN workforce is truly an issue of preparing an adequate number of nurses with the right educational mix to meet health care demands. The National Advisory Council on Nurse Education and Practice (NACNEP), an advisory body to Congress and the U.S. Secretary for Health and Human Services on policy issues related to nursing, has urged that at least two-thirds of the nurse workforce hold baccalaureate or higher degrees in nursing by 2010. Currently, only 40 percent of nurses hold degrees at the baccalaureate level and above. Baccalaureate education provides a base from which nurses move into graduate education to fulfill the expanding needs for nurses in advanced practice and management of complex health care systems. Nurse executives, Federal agencies, the military, national nursing organizations, health care foundations, magnet hospitals, and minority nurse advocacy groups concur with NACNEP and recognize the need for more baccalaureate and graduate-prepared nurses in the workforce.

- Increase funding for graduate nurse education. There is a shortage, not only of registered nurses, but also of future teachers and researchers. In fact, thousands of qualified students are turned away from nursing schools each year due to an insufficient number of faculty members available to teach in nursing programs. With a wave of faculty retirements projected over the next 5 years, funding should be allocated for fast-track faculty development programs and scholarships to encourage full-time doctoral students to pursue teaching careers.

¹ Rosenbeck, Robert A., et. al. (1999). Effect Of Declining Mental Health Service Use On Employees Of A Large Corporation. *Health Affairs*; 1999 Sept.-Oct.; 18(5): 192-203.

- Fully fund the Nurse Reinvestment Act that was passed by unanimous consent by the Senate on July 22. These programs will provide scholarships for nursing students, incentives for nursing faculty, grants for career ladder partnerships, and best practices grants.

- Provide incentives to colleges and universities that house nursing education programs. For example,

- (1) Provide support for educational initiatives, such as creative programs designed to meet the diverse academic needs of students entering nursing. In our nursing program, 30 percent of the students accepted into the nursing program last year reported having English as a second language, 91 percent are employed (20 percent full time), and many have significant family responsibilities. In Rhode Island, reduced State funding is likely to decrease student services at a time of increased need.

- (2) Fund faculty development. Restricted budgets will impair our ability to support faculty development activities and attract new faculty.

- (3) Contribute to improvements of physical facilities. The learning environment of the Department of Nursing at Rhode Island College needs improvement. A critical need, is for computers in the Nursing Resource Laboratory. Classrooms need to be renovated and outfitted with current teaching technology.

The expert panelists attested that the health care delivery system needs improvement. There are many problems, but the nursing shortage is a critical one. As the American Nurses Association has put it, supporting nursing means “keeping the care in healthcare.” The nursing shortage must be addressed. The nursing profession must be strengthened.

Thank you for notifying me of the hearing and offering the opportunity to contribute to the discussion of these important issues. If I can be of any assistance please contact me.

[Whereupon, at 1 p.m. the hearing was adjourned.]