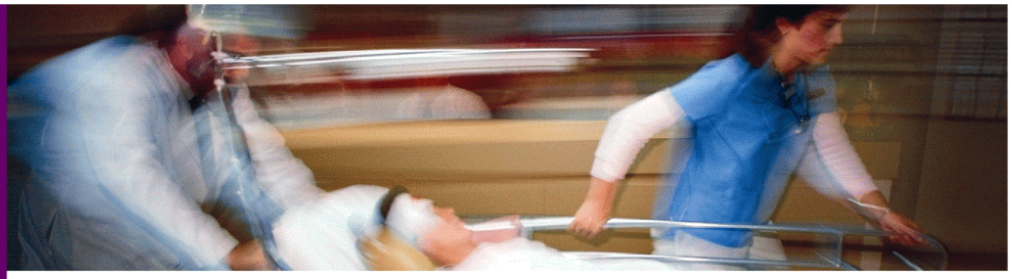
EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE
915 Lee Street
DesPlaines, IL 60016
www.ena.org



ENA Washington Update
September 30, 2009

Kathleen A. Ream, Director, Government Affairs 703/241-3947 E-mail: enagov@aol.com

Health Care Reform Approaching Floor Action

The Senate Finance Committee's long-awaited health care overhaul proposal was released by Chairman Max Baucus (D-MT) on September 16. In trying to get bipartisan backing, Baucus had worked for months with a group of six Finance Committee members (the "gang of six" comprises Baucus, Jeff Bingaman [D-NM], Kent Conrad [D-ND], Mike Enzi [R-WY], ranking member Chuck Grassley [R-IA], and Olympia Snowe [R-ME]), but none of those senators joined Baucus as he formally unveiled the bill. The senators did pledge to continue negotiating in the markup scheduled that began September 22, and Baucus said he hopes the bill will attract GOP support as a result of changes made during that process. Numerous amendments are expected; in just two days following the bill's release, committee members filed 564 amendments.

As it now stands, the main provisions of the Finance Committee's bill would require individuals to get health insurance coverage, establish a health insurance exchange enabling individuals and small businesses to comparison-shop for coverage, reform the private insurance system, expand Medicaid to include those earning up to 133% of the federal poverty level, and – as an alternative to the public plan option included in the House and the other Senate Committee's (Health, Education, Labor and Pensions [HELP]) bills – establish state-based cooperatives to compete with private health plans. The $856 billion cost of the bill is "within President Obama's target of $900 billion," Baucus said.

Numerous Medicare changes are proposed. Among others, the bill includes: a value-based purchasing program for hospitals, physicians, and other providers; new health care quality measures; and penalties for hospitals with high readmission rates. Of particular interest to Medicare providers is the replacement of the scheduled 21% cut in physician payment rates in 2010 with a 0.5% increase. The bill does not have a specific provision on medical malpractice reform, but it does include a section akin to what President Obama said in his speech to a joint session of Congress on September 9 (in recognition of the position of many Republicans and provider groups) concerning states' demonstration projects seeking to limit malpractice lawsuits and the costs associated with them.

Moderate Democratic senators have stopped short of endorsing the Baucus plan, and several said they were unwilling to commit to helping their party overcome a potential Republican-led filibuster. The plan has also failed to gain support from liberal Democrats and Republicans. Before legislation can move to the Senate floor, the bill that emerges from the Finance Committee's markup will have to be melded with the HELP bill. In explaining what will follow, Senate Majority Leader Harry Reid (D-NV) said, "The first amendment will be a composite of the HELP Committee bill and the Finance Committee bill, working with the White House. And we will see if we can get 60 votes on that. If we can't get the 60 votes we need, we'll have no alternative but to do reconciliation." The strategy of reconciliation is controversial and considered risky, but it could prevent a Republican filibuster and allow the bill to reach the full Senate for a yes-or-no roll call vote needing only a simple-majority vote for passage.

IN THIS ISSUE . . .

Meanwhile in the House, Democrats are divided over how to proceed. Liberals are advocating to bring health care reform to the floor as quickly as possible, and centrists are pressing for a delay until the Senate acts on its version. Representative Henry Waxman (D-CA), Chair of the House Energy and Commerce Committee, indicated that he was putting off (Cont'd page 2)

IOM Holds Emergency Care Workshop

In 2006, the Institute of Medicine (IOM) issued three reports on the ***Future of Emergency Care in the United States Health System*** that included recommendations for the federal government and private stakeholders to initiate changes aimed at improving the emergency care system. A central recommendation was that the federal government should more effectively coordinate the many emergency care-related activities dispersed among various federal departments and agencies, although it was noted that *pre-hospital* emergency care was already advancing through the Federal Interagency Committee on Emergency Medical Services (FICEMS).

As a follow-up to the 2006 reports, IOM held a workshop in May 2009 to examine the progress made in achieving the objectives called for in its recommendations and to help assess priorities for future action. The workshop was sponsored by the Emergency Care Coordination Center (ECCC) – the newly formed federal lead agency within the Department of Health and Human Services – with additional support provided by the American College of Emergency Physicians and the Society for Academic Emergency Medicine. Mary Jagim, a past **ENA** president, was a member of the workshop planning committee.

