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## **Testimony of Diane Barrett, Director of Government Relations, Continuing Care Leadership Coalition**

### **Comments on Mandatory Staffing Models and Alternatives**

#### **INTRODUCTION**

Good Afternoon. I am Diane Barrett, Director of Government Relations with the Continuing Care Leadership Coalition (CCLC), which represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. Our members represent the full continuum of long term care services including skilled nursing care, home health care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. We appreciate the opportunity to offer our recommendations to the Department of Health in this forum.

I want to begin by stressing that the members of CCLC are deeply committed to delivering the highest quality of quality care to their residents, and to providing safe, person-centered workplaces for the direct care providers that they employ. These values are tied to our members' missions as not-for-profit providers, and they are reflected in the fact that fully 84% of CCLC members score at the 4 and 5 star level on overall quality - as measured by CMS (the Federal Centers for Medicare and Medicaid Services).

Key to our members' success is their dedication to team-based models of care - where interdisciplinary teams comprised of nurses, LPNs, and CNAs, working in collaboration with physicians, with dietary staff, and with physical, occupational, speech-language, and recreational therapists, among others, work together in a thoughtfully calibrated way to care for specific populations with distinct needs.

Against this backdrop, our members have strong objections to the application of fixed, one-size-fits-all, numeric staffing ratios - which inherently lack the flexibility needed to meet the diverse needs of patients in the State's nursing facilities, and which would come with costs that neither facilities nor the State could realistically absorb.

In the balance of my remarks, I will address four key points.

- **Fixed staffing ratios are fundamentally the wrong option in the nursing home setting given the highly diverse needs of residents, and they are incompatible with the ability of nursing home providers to implement staffing plans based on specific patient care needs.**

- **Mandating staffing ratios would cost New York State nursing homes close to \$1 billion to implement. This would be unsustainable and would accelerate the rate of closures and sales of not-for-profit nursing homes in NYS - with dire effects on care access and quality for New Yorkers.**
- **The Federal agency responsible for overseeing nursing home quality - CMS - rejected fixed staffing ratios as insufficiently flexible when updating its requirements for nursing homes participating in the Medicare and Medicaid programs - electing instead to require nursing homes to adhere to "Competency-Based Staffing Standards" - standards based on each facility's unique needs, and subject to enforcement in cases where the standards are not met.**
- **There are a wide variety of recruitment and retention programs, management practices, and human resource models that would address staffing issues in a sensible and meaningful way while simultaneously improving quality of care.**

Our threshold comment is that fixed staffing ratios simply don't work in the nursing facility context. Flexibility is a vital component in delivering person centered care. Fixed ratios would undermine the ability of long term care organizations to customize staffing models to best meet the needs of the wide range of populations they serve. Decisions about the structuring of staffing models are influenced by a number of factors, including but not limited to the acuity of the patients, the training level of the nurses, and the availability of other health professionals and presence of certain technologies. Because there are so many variables in staffing determinations, facilities need the flexibility to structure staffing in ways that align with the distinct needs of their patient populations. Requiring health care organizations to adhere to predetermined levels of nursing staff takes away their ability to operate efficiently and appropriately in light of their specific circumstances.

Of particular note, it is important to recognize that our State's nursing facilities care for a wide variety of specialty populations including persons with dementia and mental illness, those requiring mechanical ventilation, those requiring special bariatric care, specialty wound care, IV therapy, palliative care, pediatric care, and many other special services. As a result, the care needs vary dramatically across nursing facilities. Because of these variations, there is no one "most appropriate" staffing configuration. To the contrary - what would be appropriate in one facility would be too little in a facility with more acutely ill patients - and it would be too much in another facility where the majority of patients require relatively lighter assistance in their activities of daily living. Having the ability to staff based on acuity level is essential to meeting the daily needs of such a wide variety of patients.

Our second key point is that staff ratios are cost-prohibitive and would lead to serious unintended consequences - including an acceleration of nursing facility closures and the potential displacement of those working in distinct job categories, such as licensed practical nurses.

The implementation of mandatory staffing ratios in New York State for hospitals and nursing homes would cost approximately \$3 billion a year. Nursing homes would shoulder close to \$1 billion of that cost. For not-for-profit (NFP) nursing homes - the majority of which are already operating with negative margins and are already financially burdened - such costs would have dramatic impacts, and would without question serve to accelerate the worsening trend of not-for-profit closures and sales.

In 2018 the Office of the New York State Attorney General released a report *The Sale of Non-profit Nursing Homes Pursuant to the Not-For-Profit Corporation Law*. In the report it clearly describes the accelerated pace at which not-for-profit nursing homes are being sold to for-profit corporations, and the deteriorating effect this has on the quality of care in nursing homes. From 2010 to 2014 approximately 5 percent of not-for-profit nursing homes were sold to for-profit entities annually. This trend applies to county nursing homes as well, which, according to a New York State Health Foundation report entitled *The Future of County Nursing Homes in New York State*, have decreased in number by over 20% over a recent fifteen period.

Ownership and sponsorship type have repeatedly been shown to make a difference in the quality of care given to residents. Adding a new unfunded mandate at a time of such instability will only accelerate the recent pattern of closures and conversions - to the detriment of quality care. Our association's internal analyses also show that the imposition of the ratios called for in the so-called "Safe Staffing Act" would likely lead to layoffs of those in certain categories that today are vital to the care teams in our facilities - with more than 4300 LPN positions potentially at risk if the legislation were implemented.

CCLC strongly recommends that DOH consider practices that will stabilize the NFP long term care sector to improve the overall quality of care in every nursing home and the State's overall quality position relative to other states.

## **RECOMMENDATIONS**

### **I. CCLC RECOMMENDS THAT NEW YORK STATE ALIGN ITS NURSING HOME STAFFING APPROACH WITH CMS'S COMPETENCY BASED MODEL**

In July of 2015 CMS rolled out proposed revisions to the nursing home Conditions of Participation (COPs) – the first step leading to the ultimate release (in October 2016) of a new set of Federal guidelines that nursing homes throughout the country must adhere to (see attachment). The proposed regulation has pages of discussion covering the extensive deliberations that the agency undertook - including its review of the literature on optimal staffing and its consideration of how different approaches to ensuring appropriate staffing would fit with the realities of the care issues that nursing facilities deal with every day. In the end, CMS rejected fixed ratios as too inflexible for application in the skilled nursing facility setting. In addressing the shortcomings of fixed staff ratios, the proposed rule stated:

*"... we do not necessarily agree that imposing such a requirement is the best way to clarify what is "sufficient" to the exclusion of other factors that are important in improving the quality of care for each resident. We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and staffing abilities including professional characteristics, skill sets and staff mix."*

The final nursing home requirements of participation (ROPs), which officially went into effect on November 28, 2016, gave clear guidance on how to meet the staff competency requirements. CCLC recommends that the NYS DOH consider adopting the staffing competency based approach that CMS implemented. CMS includes the following provisions in its requirements of participation.

- Nursing homes are required to develop facility-tailored staffing plans based on staff competency and education, and those staffing plans must be made available for public review and evaluation by surveyors during annual inspections.
- The Conditions of Participation define competency in skills and techniques necessary to care for residents' needs in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services and resident rights.
- The objective also includes the requirement for ongoing evaluation of competency and education to include both remedial and regular clinical programs, consisting of evidence based best practices and general nursing skills and facility policies and procedures to provide quality of care for the resident population in the facility.
- The facility must now have not only sufficient nursing staff, but staff with appropriate competencies and skills sets to assure resident safety as well as to attain or maintain the resident's highest level of well-being.

Unlike overly prescriptive mandatory staffing standards, the ROPs encourage an interdisciplinary care model that requires long term care organizations *to know themselves, their staff, and their residents*. The new requirements consider a variety of nuances that need to be assessed when caring for long term care residents. The combination of consistent staff evaluation, consideration of patient acuity levels, and the focus on the use of the interdisciplinary care team, allows for the flexibility necessary to successfully meet the changing needs of patients while providing comprehensive quality care. Introducing a new State standard that would mandate staffing ratios would be incongruous with the direction of the Federal guidelines, and with their emphasis on patient centered care. The final phase of the new Federal requirements will be implemented on November 28, 2019. CCLC recommends that long term care organizations be allowed to implement the final phase of the new requirements without any disruption.

## **II. CCLC RECOMMENDS THAT NEW YORK STATE CONSIDER A MENU OF ALIGNED STRATEGIES FOCUSED ON RECRUITMENT AND RETENTION MODELS AND OTHER PRACTICES THAT WOULD ADDRESS STAFFING ISSUES IN A SENSIBLE AND MEANINGFUL WAY WHILE SIMULTANEOUSLY IMPROVING QUALITY OF CARE**

Although CCLC opposes mandatory staffing ratios for the various reasons discussed throughout the testimony, we align ourselves fully with the principle that all who need care should receive care that is safe, high-quality, and reflective of their needs and wishes. There are creative, holistic approaches to improving patient outcomes that deserve meaningful consideration and discussion. Several of the programs listed below have been tested or implemented in other States with success. These programs have helped lower staff turnover in nursing homes, raised the skill level of direct care personnel, and advanced person centered care. These approaches promote interdisciplinary care models that are oriented to meeting the unique needs of each individual patient.

