Click here for Full Issue of EIR Volume 23, Number 43, October 25, 1996

Interview: David Schildmeier

Massachusetts nurses are 'going public' with the hospital crisis

David Schildmeier is Director of Public Communications for the Massachusetts Nurses Association (MNA). He was interviewed by Marianna Wertz on Oct. 3, for New Federalist *newspaper, which published excerpts in its issue of Oct. 14, and passed the full text along to* EIR.

NF: In last week's issue of our newspaper, I interviewed the head of the Pennsylvania Nurses Association, who just testified at a hearing there. I'd like to get a picture of what's happening to nurses in hospitals in Massachusetts. I'd also like to discuss the situation with the two current negotiations, at Boston Medical Center and Brigham and Women's.

Schildmeier: Let's start with the broader picture. It's important to look at Massachusetts, because, outside of California, Massachusetts has the greatest penetration of managed care and we have a large population of nurses too, given our state size. We're the third or fourth largest population, behind New York, California, and Texas. So we're a good microcosm to look at what's happening and what that's done.

What it's done, is it's driven the whole industry in Massachusetts into a massive state of consolidation. It is estimated, there was a prediction by a person at the Hospital Association, that within five years, in Masschusetts, there will be at the most five and probably two or three networks that control the entire industry—this is the acute care side. That is being driven by managed care. The people who control the patients are the managed care providers, especially when you have a very high penetration of patients being driven by managed care companies. Most of the companies are in managed care plans. Those managed care plans dictate where they send those patients for care.

NF: Who are the largest providers there?

Schildmeier: Harvard-Pilgrim Health Care, Tufts, Harvard Community Health Plan, Blue Cross/Blue Shield. They control where the patients go. So what has happened in Massachusetts, in 1992, there was deregulation, which meant that for the hospital industry, there was no regulation on discounts the hospitals could award the HMOs.

NF: Was that a proposal by Gov. William Weld?

Schildmeier: Yes, it came in because of Weld. And the hospital industry lobbied for it, the deregulation of the industry. So that what you had was hospitals being able to award discounted costs to these managed care companies, to win contracts. That's how hospitals now get their money. They get locked into an HMO provider, who can then send their patients to them.