Together, ECCC and FICEMS have established the National Emergency Care Enterprise, a collaboration that covers the entire spectrum of emergency care, including pre-hospital, in-hospital, intensive care, surgery, and post-hospital placement. Through its body called the Council of Emergency Medical Care, the collaboration promotes information exchange and joint problem solving across the various federal agencies. Workshop attendees included policy makers from these federal agencies, along with state and local officials, and stakeholders from the health care provider community.

A report on the workshop, published by the National Academies Press in paperback book form and entitled ***National Emergency Care Enterprise: Advancing Care Through Collaboration***, is available. A free executive summary of the report can be found at **http://www.nap.edu/catalog/12713.html**.

Health Care Reform Approaching Floor Action (Cont'd from page 2)

putting off indefinitely a markup to complete action on outstanding amendments to the House health care legislation, H.R. 3200. Waxman denied that he was bowing to pressure from undecided committee members, many of whom are part of the Blue Dog Coalition, a group of fiscally conservative Democrats. Representative Anna Eshoo (D-CA), an adviser to Speaker Nancy Pelosi (D-CA) and a member of the Energy and Commerce Committee, said the panel's final markup was delayed in part to consider new amendments that Democrats want to offer to respond to constituents' concerns and to proposals that Obama outlined in his September 9 speech to Congress. Among the proposals being considered are pilot programs and other measures intended to curb or discourage medical malpractice lawsuits. In its present form, H.R. 3200 already has a provision allowing incentive payments for states that institute malpractice reforms, and Pelosi has said she expects the final bill will retain that provision.

Representative Jim Cooper (D-TN), a longtime Blue Dog and among the many centrist members who want to let the Senate act first, explained that he and other Blue Dogs consider it politically unwise for the House to vote on a bill that includes provisions the Senate is likely to omit. "We want it to fit within President Obama's budget guidelines, and not add one dime to the deficit," Cooper said.

The day before the Baucus plan was released, House Democrats held a three-hour health care forum convened by Pelosi and the Democratic Steering and Policy Committee. During the session, White House senior adviser David Axelrod urged lawmakers to act as soon as possible on the bill and include a public option in it; and Pelosi reiterated her vow to send Obama a health care overhaul bill this year and stressed support for the inclusion of a public option. While Eshoo and other Pelosi advisers said that no final decision has been made on whether the House will take floor action first or wait for the Senate, Louise Slaughter (D-NY), Chair of the Rules Committee, cited the long-held reality that guides the timing of House votes. "When we have the votes, we are going," she said.

Shorts . . .

Senate Finance Committee Passes Parity Amendment

Under an amendment to the Senate Finance Committee's healthcare reform bill, health insurance plans in the small-group and non-group market would be required to adhere to the addiction and mental health parity provisions of the ***Mental Health Parity and Addiction Equity Act of 2008***. The Finance Committee passed the amendment by voice vote on September 23.

The amendment, sponsored by Senators Debbie Stabenow (D-MI), John Kerry (D-MA) and Ron Wyden (D-OR), fills a major loophole in the Finance Committee bill. As originally drafted, the measure would have required small-group and non-group health plans – including those with fewer than 50 employers and those that buy individual insurance plans – to provide addiction and mental-health benefits. However, the bill would not have subjected these health plans to the mental health parity law signed into law last year, which bars health plans from placing any limits or restrictions on addiction and mental-health coverage that do not apply to any other type of healthcare services.

Harkin New Chair of Senate HELP Committee

On September 9, Senator Tom Harkin (D-IA) accepted the chairmanship of the Senate Health, Education, Labor and Pensions (HELP) Committee. Harkin, who succeeds the late Senator Edward Kennedy (D-MA), indicated that his priorities for the fall – the health care, student loan, and food safety bills – follow the agenda set largely in motion under Kennedy's leadership. He called his new role a "daunting prospect" but also a "great honor" to serve and carry on the legacy of Kennedy.

Harkin has made his mark on many HELP issues. As an advocate for workers and disabled people, he was the driving force behind the original ***Americans with Disabilities Act*** and its reauthorization. He chaired the committee's working group on prevention and public health, which was responsible for the section relevant to those issues (Title III) in the Committee's health reform bill, the ***Affordable Health Choices Act***, approved in July. He expects to have the panel's bill to overhaul the student lending industry marked up and reported to the Budget Committee by October 15 (the House passed its version of the legislation [H.R. 3221] on September 17). Also, having been asked by Kennedy to take charge of food safety, Harkin said he wants to have that bill ready to go this fall as well.

On health care, Harkin said he will work closely with Senator Chris Dodd (D-CT), but he pledged to keep Dodd in charge of the panel's role in negotiations. Those negotiations have reached a critical juncture and, while Dodd has been a willing negotiator, he also has indicated that the time should come when Democrats must stop chasing recalcitrant Republican votes. And Harkin has made it clear that he would not support an upending of the HELP bill.