### ***Pilot Recruitment and Retention Programs***

The turnover rate for Certified Nursing Assistants (CNAs) in a typical nursing home in New York State is 25 percent. For registered nurses the turnover rate is 19 percent while on Long Island, the median is 22 percent. There is abundant evidence demonstrating that by implementing effective management tools that motivate and empower nursing home staff, retention will increase, thus improving patient outcomes in a cost effective manner.

In Massachusetts, the Massachusetts Senior Care Association with support from the National Fund for Workforce Solutions, implemented a pilot program that teaches a relational approach to supervision that builds skills in interpersonal communication and problem solving. After a year-long study the results demonstrated that training can reduce disciplinary actions and improve workers' ability to communicate with coworkers and patients to solve complex problems. The results of the pilot project reinforce the vital importance of quality supervision to building supportive workplace cultures, but also make clear that solving the recruitment and retention crisis will require a multifaceted approach to job quality.

The individual worker is fundamental to the quality improvement paradigm (Gaucher and Coffey 1993; Milakovich 1991). To promote a comprehensive quality improvement program each level of an organization must understand the processes that relate to specific outcomes the organization values; that is, all members need to see how their work affects the end product (Phillips 2001; Shortell, O'Brien, and Carman 1995). *In What a Difference Management Makes!* Susan Eaton found that nursing homes that have low turnover had the following similar traits:

- High quality leadership throughout the organization (from the boardroom to the break room);
- Valuing staff from day to day, in practice, word and deed;
- High performance-high commitment human resource policies;
- Work systems aligned with and serving organizational goals; and
- Sufficiency of staff and resources to care humanely.

As with the Massachusetts pilot, most successful models rest on staff empowerment. Some practices commonly associated with staff empowerment include the provision of greater career development opportunities and the intentional development of more supportive organizational cultures. Supportive activities include investments in the delivery of meaningful and relevant training and education, and the implementation of practices designed to engage staff in joint decision-making. An example would be the Quality Care Community (QCC), a partnership that CCLC took part in, which was designed to bring together workers and administrative staff to collectively solve problems in their facilities, creating a more satisfying and positive work environment and improve patient care.

In one specific example of this partnership's work, QCC convened a 15-month collaborative (October 2017-December 2018) designed to increase the knowledge of nursing home front line staff about caring for residents with behavioral health diagnoses, applying their learning by engaging in related performance improvement projects within their organizations, deepening management and direct care staff relationships, and meeting the latest CMS regulations regarding staff competency in behavioral health. To respond to CMS's priority to reduce use of antipsychotic medications among nursing home residents, this collaborative worked toward boosting non-pharmacologic interventions among residents with dementia. As a result, the Collaborative achieved a 16% reduction, from 11.91 percent use of antipsychotics in October 2017 (pre-intervention) to 10.15 percent use in January 2019 (post-intervention).

Many studies have shown that maintaining a staff that is satisfied with their organization, is effectively trained, and has a strong mix of high-level skills will raise the level of care quality in any organization. Delivering care effectively includes orchestrating complex interactions between professional, paraprofessionals, service staff, agencies, and clients<sup>1</sup>. Targeting and investing in

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<sup>1</sup> Eaton, Susan C. *Beyond Unloving Care: Human Resource Management and Patient Care Quality in Nursing Homes*. pp.27

programs that will achieve these is the best pathway to ensuring that nursing homes in New York State are equipped consistently to deliver the highest quality of care.

### ***Increase the Share of Reimbursement Dollars Tied to Quality Outcomes***

The Nursing Home Quality Initiative in New York State annually takes \$50 million from the total pool of money allocated to pay Medicaid rates to nursing homes and redistributes these funds based on facility rankings. If the quality pool were made more robust it would could materially influence practices, including those related to staffing, in ways that would elevate quality outcomes broadly. Further, if the scoring methodology were expanded to included metrics specific to staff training, consistent assignment, and decreased turnover it would meaningfully reward facilities that invest in their workforce. It is vital to the long term care delivery system to re-evaluate basic quality measures with a focus on investments in training and workforce development. If measures were introduced that evaluated workforce training, turnover, or other metrics involved in high-quality staffing, all long term care providers in the State would have greater incentives to invest in those areas. CCLC recommends that DOH include workforce training in the State's quality metrics, that it increase the share of Medicaid reimbursement dollars linked to quality performance, and that it invest additional resources in workforce training programs.

### ***Focus on Person-Centered Care Needs and Consistent Assignment When Staffing***

The American Nurses Association (ANA) the nation's largest and oldest nursing association, recommends in any approach used to determine staffing, consideration must be given to the elements affecting care at the individual setting level. In ANA's view, expressed in their *Principles For Nurse Staffing*, **no single method, model or assessment tool (e.g., nursing hours per patient day, nursing intensity weights, strict nurse-to-patient ratios) has provided sufficient evidence to be considered optimal in all settings and all situations.**

Each setting should have staffing guidelines based on safety indicators and outcomes specific to that area specific setting and work environment.

The ANA recommends considering the following criteria to safely determine staffing.

- Governance within the setting (i.e., shared governance)
- Involvement in quality measurement activities
- Quality of work environment of nurses
- Development of comprehensive plans of care
- Practice environment
- Architectural geography of unit and institution
- Evaluation of practice outcomes that include both quality and safety
- Available technology
- Evolving evidence

The ANA realizes that a fixed arbitrary does not adequately consider each of the items listed above to adequately staff to address patient needs. A fixed ratio overlooks the criteria needed to safely and adequately address patient's needs and improve outcomes.

CCLC strongly recommends considering the ANA's criteria and urges DOH to promote and encourage consistent assignment in nursing homes. Consistent assignment is defined as using

the same caregivers to care for the same residents on every shift. This allows staff to develop closer relationships with residents in their care and with co-workers. Researchers have found that implementation of consistent assignment programs in nursing homes leads to improved job satisfaction, greater staff morale, and better care for residents.

## **CONCLUSION**

I greatly appreciate the opportunity to provide these perspectives and recommendations. CCLC looks forward to working in partnership with the Department in ensuring that essential long term care services remain strong and available to our State's older and disabled citizens as the demand for these services grows in the year ahead.

## NYONEL SAFE STAFFING TESTIMONY

### October 22, 2019

My name is Kimberly Glassman, PhD, RN, NEA-BC, FAONL, FAAN, and I am a registered nurse with 43 years of experience in hospital clinical and leadership roles. Currently, I am the Senior Vice President for Patient Care Services, Chief Nursing Officer and the Lerner Director of Health Promotion at NYU Langone Health. I am also the immediate past president of New York Organization of Nurse Executives and Leaders. (NYONEL). Today I represent NYONEL's over 700-members who are nurse leaders at all levels – Chief Nurses, Nursing Administrators, Managers, clinical nurse leaders – in all areas where nursing is practiced: hospitals, primary care, home care, schools, long term care, and in education and research. Thank you for the opportunity to testify. I plan to share NYONEL's recommendations and to provide some perspective on nurse-led staffing committees from my own experience.

There is no organization that is more committed to safe nurse staffing than NYONEL. As nurse leaders, we are held responsible by the public and all regulatory agencies, including your own, for ensuring quality patient outcomes and patient satisfaction. Safe staffing is integral to achieving the best outcomes for our patients. As registered professional nurses, we have the education and skill to design and manage safe staffing systems in our organizations.

The following are NYONEL's recommendations for plans to ensure minimum staffing levels in hospitals and nursing homes.

- Healthcare organizations should have nurse-led staffing committees that include participation from greater than 50% of the clinical nurses. Also included should be representatives of nurse leaders at all levels, organizations representing nurses, and non-professional direct care staff. These committees would be charged with designing safe nurse staffing structures that reflect



## NYONEL SAFE STAFFING TESTIMONY

October 22, 2019

the needs of the patient population and the education/competence of the nursing staff within that organization. Currently, seven states have this model (CT, IL, NV, OH, OR, TX, WA).

- Where available, specialty organization evidence-based staffing levels should be considered (AWHONN, AACN – the national women’s health and critical care nursing organizations, for example, have both established them). However, they must be tailored to the above-mentioned organization characteristics.
- Staffing structures must have flexibility to meet changing patient needs, which often occur suddenly and without warning.
- In creating staffing structures, the committee should consider the inclusion of enhanced nursing and interdisciplinary support systems beyond direct bedside-assigned staff. Examples of these include Rapid Response Teams, Care Management Teams, IV Teams, Skin and Fall Prevention Teams, as well as clinical nurse specialists and other advanced practice nurses who support bedside care.
- These staffing structures should be continually evaluated on outcomes and value provided. Established evaluation criteria should minimally include: compliance with staffing levels, patient outcomes, staff satisfaction/turnover, patient satisfaction and cost.
- Evaluation of nurse staffing effectiveness must be reported through the organization’s quality/performance improvement process.

The next points address workforce needs and direct/indirect and fiscal implications associated with minimum staffing levels/other enhancements.

- An organization-specific safe staffing structure designed with input by stakeholders (nurses and other direct care staff) enhances retention by ensuring the voice of registered professional nurses in designing their staffing plan. Retention then leads to staff advancement within their

## NYONEL SAFE STAFFING TESTIMONY

October 22, 2019

individual roles, and job security through increased seniority. Clinical/career ladders and professional advancement programs are proven solutions to improve staff satisfaction and retention. And in the case of non-professional staff, their retention contributes to the pipeline to develop and employ future registered nurses.