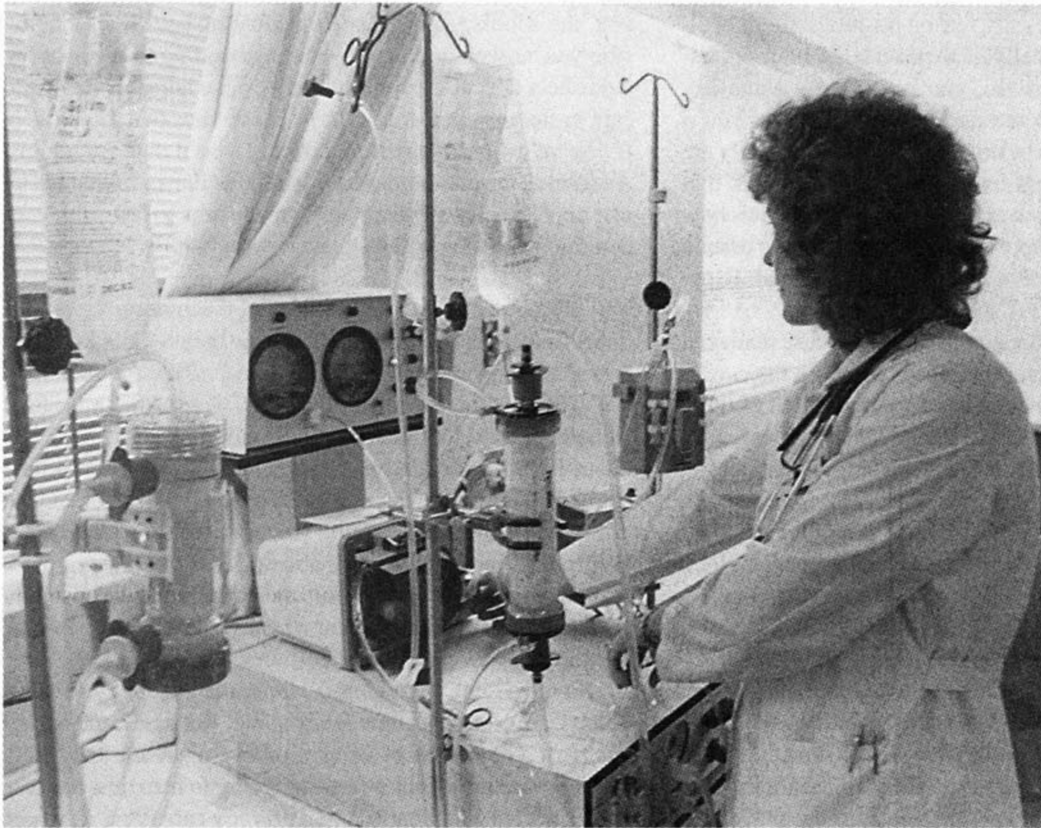
Now, to get that contract from the HMO, what the hospital does is cut a deal. These aren't actual numbers, but just by analogy: Say it costs $100 a day to care for a patient. Before the contract is cut, before the HMO signs the deal with the hospital, it costs $100 to care for a patient. The HMO says, "We'll give you our patients, but you've got to do it for $75 or $70," or whatever that number is. The hospital has a choice. It costs $100 to care for that patient, to provide the level of nursing care that is traditional and what patients have always expected; to provide the medical care, diagnostics, all that stuff—it costs $100. If they want the patient, they're going to have to do it for $75. Now, they're caught in a bind. So they look around and they see that the competitor next door is going to cut that deal if they don't. So they cut the deal.

Now they've got access to these patients that the HMOs control, and the public's happy because they're paying five bucks a pop to go to the doctor. So now you've got a system that has made a deal. They've got the patient. Now they turn around and they say, how are we going to care for patients at $75 a day?

What they do is they say, "We've got to deliver this care at $75 a day. How are we going to do that, when we've got labor contracts, and we've got so many nurses on staff at this salary and all these other things, everything that we have to pay for? Where are we going to cut?"

Traditionally in hospitals, 60% of the labor budget is nurses. So immediately, when they turn away from the contract and look where they're going to cut money, they look at the labor costs, and they look at nurses who are the highest price tag of that labor cost that they have to absorb. So that's where they're trying to cut. So they're saying, "We're going to do a couple of things. We're going to cut back on our nursing staff, cut our labor costs by just eliminating a lot of nurses; when nurses retire or move on, we don't fill those positions. Or we're just going to down-staff as low as we can, so our labor costs go down." That's one scenario.

© 1996 EIR News Service Inc. All Rights Reserved. Reproduction in whole or in part without permission strictly prohibited.



"Remember," says Schildmeier, "the nurse in the health care system is the teacher. They're the ones that are trained. If you've ever worked with a doctor, you'll understand this. As soon as the doctor leaves, you ask the nurse, 'What did he just say?'"

NF: The statistic I have is that the percentage of nurses on hospital staff has dropped from 45% nationwide 20 years ago, to 37% today.
Schildmeier: Yes, that's what's been widely bandied about.

NF: Do you have a statistic on nurses ratio per patients?
Schildmeier: I'll give you a source for that. Her name is Judith Schindul-Rothschild, of Boston College. She just completed the largest survey that's ever been done of nursing opinion in the country. Some 7,500 nurses—it's got a 1% error rate. It's going to be published this month in the *American Journal of Nursing,* all about nursing and quality of care issues. Her study is very revealing. She has all that information.

That's how managed care plays into this. They are forcing onto the health care industry, and the health care industry is colluding in this: They wanted this ridiculous open competition for these contracts. And that is forcing the hospitals now to turn around and take it out of nursing.