In addition to chairing the HELP Committee, Harkin will remain a member of the Senate Committee on Agriculture, Nutrition and Forestry. A recipient of **ENA**'s 2006 Public Service Award, Harkin was recognized by **ENA** for his longstanding commitment to and support of advancing nursing and health care in the United States.

AHRQ Planning Guide for Mass Medical Care

AHRQ released a condensed version of a 2007 mass medical care planning guide that contains updated resources and new information specific to H1N1. ***Mass Medical Care With Scarce Resources: The Essentials*** is a resource for community planners to prepare for public health emergencies, such as pandemic flu, when demand for medical resources outweighs supply. The 70-page guide sets out a framework of basic steps that planners may take to prepare for a mass casualty event. It addresses key questions that each community should ask to properly plan for a well coordinated operational response. The guide also addresses ethical and legal issues and provides tips on preparing for the provision of services to address pre-hospital, acute hospital care, alternative care sites, and palliative care during disaster conditions. To illustrate how to apply these basic principles, the guide includes a special section on influenza pandemic preparedness. This new resource is an abbreviated version of AHRQ's ***Mass Medical Care With Scarce Resources: A Community Planning Guide***. A print copy of **"The Essentials"** is available by e-mailing **AHRQPubs@ahrq.hhs.gov**.

NY/NJ Bills Revive Debate on Education Standards for Nurses

Both the **New York** and **New Jersey** state legislatures are considering bills that would require all newly licensed RNs to obtain a BSN degree within 10 years of initial licensure. The bills – S4051/A2079B in **New York** and S620/A3768 in **New Jersey**, commonly referred to as the "BSN in 10" proposals – recall initiatives dating back to 1965 that attempted to raise the minimum educational level of practice in nursing to BSN. The current proposals neither call for the BSN as the minimal requirement for entry into practice nor do they advocate for the closing of ADN or diploma programs, but they have sparked a heated discussion of the issue once again.

Concerns have been raised about what passage of the bills would mean for nursing schools in **New York** and **New Jersey** that, like the rest of the country, already are turning potential candidates away because of faculty shortages. Other major concerns include the fate of ADN and diploma programs, and the monetary burden that could be placed on nurses to fulfill the BSN requirement.

Proponents of the proposals say that the new requirement would ensure that nurses in **New York** and **New Jersey** are equipped to handle the ever-increasing complexity of patient care. Furthermore, some in favor of the bills say that, to remain viable and equally competitive in the healthcare arena, nursing needs to make the baccalaureate degree the minimal requirement for maintaining licensure.

The measures in both states cover the same general points, requiring new graduates of AD and diploma programs to obtain their BSN within 10 years of the date of initial licensure, and providing a grandfather clause for nurses who already are licensed and for those who are enrolled in nursing school before enactment. For nurses who cannot complete the degree requirement in the allotted time frame, the bills also provide options to request an extension and be granted a conditional registration.

Each bill gives similar reasons for enacting the legislation. **New York**'s bill notes that higher patient acuity, advancing technology and procedures, and complex patient care, along with shorter lengths of stay, are creating a greater demand for nurses' skills. It also cites research studies that "clearly demonstrate the added value of additional education in relation to improved patient outcomes." One study, it states, found that "each 10% increase in the number of baccalaureate-prepared nurses results in a 5% decrease in surgical patient deaths." The language in New Jersey's legislation similarly references studies comparing patient outcomes with nurses' educational background.

According to the National League for Nursing's 2007 statistics, **New York** and **New Jersey** have more ADN programs than BSN programs, and since 1987, the number of ADN programs nationally has steadily risen. Legislators in both states have offered assurances that passage of their legislation would not change this situation and that nurses will continue to be able to enter the profession through ADN and diploma programs. Yet, the call for higher educational requirements seems implicit. With respect to health care's increasing complexity, **New York**'s bill S4051 states, "Other countries are responding to these changes by requiring the baccalaureate degree as an entry requirement for nursing licensure, while other professions are demanding master and doctoral degrees as their entry point." And **New Jersey**'s S620 states, "it is the sponsor's intent that currently licensed nurses also seek to advance their education and training." If passed, the **New York** law would take effect immediately; **New Jersey**'s law would take effect after 90 days.

Texas Bans Mandatory Overtime for Nurses

With a new law that went into effect on September 1, **Texas** became the 15th state to prohibit the practice of forcing nurses to work longer than their scheduled shifts. The law also strengthens a rule set by the **Texas** Department of State Health Services in 2002 stipulating that hospitals cannot staff their facilities based on mandatory overtime.

According to Jim Willmann, general counsel and director of governmental affairs for the **Texas** Nurses Association (TNA), the bill originally included nursing homes and home health agencies, but because those nurses work a variety of shifts, they were dropped from the legislation. Willmann said that in future years TNA will try to extend the mandatory overtime rule to those practice settings.