- Well-designed staffing structures will facilitate position-appropriate task assignments, nurses working to the top of their license and reserving technical tasks for non-licensed personnel.
- Staffing flexibility will allow adjustments for RN's precepting new nurses and help deter preventable RN first year (17.5%) and second year (33.5%) separation<sup>1</sup>, and reduce the costs associated with RN turnover (>\$37,000)<sup>2</sup>.
- Registered nurse retention will help minimize the impact of anticipated shortages, strengthen the quality of the nursing workforce through knowledge retention, and ultimately better serve the members of the community.
- Staffing plan flexibility will enhance effectiveness of care transitions between levels of care within the hospital as well as from organization to community. This assures the right care for the patient in the right place at the right time, and mitigates costly outcomes such as readmissions, never-events and hospital-acquired conditions.

There has been significant discussion of California's mandated nurse staffing ratios. From published studies that evaluate intended outcomes, no definitive conclusions can be reached.

I would instead like to focus on NYONEL's recommended strategy – that health care organizations be required to establish staffing committees that include a majority of direct care nurses. This model empowers nurses to assess variables, such as intensity of patient needs, acuity, organizational staffing competencies, etc., that would dictate requisite safe staffing levels to create staffing plans specific to each unit.

## NYONEL SAFE STAFFING TESTIMONY

October 22, 2019

At NYU Langone Health, our nurses play an integral role in the day-to-day staffing decisions. Each unit has a unit practice council of clinical nurses who design a staffing guideline, and use that guideline each shift to plan the numbers of staff needed to care for the specific patients on the unit at that time. This approach aids in establishing staffing levels that are flexible and account for changes, including intensity of patient's needs, the number of admissions, discharges and transfers during a shift, level of experience of nursing staff, layout of the unit, and availability of resources (ancillary staff, technology, etc.). In my experience, this flexibility leads to the best outcomes and quality in patient experience. Just this weekend, I received an email from a nurse who decided to add additional nurses through overtime to meet the needs of a set of very acute patients. Of note, when our committees make formal requests to amend their staffing plans, they often request additional patient care technicians/aides, building services and food services staff, not additional RNs.

At NYU Langone Health, this approach has contributed to high nurse satisfaction, with many measures meeting and exceeding national benchmarks, a low nursing turnover rate (under 6%) and excellent patient outcomes. We have been ranked in the top 3 of all academic health systems in the country for 7 years in a row for quality and safety<sup>3</sup>. The four Langone hospital campuses have either received Magnet hospital recognition, or are on the journey to receive this recognition. The academic medical center campus just received its fourth recognition, placing it among less than 1% of the hospitals that have received Magnet status four or more times.

Thank you for your time and attention, and for the opportunity to testify today. We are happy to continue this discussion and provide the Department stakeholder consultation as required.

1. 2016 National Healthcare Retention & RN Staffing Report

2. 2016 National Healthcare Retention & RN Staffing Report

3. Vizient Quality and Safety Performance Award

# LONG TERM CARE COMMUNITY COALITION

*Advancing Quality, Dignity & Justice*

TESTIMONY FOR A MEETING ON:

STAFFING ENHANCEMENTS AND PATIENT/RESIDENT QUALITY  
IMPROVEMENT INITIATIVES IN HOSPITALS AND NURSING HOMES

OCTOBER 22, 2019

PRESENTED BEFORE:

THE NEW YORK STATE DEPARTMENT OF HEALTH

PRESENTED BY:

RICHARD J. MOLLOT

EXECUTIVE DIRECTOR

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## I. Introduction

Thank you for the opportunity to testify today.

My name is Richard Mollot. I am the executive director of the Long Term Care Community Coalition (LTCCC). LTCCC is a non-profit, non-partisan organization dedicated to improving care and quality of life for residents in nursing homes and assisted living. As a coalition, we include a range of organizations and individuals representing the interests of the elderly and disabled, and their caregivers, across New York. LTCCC focuses on systemic advocacy, conducting research on LTC issues to identify the root causes of problems and develop practicable recommendations to address them.

My comments today are focused on nursing home care. Nursing home residents are among our most vulnerable citizens. By definition, they require 24-hour a day monitoring and care. For these reasons, there are federal and state standards to ensure that residents are protected and receive the care and services they need to attain their highest practicable medical, emotional and social well-being.

While there are efforts underway to help people access long term care services outside of nursing homes, nursing homes will always provide critical services, particularly as our citizens age and more people live longer with dementia and other chronic conditions. In fact, recent research indicates that over ½ of people who reach their late 50s will need nursing home care at some point. In addition to the substantial public need for nursing home care, there is a substantial public investment; New York taxpayers pay for a significant majority of nursing home care.

Thankfully, there are numerous nursing homes in NY that provide good care, treat their residents with dignity, and demonstrate a commitment every day to fulfilling the promise they make to NY residents and families as well as taxpayers. Unfortunately, too many of our nursing homes fail to take essential resident protections seriously. They take our money every day, and promise to provide good care, but fail to do so.

**We appreciate Governor Cuomo's commitment to establishing safe staffing levels to address longstanding deficiencies in nursing home staffing in New York.<sup>1</sup> Staffing is widely recognized as the most important factor in respect to the safety and dignity of life in a nursing home. The widespread failure to provide sufficient staffing, with the appropriate competencies, is responsible for unnecessary resident suffering, heartbreak for New York families, and a waste of millions of taxpayer dollars every year for substandard – or worthless – services.**

## II. We Know What Minimum Staffing Is Necessary

A landmark federal study, published in 2001, identified 4.1 hours of nursing staff time per resident per day (HPRD) as necessary to meet the clinical needs of the typical nursing home resident. That

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<sup>1</sup> Statement from Governor Andrew M. Cuomo, June 22, 2019. <https://www.governor.ny.gov/news/statement-governor-andrew-m-cuomo-190>.

number has, essentially, been the benchmark for close to two decades.<sup>2</sup> While 4.1 HPRD or higher does not guarantee high quality care or decent living conditions, staffing below 4.1 HPRD is an indicator that a facility's residents are at higher risk of abuse and neglect, and that the public may not be getting the level of services that we are paying the nursing home to provide.

Since it has been close to 20 years since the 2001 study was undertaken, further study on staffing would be useful. However, the results would inevitably indicate that more than 4.1 HPRD is needed. Why?

- The 2001 study did not assess how much nursing staff is needed to meet the quality of life and basic dignity needs that every human being has and which providers are paid – and contractually agree – to provide;
- The study was not focused on measuring the staffing levels necessary to provide the quality of care specifically required by federal regulations; and
- The facilities selected for the study were not required to be providing “high quality of care.”

Unsurprisingly, other studies have indicated that 4.1 HPRD is a low baseline. In 2000, several experts found that “[m]inimum total number of direct nursing care staff is 4.13 hr per resident day. Total administrative and direct and indirect nursing hours is 4.55 hr per resident day. Staffing must be ADJUSTED UPWARD for residents with higher nursing care needs.”<sup>3</sup>

A 2016 study, focused only on nurse aide (CNA) care staffing needs, found that residents need 2.8 to 3.6 HPRD of CNA care, on average, to keep rate of care omissions below 10%.<sup>4</sup> That is approximately 20% higher than the CNA time identified in the 2001 federal study.<sup>5</sup>

### III. Fiscal Implications of Sufficient Staffing - Funding is NOT the Problem

#### Private Enterprises Continue to See NY Nursing Homes as Valuable & Profitable

We continue to see private, for-profit companies buying up nursing homes in New York. In 2015, *The New York Times* reported on the “bull market” for nursing homes, noting that “[s]ale prices of nursing homes averaged \$76,500 per bed last year — the second consecutive year of record-breaking

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<sup>2</sup> Abt Associates (Prepared for the Centers for Medicare and Medicaid Services), *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report To Congress: Phase II Final (December 2001). Available at <https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf>.

<sup>3</sup> Harrington, C., et. al., “Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States,” *The Gerontologist*, Vol. 40, No. 1, 5-16 (2000). [Emphasis in original.]

<sup>4</sup> Schnelle, J., et. al., “Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model,” *JAMDA* 17 (2016) 970e977.

<sup>5</sup> The 2001 Abt study identified an upper range of 2.8 CNA HPRD. We subtracted 2.8 from the upper range of the 2016 Schnelle study, 3.6, resulting in .8 which is 22% of 3.6.

prices....<sup>6</sup> We do not believe that these individuals, for-profit companies, LLCs, etc... are gobbling up nursing homes in New York so that they can lose money as a result.

### One-Third of Medicare Short-Term Rehab Residents are Harmed

A 2014 Office of Inspector General study, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*,<sup>7</sup> found that an astonishing one-third of residents who went to a nursing home for short-term care were harmed within an average of 15.5 days, and that almost 60% of that harm was preventable and likely attributable to poor care.

This is particularly striking because Medicare reimbursement rates are extremely high. The Medicare Payment Advisory Commission (MedPAC) has reported that nursing homes are overpaid by the Medicare program and have enjoyed margins exceeding 10% for more than 15 consecutive years.<sup>8</sup> Why can't nursing homes take care of these highly profitable patients? What are the implications for our elderly residents, particularly the majority of residents who have dementia?