NF: What is the effect on nursing?
Schildmeier: Either the nurses are working longer hours, with less help, or, they're doing a second thing: They're looking at nursing and they're saying, all right, how can we do without nurses? What if we replace nurses with unlicensed, lesser-skilled, lower-paid people? Take a college-educated nurse, and a lot of them have a lot of experience—the nurse is an old workhorse. We have a lot of nurses in hospitals who have been working 10-20 years. What if we got rid of those nurses, replaced them with these unlicensed techs, changed how nursing care is delivered, so that we can have one nurse working with a few techs and deliver care?

NF: We have reports in Pennsylvania and other places that this has led to deaths which are directly attributable to this use of techs.
Schildmeier: Absolutely. Judy can tell you case by case. She did a study a few years ago that found 15 deaths that she could attribute to changes in staff mix. She is getting reports all the time about patient deaths.

We have been out talking to nurses. The Massachusetts Nurses Association, for two years, in town meetings, has been talking to nurses, getting them to talk to us about what they're experiencing. It's not only deaths, but injuries and mistakes and errors all over the place. Judy's found that more than 50% of the nurses she surveyed reported increases in medication errors; 37% of the nurses she surveyed said they wouldn't feel safe admitting a family member to the hospital where they worked. This is nationally.

The hospital industry, because of the pressures that are put on them to save money, has looked at nursing as an expense, and is doing everything they can to limit that expense.

Forgetting the fact that the only reason hospitals are in business, if you think of it logically, is to provide 24-hour professional nursing care. Otherwise, you would be a same-day surgery center, or you'd be getting care in an office, or you'd be getting care in a home. The only reason hospitals really are licensed and are in business, is because you're so sick that you need around-the-clock care by someone who knows how to interpret your condition and how you're reacting to certain medications every minute that you're in that hospital. Especially now.

Again, this goes back to managed care. Because managed care controls the patients and the access, because the care is "managed," patients are in there for a shorter length of time. They also don't get into the hospital unless they're very, very sick. It's harder to get an admission now into a hospital because of the "managed" care.

So you have a population of people who are extremely sick, in an institution that is there to provide around-the-clock nursing, at a time when the health care industry has made a conscious decision: We're going to do everything we can to do without nurses. That is what we're facing in Massachusetts. We are either working in institutions where there aren't enough nurses on staff, or they've cut the staff to the bone. And Judy's study and other studies have shown that the injury rate for nurses is going through the roof, and the illness rate and the burnout rate, because they're working especially hard just to keep people alive.

The other thing that's really happened on a wholesale basis is, they're going in with these fancy plans, called patient-focussed care, which is like calling an ICBM missile a peacekeeper. It is just outrageous! What they do, is they replace skilled providers, educated minds, with uneducated, low-paid, minimum-wage workers with three to six weeks, maybe, some with as little as 40 hours worth of training, and a high school education, to be at the bedside.

[Mr. Schildmeier talked about his work in Florida, before coming to Massachusetts in the 1980s, to bring in nurses during the nursing shortage. Corporate offices chose his hospital as a pilot project to look at how nursing care is delivered.]

They studied nurses just as you would in a factory. They looked at all the tasks that a nurse does. She goes and gets water, she takes vital signs, she inserts catheters and hooks up monitors. They did a whole time-motion study of what nurses do. Then they went back and they divided all that up, to see, how can we get other people to do these things? And then work with fewer nurses and with aides and assistants, to deliver care without as many nurses. They came up with a plan, missing the one important piece, which is that the real thing that nurses do, is not "tasks." What nurses are really there to do, is to be with the patient and watch them. That's what you're paying for, when you want a nurse.

You want a nurse, not to come in once every three hours and look at a chart or see what aides have done. You want that nurse in your room, caring for you, because she's talking to you, she's looking at you, she's evaluating you. She's making sure you're well and healthy and responding to medication. And she's educating you. Remember, the nurse in the health care system is the teacher. They're the ones that are trained. If you've ever worked with a doctor, you'll understand this. As soon as the doctor leaves, you ask the nurse, "What did he just say?" Nurses are there to teach you how to deal with your condition and also how to evaluate your family situation.