## **IV. Can We Learn from Enhancements in California or Massachusetts?**

In short, no. California's staffing regulation is far too low and, of even greater concern, it allows for facilities to apply for a waiver to be exempted from the staffing requirement. According to a report in *Kaiser Health News*, at its inception over half of the state's nursing homes had asked for an exemption.<sup>9</sup>

In Massachusetts, our colleagues at the Massachusetts Advocates for Nursing Home Reform (MANHR) reported that:

A couple of years ago, MA reviewed all regs to "streamline" regs, and that's when we lost a staffing standard that was in place for about 25 years --- 2.6HPRD, 2.0 CNA 0.6 RN/LPN. Albeit low, but still a benchmark. Was replaced with a watered down version of new federal reg: 150.007(2)(d)....<sup>10</sup>

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<sup>6</sup> Thomas, Katie, "In Race for Medicare Dollars, Nursing Home Care May Lag," *The New York Times* (April 14, 2015).

Available at <https://www.nytimes.com/2015/04/15/business/as-nursing-homes-chase-lucrative-patients-quality-of-care-is-said-to-lag.html>.

<sup>7</sup> Available at <https://oig.hhs.gov/oei/reports/oei-06-11-00370.asp>. Six percent of those who were harmed died, and more than half were rehospitalized.

<sup>8</sup> See <http://www.medpac.gov>.

<sup>9</sup> Ostrov, Barbara Feder, "More Than Half Of California Nursing Homes Balk At Stricter Staffing Rules," *Kaiser Health News* (December 7, 2018). <https://khn.org/news/more-than-half-of-california-nursing-homes-balk-at-stricter-staffing-rules/>. See also, "A Trojan Horse for Nursing Home Residents: The Insidiously False Promise of the New Minimum Staffing Requirements," California Advocates for Nursing Home Reform.

[http://www.canhr.org/newsroom/newdev\\_archive/2018/20180430.A\\_Trojan\\_Horse\\_for\\_Nursing\\_Home\\_Residents.html](http://www.canhr.org/newsroom/newdev_archive/2018/20180430.A_Trojan_Horse_for_Nursing_Home_Residents.html).

<sup>10</sup> Excerpt of email from MANHR.

## **V. How Can We Achieve Sufficient Staffing? – Recommendations**

### **Enforcement of Existing Staffing Standards**

Since passage of the federal Nursing Home Reform Law in 1987, every nursing home has been required – and receives payment – to have sufficient staff to ensure that each and every one of its residents receives the care and services he or she needs to attain and maintain his or her highest practicable physical, emotional, and social well-being.

Federal regulations implementing the Reform Law, federal Interpretive Guidance, and the 2017 requirements for state surveyors each detail specific expectations for identifying low and insufficient staffing and holding providers accountable when they fail to meet these expectations.

Many – about 25% - of our nursing homes take this obligation, and their commitment to their residents and communities seriously, by providing good staffing. However, in the absence of meaningful enforcement (i.e., penalties for failing to meet these important standards), most nursing homes have lower staffing.

In short, we are operating on an honor system for resident care and safety. It is not working successfully for New York State nursing home residents, New York families, or New York tax payers.

### **Minimum Numerical Staffing Standards**

New York is now one of the minority of states that fails to set minimum safe staffing requirements for its nursing homes. Staffing standards are needed now more than ever to counter abuse and neglect, the increasing corporatization of nursing home care and current efforts by the provider industry lobbyists to quash nursing home requirements and accountability.

LTCCC strongly supports the Safe Staffing for Quality Care Act. We thank Assembly leaders for their support last year and urge the Governor & State Senate to do their parts to make this happen in 2020.

## **VI. Conclusion**

Many of our nursing homes do a good job in caring for their residents. However, increasing corporatization, the largely unbridled power of industry lobbyists, and lack of accountability perpetuate a system in which, far too often, it is both acceptable and profitable to provide poor care. Though staffing is key to resident safety and dignity, as well as the efficient use of the public funds that pay for most nursing home care in New York, too many nursing homes operate with insufficient staffing. As a result, residents in nursing homes in communities across New York suffer every day: unnecessary pain, humiliation, even death.

I thank you again for your interest in the well-being of our nursing home residents and for this opportunity to present testimony. We would welcome the opportunity to work with you and other state leaders to ensure that our nursing homes residents have access to the care and other staff necessary to ensure that they are safe and able to live with the dignity that we all desire and deserve.



## VII. Appendix – Selected Reports Underscore the Need for Action on Low Staffing & Safety

“An Assessment of the Impact of Low Staffing Levels on Quality of Nursing Home Care in New York,” LTCCC (2019). <https://nursinghome411.org/wp-content/uploads/2019/06/LTCCC-Policy-Brief-NY-State-Nursing-Home-Staffing-Quality-2019.pdf>.

“‘It’s Almost Like a Ghost Town.’ Most Nursing Homes Overstated Staffing for Years,” *The New York Times*, <https://www.nytimes.com/2018/07/07/health/nursing-homes-staffing-medicare.html>.

“As NY shifts to for-profit nursing homes, abuse and neglect complaints spike,” *City & State*, <https://www.cityandstateny.com/articles/policy/healthcare/as-ny-shifts-to-for-profit-nursing-homes%2C-abuse-and-neglect-complaints-spike.html>.

“Understaffing often plagues nursing homes, but state rarely cracks down,” *The Buffalo News*, <https://buffalonews.com/2019/02/14/state-health-department-rarely-cites-nursing-homes-for-understaffing/>.

“Nursing Homes Are a Breeding Ground for a Fatal Fungus: Drug-resistant germs, including *Candida auris*, prey on severely ill patients in skilled nursing facilities, a problem sometimes amplified by poor care and low staffing,” *The New York Times*, <https://www.nytimes.com/2019/09/11/health/nursing-homes-fungus.html>.

“After nursing home stay, bedsores lead to man’s agonizing death,” *The Buffalo News*, [https://buffalonews.com/newsletter\\_promo/after-nursing-home-stay-bedsores-lead-to-mans-agonizing-death/](https://buffalonews.com/newsletter_promo/after-nursing-home-stay-bedsores-lead-to-mans-agonizing-death/).

“Letters: Safe Staffing bill allows better care,” *The Buffalo News*, <https://buffalonews.com/2019/01/03/letters-safe-staffing-bill-allows-better-care/>.

“Residents suffer as only 8% of N.Y. nursing homes comply with proposed staffing law,” *The Buffalo News*, <https://buffalonews.com/2018/12/10/only-49-new-york-nursing-homes-comply-with-proposed-minimum-staffing-law/>.

“Two city nursing homes sued for inadequate care and staffing,” *Crain’s New York Business*, <https://www.crainsnewyork.com/health-care/two-city-nursing-homes-sued-inadequate-care-and-staffing>.

“New York Should Improve Its Oversight of Selected Nursing Homes’ Compliance With Federal Requirements for Life Safety and Emergency Preparedness,” USDHHS Office of Inspector General, <https://oig.hhs.gov/oas/reports/region2/21701027.asp>.

“107 New York nursing homes receive lowest fed rating: What to know about staffing, quality,” *Rockland/Westchester Journal News*, <https://www.lohud.com/story/news/health/2019/05/16/107-new-york-nursing-homes-received-lowest-rating-check-local-scores/3682011002/>.

“NY’s Nursing Home Staffing Shortages Raise Concerns About Quality of Care,” *CityLimits.org*, <https://citylimits.org/2019/08/26/nys-nursing-home-staffing-shortages-raise-concerns-about-quality-of-care/>.

**PRESENTED TO:** Public Hearing New York State Department of Health  
**PRESENTED BY:** Debora M. Hayes, Area Director, CWA INVITED SPEAKER  
**RE:** New York State Department of Health Study on Safe Staffing  
**DATE:** October 22, 2019

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Good morning! My name is Debbie Hayes and I am the Upstate New York Area Director for the Communications Workers of America. I represent approximately 15,000 health care workers in New York with a heavy concentration in Western New York. Thank you for giving me the opportunity to testify before this panel on the New York State Department of Health's study on how staffing enhancements and other initiatives can be used to improve patient safety and the quality of healthcare service delivery in hospitals and nursing homes in New York.

While there has been a lot of debate on how to implement safe staffing, I firmly believe that universal state-mandated nurse to patient ratios are essential.

I have been a registered nurse since 1979 and have been representing registered nurses since then. Since 1982 I have bargained 14 collective bargaining agreements for the Buffalo General Medical

Center/Kaleida Health nurses, most of the 25 contracts for the nurses in the Buffalo Catholic Health system's three hospitals where we have members and a number of contracts in the Faxton St. Lukes Healthcare system. Every one of these contracts included its own language on safe staffing. Based on my experience, individualized hospital-by-hospital bargaining on safe staffing language will not work. Likewise, enforcement of agreed to language through a Labor Management Initiative or a joint staffing committee will not work. The definition of insanity is doing the same thing over and over and expecting different results. This approach hasn't worked for the past 40 years. Putting into a place an inequitable, health system by health system standard, would be a complete abdication of the responsibility with which we have been charged by New Yorkers. Patients deserve better.

The Department of Health must recommend a regulatory plan that includes unequivocal language on safe staffing ratios that addresses patient safety and healthcare provider issues. Unsafe staffing can be addressed, injuries can be prevented, and lives can be saved if we do the right thing and adopt a universal standard.

A hospital by hospital solution to the staffing issue is fraught with danger. First, safe staffing is not a local issue. It is a statewide crisis that requires a statewide solution. Second, no hospital will want to be the first one out of the gate. I have heard repeatedly across bargaining tables, “that agreeing to staffing ratios will put us at a competitive disadvantage with our competitors”. Every proposal on nurse patient ratios CWA has made at a bargaining table, has been soundly rejected. Third, the enforcement of staffing language is impossible to negotiate. Employers can and do break collective bargaining agreements on a daily basis, and grievance arbitration decisions can take years. Lastly, cuts to Medicaid, Medicare and other federal programs put tremendous financial pressure on hospitals. One way to offset these cuts is to reduce staff, as health care is a labor intensive industry. While many employers try to avoid cutting direct care givers, it is not always possible to do so.

Here’s an example as to why individualized safe staffing language does not work. In 2016, CWA negotiated what we thought was good language on staffing for the 891 registered nurses at Mercy Hospital of Buffalo. The hospital committed they would work to create better

working conditions for the RNs at the hospital and would collaborate with us on solutions to the staffing challenges. In our contract language, the hospital committed to:

- 1.) Filling vacant positions;
- 2.) Recruitment initiatives, especially for critical care nurses;
- 3.) Retention programs;
- 4.) Enhanced tuition assistance for employee to RN and RN to BSN; and
- 5.) a staffing committee to oversee the process.

Most significantly, the hospital committed to staff to the existing grids and to hire over grid when presented with highly qualified nurses. Furthermore, Mercy agreed to hire above the budgeted grids by adding:

- 1.) 25 FTEs to medical-surgical, telemetry and critical care units;
- 2.) 15 FTEs to the Float Pool;
- 3.) 5 FTEs to the critical care float pool; and
- 4.) 1 RN for every 4 patients in the Emergency Department.

In 2016 and 2017 we made strides in dealing with the staffing issues and the Union believed that we were heading to significantly

improved staffing. By 2018 however, many of the Hospitals old hiring and staffing practices started to resurface. As the Union started to dig deeper into the grids and why the increased staff wasn't making a difference we made a discovery. The Hospital had a number of over-hires on the units that put the total number of employees over the existing budgeted grid. They did not hire any more nurses, they simply added the over-hires to the grids. In addition to that, Mercy's recruitment program deteriorated to the point where they hired only 60 nurses in 2018. Bringing on 60 new nurses in a calendar year did not even begin to touch the turnover of nurses at the Hospital. Today, we have less nurses at Mercy Hospital than we did in 2016 and the work conditions are horrible. The staffing crisis in the critical care unit and the Emergency Department are taking its toll on the patients and nurses. We are at a breaking point.

And, in all of the years I've been doing this work, I've never faced such a significant problem that no one wants to deal with! When my children were in childcare, there were teacher to child ratios set for every age group. When my children were in school, I knew how many teachers

and aides would be in each class room. Yet when my children were sick, I couldn't ever leave them in the hospital alone. Emergency room visits lasted for hours.

Short staffing has been proven by study after study to be associated with death, hospital-acquired bloodstream and urinary tract infection, hospital-acquired pneumonia, cardiac arrest, respiratory failure, falls, unplanned extubations, shock, increased re-admissions, increased length of stay and increased costs of litigation. That's before you even consider the horrible toll that bad staffing has on direct care providers: burnout, injuries, depression and eventually decisions to leave nursing all together.

I am asking you today to listen to those of us who provide the care or who serve as the voices for those providers. Universal state-mandated nurse to patient ratios are the answer.

Thank you.

Public  
Testimony

TESTIMONY OF JEANINE SANTELLI, PhD, RN, AGPCNP-BC, FAAN, I  
DIRECTOR OF THE AMERICAN NURSES ASSOCIATION - NEW YORK,

DEPARTMENT OF HEALTH STAFFING STUDY MEETING TO HEAR TESTIMONY  
RELATED TO STAFFING ENHANCEMENTS IN HOSPITALS AND NURSING HOMES

OCTOBER 22, 2019

Good afternoon. I thank you for this opportunity to submit testimony for this staffing study meeting to inform the Department study that will examine how safe staffing can be used to improve patient safety, and the quality of health care service delivery, in hospitals and nursing homes. My name is Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN, and I am the executive director for the American Nurses Association - New York (ANA-NY). The mission and purpose of ANA-NY is to foster high standards of nursing, promote the professional and educational advancement of nurses, and promote the welfare of nurses to the end that all people may have better health care. To this end, ANA-NY strongly supports safe staffing in New York health care facilities. Appropriate registered professional nurse (RN) staffing makes a critical difference for patients and the quality of their care. Numerous studies bear this out including a study from 2007 entitled Nursing Staffing and Quality of Patient Care that was an evidence-based look at nursing staffing. This study found that increasing RNs within unit staffing eliminated nearly one-fifth of all hospital deaths and reduced the relative risk of adverse patient events, such as infections and bleeding.<sup>1</sup> Hospitals are under pressure to reduce costs while maintaining quality of care and improving outcomes. Since RNs comprise the largest segment of the hospital workforce, and

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<sup>1</sup> Kane RL, Shamliyan T, Mueller C, Duval S, Wilt T. Nursing Staffing and Quality of Patient Care. Evidence Report/Technology Assessment No. 151 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 07-E005. Rockville, MD: Agency for Healthcare Research and Quality. March 2007.



therefore hospital budgets, administrators not only cut resources to support the work of the RN, but often cut RN positions and other members of the team who provide direct patient care or administrators replace an RN with ancillary personnel to save money. ANA-NY knows that cutting nursing staff to save money works against efforts to improve patient care and reduce costs. This is also supported by numerous studies including one from 2011, which showed that increasing the number of RNs can yield a cost saving of nearly \$3 billion, the result of more than four million avoided extra hospital stays for adverse patient events.<sup>2</sup>

Decades of research show that appropriate RN staffing leads to better patient outcomes. Appropriate RN staffing has been associated with a reduction in hospital-acquired conditions, lower readmission rates, shorter lengths of stays and reduced mortality rates. For these reasons, ANA-NY supports efforts to address RN staffing levels in health care settings across New York. We believe that this is best accomplished by creating flexible staffing models that empower direct-care RNs to create flexible and dynamic staffing plans that recognize the essential role RNs play in monitoring patients and managing their clinical care 24 hours a day, seven days a week.

The commonly proposed solution to the safe staffing problem is a defined staffing ratio. Under this solution, an RN-to-patient ratio is established in either statute or regulations. The ANA-NY does not believe defining explicit nurse-to-patient ratios is an effective solution to address unsafe staffing in New York. In fact, there are no studies that provide support for what a safe ratio should be as it relates to quality care. Instead, the studies support increased staffing based on a variety of factors, which ANA-NY thinks are the factors that should be used per facility/unit to

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<sup>2</sup> Needleman J, Buerhaus P, Pankratz VS, Leibson CL, Stevens SR, Harris M. Nurse staffing and inpatient hospital mortality. *N Engl J Med.* 2011;364(11):1037-45.

determine appropriate staffing levels. One size does not fit all. Prescribing the number of patients for whom each RN may care fails to consider the numerous characteristics associated with the patients, the staff, and the facilities. No two hospitals or other health care facilities are the same nor are the units within. Patient needs change continually, so delivery of safe, quality care requires flexibility. Like patients, nurses cannot be reduced to numbers. The number of patients a nurse cares for is not a true measure of the “work” of the nurse. A fixed ratio doesn’t take into account human factors such as a nurse’s years of experience, knowledge, education, or skillset. For example, a first-year RN should not be compared to a seasoned nurse. Additionally, to meet prescribed ratios, hospital administrators have eliminated supportive care team positions, shifting additional responsibilities to the RN; this was witnessed in some facilities when California implemented mandatory ratios. California remains the only state with mandated ratios in hospitals. Tasking RNs with other functions, such as transporting patients off the unit or passing meal trays, limits their ability to focus on the unique functions of their practice: assessment & analysis, provision of and coordination of care, teaching and counseling, monitoring .....and ultimately being the first and last line of defense to protect the patient from harm. A study from 2016 bears this out and shows that hospitals could treat more patients, increase revenue and improve patient satisfaction if they hired more staff working directly with patients.<sup>3</sup> Finally, affixing a ratio in statute or regulation will mean that the prescribed numbers cannot be readily adjusted to accommodate for an ever changing and evolving health care delivery system. ANA-NY strongly supports legislation that empowers direct care nurses to work in conjunction with management to create staffing plans that address the unique patient, staff, and facility characteristics rather than relying on a set ratio that does not take into consideration the unique

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<sup>3</sup> Low staffing levels hold back hospital revenue, patient satisfaction scores January 24, 2016 | By Julie Bird. Published on FierceHealthcare (<http://www.fiercehealthcare.com>)

characteristics of the setting. The legislative model we would support requires each facility to establish an on-going facility-wide committee, composed of at least 55% direct-care RNs, to create and have the authority to implement, nurse staffing plans that are specific to each unit of the hospital or long-term care setting. This legislative approach would also require the public reporting of the staffing plans and tracking of corresponding patient outcomes. This approach is starting to be implemented in large and small hospital settings including at the Veteran's Health Administration, Adirondack Health, and NewYork - Presbyterian. ANA-NY believes this is the approach of the future to determine appropriate staffing levels thereby improving patient care outcomes.

Outcome-based staffing models will require partnerships between nurses and hospital/health system leadership, including those in finance, operations, and clinical areas. Working in a collaborative way to address the RN staffing challenge will ensure that the needs of the patient and RN are met and that direct-care nurses are empowered to create flexible and dynamic staffing models that recognize the essential role RNs play in monitoring patients and managing their clinical care. This collaboration will not only serve to influence quality care but result in a healthy work environment leading to increased retention of RNs.