NF: The patient is also not a piece of machinery.

Schildmeier: Exactly. But that's how they look at it. This is how the people who are making the decisions out there look at it. They don't talk about patients and illness, they talk about "length of stay." If you talk to an administrator, they talk about LOS, that's all you hear. You hear FTEs—full-time equivalents—how many people, not how many nurses, but how many full-time people do you have working? You don't talk about illnesses, you talk about DRGs, the government-assigned diagnosis groups that are attributed to revenue you get for Medicare patients. The whole system is set up to look at patients as a business, as line-items.

So they came up with this whole plan and they called it Team Care Nursing, some fancy name. But here's the nefarious part. They came to us as a pilot project and they said, "Listen, we know your nurses are going to hate this, because nurses are used to what's called primary care nursing, where one nurse has four or five patients and does pretty much, with an aide, everything for that patient. So we put in a whole system to basically convince them to like it, or how to pick the nurses that will work in the system and those that won't."

On top of developing the scheme, they developed a whole manipulative way of convincing nurses and the community, and the system, to buy it. Then they tried to push it on our nurses.

I leave, and the nursing shortage enters. I came back into health care a few years ago with MNA, and, all of a sudden, there are all these consultant firms popping up all over the place in hospitals all across the country. What are they talking about? First they do time-motion studies. They have these special committees with nurses. The whole process that started during the nursing shortage has become a full-scale industry, many of them run by big-name accounting firms, who are now taking this model, which started because of a shortage, and they realized that nurses were getting too expensive, and it's now being foisted on the public and on the industry as the norm. They would point-blank, no exaggeration, if they had their way, do away with nursing altogether. They would do away with traditional nursing, which is the nurse at the bedside, trained and educated to care for a patient, provide hands-on care. They want to make them supervisors of a whole cadre of lesser-skilled, lower-paid people.

NF: You have a very hot Senate race going on in Massachusetts. Is there a difference in those two candidates?

Schildmeier: Sure, with Kerry and Weld. Kerry, and Kennedy, too, though he's not in the race, have been more supportive of nursing care and of greater universal access to care and financing models, than Weld. I can tell you a pointed difference between Weld and Kerry, when it comes to the care. It really comes to the fore in the care of the most vulnerable. He [Weld] has stewardship over the Department of Mental Retardation, Department of Mental Health, all those agencies that care for those most vulnerable that government traditionally cares for. He's done two things. He's wanted to privatize those industries and turn them over to mostly for-profit-type people or profiteering-type companies, that want to really bring managed care to those types of clients, which is crazy. That's one aspect of it, and Kerry and others have opposed that across the board.

The other thing that he has done, is that Weld, at DMH and DMR [Department of Mental Health and Department of Mental Retardation], where we have a major fight going on and we have legislation proposed to address it, has put in place, for these mental health and mental retardation clients, a process where he has licensed—there's a loophole in our state law. He has licensed or authorized 6,000 direct care workers who aren't nurses, to administer medications to severely compromised clients in those systems, mentally ill and mentally retarded patients, some with dual diagnosis, some on severe, Class IV psychotropic medication. He has purposely and aggressively gone ahead and tried to eliminate the nurse and make direct care workers, people with high school education, with no training, with 16 hours of course work, administer these medications. This is what a nurse spends two to four years—and a lot of these nurses have been doing it for 10-20 years, handling medications—learning to evaluate, document problems, report problems, intervene with patients. He has blatantly tried to destroy that system, and is still aggressively pursuing it, and we have been fighting him every step of the way.

NF: Is it actually implemented now?

Schildmeier: Oh, yes. There are 6,000 people out there in the system who are ready and doing this. We just got a front-page story in the *Boston Globe* about some deaths in the system. We get reports all the time.