This approach is based on research and evidence-based practices. The American Nurses Association commissioned a comprehensive evaluation of RN staffing practices as they influence patient outcomes and health care costs. This evaluation included a review of published literature, government reports, and other publicly available sources, complemented by information gathered from a series of panels of nurse researchers, health care thought leaders, and hospital managers.

The resulting white paper, *Optimal Nurse Staffing to Improve Quality of Care and Patient*

*Outcomes*, had the following key findings:

- Best practices consider many variables when determining the appropriate care team on each hospital unit:
  - **Patients:** Ongoing assessment of patients' conditions, their ability to communicate, their emotional or mental states, family dynamics, and the amount of patient turnover (admission and discharges) on the unit
  - **Care teams:** Each registered professional nurse's experience, education, and training; technological support and requirements; and the skill mix of other care team members, including nurse aides, social workers, other direct care staff, and support services, both on and off the unit

Findings point to the importance and cost-effectiveness of RN staffing decisions that are based on evidence rather than traditional formulas and grids. To foster innovation and transparency in staffing models, it is essential to capture and disseminate outcomes-based best practices. I have attached a copy of this white paper to my official testimony today.

We are pleased to be a part of this conversation, and we look forward to having more conversations regarding the critical issue of safe staffing. Our health care system faces immense challenges. Staff shortages brought about by cost-cutting decisions, an aging population, increased patient complexity and need, and an aging workforce places stress on working conditions for nurses and affects patient care and overall outcomes. An increasing body of evidence shows appropriate nurse staffing contributes to improved patient outcomes and greater satisfaction for both patients and staff. Appropriate nurse staffing is essential to both the nursing profession and to the overall health care system. Staffing affects the ability of all nurses to deliver safe, quality care in all practice settings. By eliminating unsafe nurse staffing practices

and policies, we can provide better health care for all.

Thank you for your time and attention today.

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# Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes : Executive Summary

September 2015

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Prepared for the  
American Nurses Association

Prepared by:  
Avalere Health LLC



## ACKNOWLEDGEMENTS

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## EXECUTIVE SUMMARY

### Background and Rationale

Expanding access to healthcare, improving the quality of care, and reducing cost have long been goals for “reform” of the U.S. healthcare system.<sup>1</sup> The Affordable Care Act (ACA), passed in 2010, has implemented new models of healthcare delivery and payment aimed to improve quality and reduce cost. Central to health reform is the emphasis on value-based healthcare. New programs reward or penalize hospitals based on their ability to meet certain quality, outcomes, and cost metrics. As a result, hospitals are exploring many approaches to improve quality and patient outcomes and contain costs.

As nurses comprise the largest clinical subgroup in hospitals, a common reaction to cost-containment pressures is to reduce professional nurse labor hours and their associated costs. This strategy, however, is shortsighted as appropriate nurse staffing levels are essential to optimizing quality of care and patient outcomes in this era of value-based healthcare.

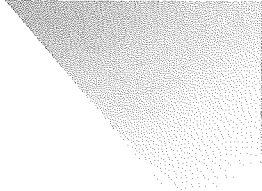
### Methods

In this, the first in a series of papers that makes the case for nursing value, American Nurses Association (ANA) collaborated with Avalere to explore the clinical case for using optimal nurse staffing models to achieve improvements in patient outcomes. Avalere conducted a targeted review of recent published literature, government reports, and other publicly available evaluations of nurse staffing and patient outcomes. Avalere also convened a panel of leading nurse researchers, thought leaders, managers, and those in practice from across the country to provide additional context and to help identify best practices in nurse staffing. While this analysis focused on nurse staffing in acute care hospitals, the principles can be applied to other settings such as post-acute care.

### Key Findings

- Optimal staffing is essential to providing professional nursing value. Existing nurse staffing systems are often antiquated and inflexible. Greater benefit can be derived from staffing models that consider the number of nurses and/or the nurse-to-patient ratios and can be adjusted to account for unit and shift level factors. Factors that influence nurse staffing needs include: patient complexity, acuity, or stability; number of admissions, discharges, and transfers; professional nursing and other staff skill level and expertise; physical space and layout of the nursing unit; and availability of or proximity to technological support or other resources.



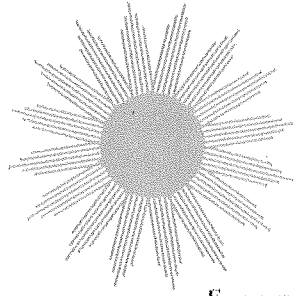
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- Published studies show that appropriate nurse staffing helps achieve clinical and economic improvements in patient care, including:
    - Improvements in patient satisfaction and health-related quality of life
    - Reduction/decrease in:
      - Medical and medication errors
      - Patient mortality, hospital readmissions, and length of stay
      - Number of preventable events such as patient falls, pressure ulcers, central line infections, healthcare-associated infections (HAIs), and other complications related to hospitalizations
      - Patient care costs through avoidance of unplanned readmissions
      - Nurse fatigue, thus promoting nursing safety, nurse retention, and job satisfaction, which all contribute to safer patient care.
  - Organizations such as ANA support state and federal regulation and legislation that allows for flexible nurse staffing plans. In addition to promoting flexible staffing plans, ANA and like-minded constituents support public reporting of staffing data to promote transparency and penalizing institutions that fail to comply with minimal safe staffing standards.
  - Further, ANA has introduced a legislative model in which nurses themselves are empowered to create staffing plans. Optimal staffing is much more than just numbers, and direct care nurses are well equipped to contribute to the development of staffing plans.

To conclude; appropriate nurse staffing is associated with improved patient outcomes. With the increased focus on value-based care, optimal nurse staffing will be essential to delivering high-quality, cost-effective care. Implementation of a legislative model will help set basic staffing standards, and encourage transparency of action through public reporting and imposing penalties on institutions that fail to comply with minimal standards.

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*Note: A glossary of nurse staffing terms is provided in Appendix A.*

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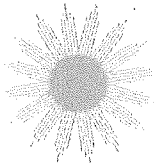
CENTER FOR  
ELDER  
LAW &  
JUSTICE

*Empower Seniors. Change Communities.*

Thank you for the opportunity to provide the Department with testimony regarding the Staffing Study. I am a Supervising Attorney with the Center for Elder Law & Justice. We provide free civil legal services to seniors, people with disabilities, and low-income populations in the 8 Western New York Counties. Our mission is to improve the quality of life for our clients and the communities we serve. Our goal is to protect the essentials of life such as access to quality healthcare and protection from abuse. Sadly, due to inadequate staffing, our most vulnerable community members, are being abused and neglected in our nursing homes.

Our written testimony will provide more details about the horrors of inadequate staffing in WNY, the need for set minimum standards, and proposals aimed to increase the workforce to meet resident needs/standards. Today I wanted to take my 5 minutes to paint you a picture of how short staffing directly impacts nursing home residents, their families, and the staff tasked with providing care. Inadequate staffing is a problem and nursing homes must be held accountable, this means requiring minimum and specific staffing standards.

A WNY Nursing Home, Safire Rehabilitation of Southtowns, LLC (Safire South) has been cited 5 times in a row for insufficient staffing over the past 5 inspections: August 22, 2019, June 5, 2019, July 26, 2018, April 24, 2018, and December 28, 2017. While our written testimony will also highlight other nursing homes, we discuss Safire Rehab here due to its repeat deficiencies for insufficient staffing. This 120 bed facility averages 109 residents per day but only 1.8 total staffing hours per resident per day. This information is from a recent report issued by the Long Term Care



Community Coalition.<sup>1</sup> Safire Rehab's staffing levels are the lowest in Erie County and well below the 2001 study that recommended hours of 4.1 total staffing hours per resident per day.

The lack of staffing directly impacts resident care and safety and we will include literature on related studies in our written testimony. Safire South is an example of the correlation of insufficient staffing to poor quality care. Compared to state-wide averages, this nursing home has 4x the average health citations (75 compared to 19) over a three year period.<sup>2</sup> This nursing home has also been on the CMS Special Focus Facility Candidate List for 36 months.

Safire South has been cited 5 times in a row, for insufficient staffing. The following comes from the Department's publically available Statements of Deficiencies. As you listen, keep in mind I am only referencing sections of the Statements of Deficiencies that pertain to F Tag 725 (Sufficient Staffing):

On December 24, 2017 (complaint), surveyors determined:

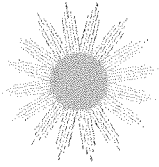
- Residents did not receive medications and treatments as ordered by the physician due to the lack of adequate staffing
- For 40/41 residents reviewed, the facility did not notify the physician that the medications or treatments were not provided.
- For 22/22 residents reviewed, the facility did not provide treatment for skin ulcers and wounds per physician order.

On April 24, 2018 (complaint), surveyors determined:

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<sup>1</sup> Data from LTCCC Staffing Report, accessed 9/18 at <https://nursinghome411.org/nys-nursing-homes-2019/>

<sup>2</sup> Data from NY Health Profiles, [https://profiles.health.ny.gov/nursing\\_home/view/150797#inspections](https://profiles.health.ny.gov/nursing_home/view/150797#inspections)

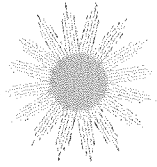


- The facility was not staffed per its own assessment resulting in the delay of an assessment of an acute resident and the subsequent transfer to a higher level of care due to the lack of staffing.
  
- The RN on duty that night told surveyors the following “Everything looked ok but the pulse was elevated. I don’t remember exactly what it was but I do remember it was elevated. I was so busy that day I don’t think I even wrote a note. It’s busy at the change of shift. I was getting staff call-ins, I was trying to figure out staffing and print out Closet Care Plans. When LPN #1 came in (for the day shift) I told him there was a change in condition, he should asses her and send her out. I was so busy that day I didn’t do an assessment of the resident, just got vitals. I didn’t call the MD. I laid it on LPN#1’s hands. If I didn’t have the dual responsibility it would’ve been a different scenario. I would’ve been able to concentrate on that one resident.”
  
- LPN #1, was scheduled as the day shift supervisor, due to major staffing issues, LPN#1 had to work as the Charge Nurse on the Subacute Rehab Unit. The LPN could not recall what time he got to the floor to begin the Charge Nurse duties on the unit, as he was making phone calls attempting to get staff into the building.

The resident was found curled up in a fetal position, moaning, and her pupils fixed. Short staffing resulted in delay for a resident being transported to the hospital.

On July 26, 2018 (annual) surveyors determined:

- The facility did not have sufficient nursing staff to get residents up in the morning.
  
- This impacted a resident who did not want to eat breakfast in his room,



- LPN # 2 stated there was only one CNA for 40 residents when she came in Saturday morning. They did not get another CNA until 8:30am. We couldn't get residents out of bed with that kind of staffing.

The impacted resident is a two person assist. It is hard for a CNA to provide proper care/services when there is only one CNA and a resident is a two person assist.

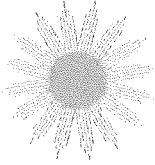
On June 5, 2019 (complaint), surveyors determined:

- The short staff directly impacted a resident who is incontinent of bladder and bowel and is care planned to receive incontinent care every two to four hours; and instructions to "Please check resident frequently for incontinence."
- Review of a nurse's note dated 5/20 stated "unable to do well checks on 5/19/19 due to one aide on unit and no aide this shift 5/20. Only visual. Family in to visit and upset with circumstances."

On August 22, 2019, Safire Rehab, during its annual inspection, was cited for insufficient staffing.

These examples were only from F Tag 725. Throughout the complete Statements of Deficiencies, we see residents who just want to receive decent care and be treated with some humanity. We also see staff trying their best but to no success.

I know the nursing home industry is against minimum staffing standards because they claim it is too costly. I respectfully disagree and will detail so in our written testimony. I ask the Department, and the industry the following: How would you feel if you or a loved one, was forced to lay in your waste for hours? To not be able to eat a meal at a table? Or not be able to participate in skilled therapy (which is needed to return to the community) because you were not provided your pain medications? How

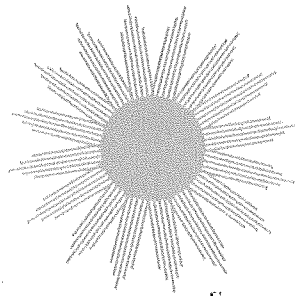


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would you feel if you were the staffer trying to do their best to provide care to their residents?

Our written testimony will offer proposed solutions to address this issue. One such proposal is that nursing homes, who have insufficient staffing levels, cease admitting new residents. People are being harmed because facilities are continuing to admit those they do not have the staff to provide care. We also encourage the Department to assess State fines for citations issued at the Greater Than Minimal Harm Level (D-F) rating, as allowed by Public Health Law and CMS.

Thank you for your time.



# CENTER FOR ELDER LAW & JUSTICE

*Empower Seniors. Change Communities.*

October 18, 2019

*Via Email: [health.sm.StaffingStudy@health.ny.gov](mailto:health.sm.StaffingStudy@health.ny.gov).*

## Testimony: Department of Health Safe Staffing Study

Thank you for the opportunity to submit written testimony for the Department of Health (Department) Safe Staffing Study. The Center for Elder Law & Justice (CELJ) is a non-profit civil legal services agency, providing free legal representation to seniors, people with disabilities and low-income populations in the eight Western New York (WNY) counties. Our mission is to improve the quality of life for our clients and the communities we serve. Our goal is to protect the essentials of life such as access to quality healthcare and protection from abuse.

As stated in our public testimony on September 20, 2019, low staffing and substandard care are problem.<sup>1</sup> Members of our most vulnerable population are being harmed because of insufficient staffing and poor training. Accountability of nursing home providers is lacking and current enforcement efforts are not effective. How many times in a row is the Department going to issue deficiencies before action is taken? It is time that the Department and society answer an important question: are the lives of our most vulnerable worth protecting? Our answer is a resounding yes.

This problem has been around for over a decade.<sup>2</sup> It is time to require providers improve their recruitment and retention efforts by requiring minimum staffing. New York (NY) nursing homes have among the lowest staffing levels of all the US states. For example, based on CMS Payroll Based Journal (PBJ) Quarter 1 data, NY ranks 30<sup>th</sup> for average total care staff hours per resident per day (hprd), and 32<sup>nd</sup> for average RN care staff hprd.<sup>3</sup> NY is also in the minority of states that don't have minimum standards. It is time for that to change.

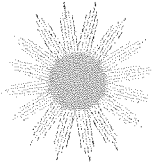
As explained below, CELJ supports the implementation of minimum staffing standards and encourages the Department to recommend such standards in conjunction with effective enforcement measures and workforce development initiatives. While some nursing home operators do a good job recruiting and training staff, all do not. Minimum staffing standards are needed to ensure every NY resident has access to quality and safe care.

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<sup>1</sup> A copy of the September 20 testimony is enclosed.

<sup>2</sup> For example, see: AGMFCU, "Staffing Levels in New York Nursing Homes: Important Information for Making Choices.", January 2006.

<sup>3</sup> LTCCC "Compare Average Staffing Levels for Each State" database, located at <https://nursinghome411.org/nursing-home-staffing-2019-q1/>. Data used by LTCCC is directly from the CMS PBJ databases



CELJ Supports Minimum Staffing Standards

We encourage the Department to support the minimum staffing standards as outlined in A02954 Safe Staffing for Quality Care Act.

We support the minimum staffing levels as stated in A02954 Safe Staffing for Quality Care Act that would require the minimum of:

- 2.8 hours of care per resident per day by a certified nurse aide;
- 1.3 hours of care per resident per day by a licensed practical nurse or registered nurse;
- 0.75 hours of care per resident per day by a registered nurse<sup>4</sup>.

Numerous studies and reports have demonstrated the need for minimum staffing standards in our nursing homes:

*Department of Health & Human Services Report*

The comprehensive congressionally mandated study found that there are critical staffing thresholds in nursing homes, and below these thresholds, the quality of care delivered to nursing home residents can be compromised.<sup>5</sup> Specifically, the study determined the following thresholds were necessary to maximize quality outcomes and that quality is improved up to and including these thresholds:

- CNAs: 2.4 (short stay)-2.8 (long stay)
- Licensed Nurses: 1.15 (short stay)-1.30 (long stay)
- RNs: 0.55 (short stay)-0.75 (long stay)

Keeping in mind that this study is from 2001. Resident acuity since then has increased, and as a result, the long stay thresholds, in our opinion, are more appropriate for short stay residents.<sup>6</sup> The report also recommended a daily minimum standard of 4.1 hours of total nursing time (RN, LPN, CNA) per resident.

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<sup>4</sup> CELJ would support this being increased to 1 hprd.

<sup>5</sup> CMS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I*, Vol. I (Winter

2001), [http://phinational.org/sites/phinational.org/files/clearinghouse/Phase\\_I\\_VOL\\_I.pdf](http://phinational.org/sites/phinational.org/files/clearinghouse/Phase_I_VOL_I.pdf); Vol

II, <http://phinational.org/legislation-regulations/report-congress-appropriateness-minimum-nurse-staffing-ratios-nursing-home-1>; Vol.

III, [http://phinational.org/sites/phinational.org/files/clearinghouse/Phase\\_I\\_VOL\\_III.pdf](http://phinational.org/sites/phinational.org/files/clearinghouse/Phase_I_VOL_III.pdf). CMS, *Report to*

*Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II*, Vol. I (March

2002), <http://phinational.org/sites/phinational.org/files/clearinghouse/PhaseIIVolumeIofIII.pdf>; Vol.

II, <http://phinational.org/sites/phinational.org/files/clearinghouse/PhaseIIVolumeIIofIII.pdf>; Vol.

III, <http://phinational.org/sites/phinational.org/files/clearinghouse/PhaseIIVolumeIIIofIII.pdf>.

<sup>6</sup> See Medicare Payment Advisory Commission (MedPac) Report to Congress: Medicare Payment Policy: Skilled Nursing Facility Services, Chapter 8. Washington, DC: MedPac; 2015. pp. 181–209.





*Charlene Harrington et.al: The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*<sup>7</sup>

This commentary focused on two issues: need for higher minimum staffing standards in U.S. nursing homes, and the barriers to staffing reforms. The authors documented that over 150 staffing studies have been done on this issue, and that the strongest positive relationships are found between RNs and quality. It is also documented that total nurse staffing is related to quality. We encourage the Department to review this commentary and the studies it cites.