We've got a bill that we've had before the legislature for two years, and we're hoping, with the publicity we're getting and with the whole knowledge of what's happening, with unlicensed people delivering medications, that we're going to get the political support and the political will to stop it, and to close that loophole and ensure that only nurses deliver medication and evaluate patients and take care of them.

On the face of that issue alone, we're supporting and have endorsed Kerry.

NF: Let me move on to the situation with your contract negotiations with the hospitals.

Schildmeier: The one that applies to the issue of managed care directly, is Brigham and Women's Hospital. It's a flagship hospital in the country and state, and it's one of our largest bargaining units. We have 1,900 personnel there. It's also our most politically aware and active, well-organized bargaining unit.

Historically, Brigham and Women's nurses have been given a lot of autonomy. Because of the union representation that they've had for many, many years, and the power of that local, and because of the high professionalism of the institution itself, and, to give credit to the hospital, in the past they have given their nurses a lot of autonomy, a lot of power to stand up for themselves and to see themselves as powerful players on the health care team.

Because of all that, as these changes have been taking place in the health care system, those nurses have been aware of it. Just over the past year, during negotiations, the hospital attempted to implement a plan where they laid off some nurses in their center for women and newborns, and replaced them with aides. The original job descriptions for those aides were outrageous. It's like pulling the tail of the tiger. They woke up those nurses, enraged those nurses, and we impact bargained over that specific little situation in that one unit in the hospital, and got the hospital to give up a lot in determining what tasks the nurses would do and what tasks the aides would do.

But that also woke up the entire bargaining unit. So the nurses made it their objective to make sure that they included language in their new contract that guaranteed nurses the right to decide who delivers nursing care and to whom they will delegate under any circumstances. And that's what they did.

Another issue is, one of the things that our hospitals are doing, is getting a smaller core staff, because hospital censuses, how many people are in the hospital on a given day, fluctuate from unit to unit. So they have a smaller core staff and what they call "float nurses," to different units on different days, under the theory that a nurse is a nurse is a nurse and that sick people are sick people are sick people. The problem with that, is that it's not true. Given the sophistication and the specialization of medicine, nurses can't just transfer from pediatrics to oncology to medical/surgical. Every area has its own special drugs, its own special policies. So the whole thought process is wrong to begin with.

But when they do have floating, what nurses usually ask for is, if you're going to float nurses on a periodic basis, you have to ensure that that nurse has proper training and orientation and feels comfortable accepting that assignment, before she's sent there. Most hospitals across the country don't give a damn. They just send nurses everywhere.

So even when you have nurses on the floor now, you can't guarantee that that nurse is really that qualified for your condition, because you don't know how long she's been there and whether she's going to be there tomorrow.

So, in addition to the unlicensed personnel issue, one of the things they were looking at, too, to protect quality of care,

is to put language in the contract that stipulates how much training and orientation nurses receive before they're moved to another floor. Those two issues are what drove that contract.

The nurses put forward to the hospital, language that said, basically, it is up to the nurse to decide when and to whom she will delegate any nursing task, and the nurse has the right to refuse delegation, the nurse is in total control of the practice—and by law, in Massachusetts they are—but we wanted to write it into the contract. The hospital came back with a proposal, and this is what stalled the negotiations, it was outrageous. They basically said, we all agree that unlicensed personnel are a necessary evil—I'm just paraphrasing—a necessary evil in the health care environment, and that nurses, to the degree possible, will delegate to them. Basically, they were saying, we want language in the contract that says they're necessary and they're coming and you're going to delegate to them.

They also, initially in the negotiations, proposed that a nurse could be disciplined, should she not delegate appropriately to assistant personnel. That was the crux of the whole contract fight. We said no, we're not going to take that language. We want language that guarantees us protection to a greater degree than any nurse in Massachusetts and probably very few nurses in the country have. We want our nursing licensure regulations basically written into our contract, so that nurses have total autonomy to decide how they practice. The hospital said no, we absolutely don't want to do that. That was the center of the fight.

It drew a lot of attention, because of the nurses and other health care providers fighting that battle right now.

NF: Did you win?
Schildmeier: Oh, we won, totally. We won it because we went public, and because they voted to strike. The nurses decided to let their contract expire and not to have any more extensions and to call for a strike vote. They got 85% of the bargaining unit to vote to strike. And we went public with that whole process. We went to the media, and we said the nurses are going to call for a strike because of the issues. When they went to a strike vote, the media covered it, the whole process, all the way through the contract negotiations. . . .

What happened was, after the strike vote and after all the publicity hit, we had one more negotiating session that was going to be the telltale. If that negotiating session didn't go well, we were going to walk out, and it was going to be over those issues. And the public knew it, and the whole health care industry knew it. So, it was a terrible night until it was over, then it ended up being a happy night, but they negotiated for 19 hours and they gave in to all our demands and they put our language in there. And we won.

The hospital gave the nurses what they were asking for. And I'll tell you why. Because, first of all, they didn't want to face a strike, but also because the press and the public sentiment were incredibly in our favor. The public *knows.* They've seen their care deteriorating and they have seen in certain hospitals people at the bedside who shouldn't be there and they've heard about this. And now they are speaking up and speaking out that the hospitals cannot do it.

Until now, nobody knew. Everybody talked about the changes in the health care system, and even nurses for a few years weren't saying anything about it. So to the public it meant, gee whiz, it's all financial, it's all technical, but when I go in the hospital everything's the same. It's just who pays for it, and all that. But the health industry has made a determination that they need to cut the cost of their care, and they're going to cut the cost of the care by cutting out the people that provide the care.

NF: It clearly shows that a battle for the truth can win.
Schildmeier: It really did and it's a beginning. We've had a two-year campaign here that we've waged, it's called the Statewide Campaign for Safe Care. It started internally with the association, just talking to our 20,000 members, saying, "Is this an issue, is this, what we've been hearing about all this awful stuff going on, is it true?" We held meetings and they said, "Yes, it's true." The next question we asked is, "What should we do about it? Should we go public?" That is a very hard thing for nurses to do, to go public and say that the care where they're working might not be safe. They said, "Yes, we need to aggressively go out and tell the public."

Then. over the last two years, we first went out and started publicizing the issues. Last year was the second phase of the campaign, where we drafted and introduced legislation to try to address the problem on the state level. We introduced four bills related to these issues. They're still in process. and we're going to reintroduce them this year.

Now we're in the third phase of the campaign, which is lobbying and building coalitions among consumer groups and other outside providers, to move this legislation over the next few years to get it passed. We've got the Massachusetts Association of Older Americans who've endorsed our legislation. We've got the Massachusetts Senior Action Council, which is a very politically active group of seniors, who have signed on and have joined our campaign by testifying and going to the media. . . .

There are three key bills that we're trying to pass. One is a very simple bill, an identification bill. It basically would be a law that all providers of health care would have to have visible identification by their licensure status. So an RN would have an RN pin, an MD would have an MD pin. Because what hospitals are doing, is forbidding employees, or encouraging employees, not to identify themselves other than as a "multi-skilled worker."

The piece that goes with it would include in the patient's bill of rights, notification of who their providers are, what their staffing level is, and who the RNs are and aren't, so the patient would know. It's important to tell consumers: You need to start asking the person at the bedside. Don't assume

they're a nurse or a skilled provider. Don't ask questions of unskilled people. With all these aides around, patients ask questions of them, and the aides answer them. And they have no business answering questions. Look for an RN, look for an RN or an MD, and if you can't find them, complain.

The second piece is in answer to the charge from the health care industry, which says there is no data to support what you're saying. All you have is anecdotal data. And it's kind of true. The problem is that the people who control the data about what happens to patients in hospitals, are the people who are providing the care and perpetrating the crime. They control the data. So the way around that, we believe, is that we have filed legislation that would mandate the collection and the reporting of nurse-sensitive data which relates to quality care. A lot of hospitals don't even collect this data, and they should be.

NF: It's in the incident reports, isn't it?
Schildmeier: Well, yes, but there are also other indicators. Things like patient falls, bed sores, medication errors, readmission rates. All of those things, if you track them, can tell you. And people who do studies tell you those are the things they look at. Because those are indications that there's not enough staff around or they have the wrong people handing out medication. Readmission rate is very important, and that's a cost issue that I would think anybody who cares, a business person who says, "I really care about cost," should look at. Nurses think readmissions are going through the roof. Because of the short length of stay and because of the poor education and quality of care they're receiving, patients are going out of the hospital and they're back two days later with complications because they didn't get cured while they were in there. It happened to my mother. She had open heart surgery, and she was out after three days. She was back in for two more days at a huge expense, because she had pneumonia, because she wasn't cared for well in the first admission.

We put a bill that would mandate that all health care providers collect certain data and report it, so that the public and purchasers of health care, businesses, can look at hospital A and hospital B, and can make an objective decision as to what's going on in your system. They absolutely refuse to do that. That's why we know we're on the right track.

The Institute of Medicine did a major study last year of the adequacy of nurse staffing in nursing homes and hospitals. One of the things they looked at was a model of data collection that I've just described (from the American Nurses Association), and they thought it was outrageous that this data aren't collected already in the system. One of their recommendations is that just such a system as our legislation is proposing be put in place. Because, how can the hospitals come into a system and say, "We are going to totally change," making the most radical change in the world, analogous to going into an airline and saying, "We're going to have flight attendants fly the planes"—we're going to make the change but we don't have to study the impact of that.

NF: That's why we call these people Congressman ValuJet.
Schildmeier: Exactly. That's the perfect analogy.

The second piece, connected to that, which I think is very important, and is being totally opposed by the industry, is, in Massachusetts law it only says hospitals and health care providers are required to provide "sufficient" nursing care. They never define "sufficient." In Massachusetts, if you want to care for perfectly well children, you can't care for more than six children per daycare setting. . . . But there is nothing in regulation or law that mandates basic levels of nursing care in any setting, except for intensive care and dialysis and a few specific settings. Especially in a long-term care facility, we have nurses who have 80-90 patients, working the night shift all by themselves, LPNs sometimes. There are no minimum staffing levels. Or, if there are, they staff to the minimum.

So we proposed legislation that would give the nurses the power to evaluate, and we're not just saying we want a blatant ratio, because we know there are some problems with that. We put in our legislation a formula that looks at the acuity level of the patient. The acuity level is a nursing measurement that rates how sick patients are. There will be functional levels, ability to communicate, which influences how much care they are to receive. The last thing is basic standards of nursing care. How many visits is it right for a visiting nurse to do in a day? When can you go over that level?

With that whole formula put into place, we would hope to have the ability for a nurse and a nurse-manager on a floor to turn to her administrator and say, listen, my acuity level is this, they're at this functional level, and my standards in the law say that I've got to have at least this many nurses, to provide competent, *sufficient,* nursing care. They don't have that power now. If a nurse-administrator says no, she's fired. If a nurse says, "I can't provide this level of care," unless she has a union, she is fired. If she has a union and she grieves it, she'll probably be punished and penalized and we'll have to spend months in court, in arbitration, trying to protect her to be able to say, "This is what I need to provide safe care."

So, this law, if it were put in place, would give the nurses and the nurse-administrators the power to care for their patients.

NF: And these laws are pending in the legislature now?
Schildmeier: Yes. The legislature ended and is starting up again for a two-year session, and we will be re-filing all of them. We have sponsors for them again, and, in fact, we're building a ton of support. The number of legislators who want to sign onto our bills is growing every week, because of the publicity that's been generated and the public consciousness of what's happening to the system, that the flight attendants are flying the planes. People are saying, "I don't want this. This isn't what I paid for when I paid my five dollars to go to my doctor."