*Long Term Care Community Coalition: 2019 Assessment of NYS Nursing Home Staffing & Quality*<sup>8</sup>

Most recently, the Long Term Care Community Coalition (LTCCC) conducted an assessment of NYS nursing homes, staffing and quality, and issued two reports:

- (1) An Assessment of the Impact of Low Staffing Levels on Quality of Nursing Home Care in New York;<sup>9</sup> and
- (2) Patients vs. Profits: An Assessment of the Impact of For-Profit Ownership on Nursing Home Staffing and Safety in New York.<sup>10</sup>

The first report concluded the following:

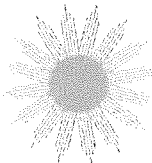
- There is a strong correlation between total staffing hours and health inspection results, which implies higher staffing equates to higher quality of care.
  - The majority nursing homes that provided between 2-6 hours of total care staff per resident per day, as staffing rates increased the pressure ulcer rate decreased.
    - The rate of decrease was higher for 4-6 hours.
    - Staffing at 4 hprd or higher significantly reduces pressure ulcer rates.

<sup>7</sup> Harrington C, Schnelle JF, McGregor M, Simmons SF. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Serv Insights*. 2016;9:13–19. Published 2016 Apr 12. doi:10.4137/HSI.S38994

<sup>8</sup> See <https://nursinghome411.org/nys-nursing-homes-2019/>

<sup>9</sup> Mollot R., Valanejad D., Whang S., *An Assessment of the Impact of Low Staffing Levels on Quality of Nursing Home Care in New York*. 2019. Accessed at <https://nursinghome411.org/wp-content/uploads/2019/06/LTCCC-Policy-Brief-NY-State-Nursing-Home-Staffing-Quality-2019.pdf>

<sup>10</sup> Mollot R., Valanejad D., Whang S., *Patients vs. Profits: An Assessment of the Impact of For-Profit Ownership on Nursing Home Staffing and Safety in New York*. Accessed at: <https://nursinghome411.org/wp-content/uploads/2019/06/LTCCC-Policy-Brief-NYS-Nursing-Home-Ownership-Quality.pdf>



- For the majority of nursing homes that provided between 2-6 hours of total care staff per resident per day, as staffing rates increased, use of antipsychotic drugs decreased.
- As total staffing hours increased, the number of substantiated complaints decreased.

In addition, the LTCCC report found that there was a strong positive relationship between average RN hprd and health inspection ratings.

The second report concluded the following:

- For-profit nursing homes have 20% lower total care staffing hours per resident per day than government/non-profit facilities.
- Government/non-profit nursing homes provide on average close to twice as much RN care staffing as for-profit facilities.

Proper staffing is a key component to quality of care and life for nursing home residents (both short and long term care). NY nursing homes are among the lowest staffed in the U.S. The implications from the data are clear: for-profit nursing homes staff at lower levels compared to government/non-profits, and safety and care are more likely to be lower in for-profits as well.<sup>11</sup>

As will be discussed in the WNY section below, LTCCC's conclusions, and those of nation-wide studies remain true: poor staffing levels correlate to poor quality of care.

#### Response to Operator Concerns about Cost

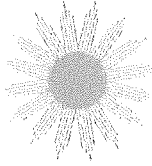
In the absence of any limits on nursing home profits, minimum staffing requirements are needed to ensure that billions of tax-payer dollars spent on care in NY is used wisely and appropriately. While industry organizations claim that minimum staffing standards are too costly, we disagree. As discussed below, nursing home operators as a whole, are making money, and minimum staffing will reduce occurrences of harm and consequences of poor care.

As seen in multiple news reports, the nursing home industry is becoming increasingly corporatized and sophisticated about diverting funds meant to support resident care. For example, the New York Times reported on a nursing home where the facility:

appeared to have been severely underfunded...with a \$2million deficit on its books and a scarcity of nurses and aides... Yet, that same year, \$2.8 million of the facility's \$12 million in operating expenses went to a constellation of corporations controlled by two Long Island accountants who, court records show, owned [the facility] and 32 other nursing homes. The homes paid the men's other companies to provide

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<sup>11</sup> See also Comondore VR, Deveraux PJ, Hou Q, et al. Quality of care in for-profit and not-for profit nursing homes: systematic review and meta-analysis. *BMJ*. 2009;339:b2732.



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physical therapy, management, drugs and other services, from which the owners reaped profits.<sup>12</sup>

This issue is not unique to one operator. In addition, if operators are not making money, why are they purchasing new nursing homes? As detailed in our Emerald South report,<sup>13</sup> standalone not-for profits are selling to for-profit entities. Most recently, Absolut Care Facilities Management sold four of its nursing homes to Personal Healthcare LLC for \$20.15 million.<sup>14</sup>

In addition, some of the for-profit operators who are coming into WNY have been public about cutting staffing while implementing a business plan to accept higher needs residents.<sup>15</sup>

We understand that operators need to bring in money in order to remain open. However, operators have a legal obligation to ensure their facilities are properly staffed and that staff are properly trained to ensure every resident receives the care and services needed to attain or maintain the resident's highest physical, mental, and psychosocial well-being. Operators, such as those identified in our Emerald South report, should not be enabled to continue to cut costs at resident expense.

If operators need additional funding in order to provide safe and effective care, we encourage them to prove it. While the financial records of not-for-profits are public, private, for-profit nursing home operators are allowed to keep their business records and dealings private. CELJ's call to the nursing home operators in NY (and the Department) is simple: prove it. Demonstrate to the public that in order to provide safe and quality of care, the nursing home goes into the 'red.' Since more for-profit nursing home operators also own related businesses, show the public the contracts and what funds are going back to the operator and family/business associates.

*Minimum Staffing Standards will Save Lives and Money*

The HHS Office of the Inspector General (OIG) reported that an estimated 22% of Medicare beneficiaries experienced adverse events, and an additional 11% of Medicare beneficiaries experienced temporary harm events during their skilled nursing facility stays.<sup>16</sup> Physician review determined 59% of the adverse events and temporary harm were clearly or likely preventable. The physician's attributed much of the preventable harm to substandard treatment, inadequate resident

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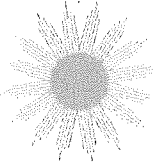
<sup>12</sup> Jordan Rau, "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs", The New York Times, Jan. 2, 2018, last accessed Oct. 11, 2019. <https://khn.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/vhttps://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html>

<sup>13</sup> Emerald South Report may be Accessed at: <https://elderjusticenyc.org/emerald-south-profile-of-a-nursing-home/>

<sup>14</sup> Jonathan Epstein, "Absolut Care Sells Four Area Nursing Homes", The Buffalo News, last accessed October 11, 2019. <https://buffalonews.com/2018/04/27/absolut-care-sells-four-area-nursing-homes/>

<sup>15</sup> See State Public Health and Health Planning Council CON Project #131156-E

<sup>16</sup> OIG Reports <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>



monitoring, and failure or delay of necessary care.<sup>17</sup> This preventable harm, in CELJ's opinion, can be tied to insufficient staffing.<sup>18</sup> The OIG also determined that over half of the residents who experienced harm went to the hospital for treatment, which cost Medicare an estimated \$208 million in August 2011. It is estimated that \$2.8 billion was spent on hospital treatment for harm caused in skilled nursing facilities in FY 2011.

In addition, a recent study indicates that there is evidence of a positive relationship between quality and financial performance.<sup>19</sup> As many studies have demonstrated, there is a positive correlation between staffing and quality of care. For example O'Neil et al. examined the relationship between profit levels and quality and found that nursing homes with the highest profit margins were found to have the poorest quality.<sup>20</sup>

We request that the Department look at the unmeasured savings that are associated with proper staffing. For example, evaluate the savings in reductions in antipsychotic drug use and reduction in pressure ulcers.

#### *Antipsychotic drug use*

In addition to the FDA black box warning against the use of antipsychotics in adults with dementia, the American Geriatric Society conducted a study that determined that antipsychotic medications should be avoided for older people, except in the extremely rare circumstance. The study cited there was "increasing evidence of harm associated with antipsychotics and conflicting evidence on their effectiveness in delirium and dementia,"<sup>21</sup> Inappropriate use of antipsychotic medications

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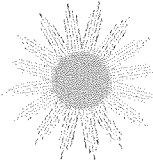
<sup>17</sup> *Id.*

<sup>18</sup> Harrington C, Schnelle JF, McGregor M, Simmons SF. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Serv Insights*. 2016;9:13–19. Published 2016 Apr 12. doi:10.4137/HSI.S38994

<sup>19</sup> Weech-Maldonado, Robert et al. "Nursing Home Quality and Financial Performance: Is There a Business Case for Quality?." *Inquiry : a journal of medical care organization, provision and financing* vol. 56 (2019): 46958018825191. doi:10.1177/0046958018825191

<sup>20</sup> O'Neill, C., Harrington, C., Kitchener, M., & Saliba, D. (2003). Quality of Care in Nursing Homes: An Analysis of Relationships among Profit, Quality, and Ownership. *Medical Care*, 41(12), 1318-1330. Retrieved from <http://www.jstor.org/stable/3768307>

<sup>21</sup> The American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults," *Journal of the American Geriatrics Society*, Vol. 63, No. 11, page 2233, Table 2 (Nov. 2015), <http://onlinelibrary.wiley.com/doi/10.1111/jgs.13702/pdf>



is also associated with increased risk for falls and fractures,<sup>22</sup> acute kidney injury,<sup>23</sup> and hospitalization,<sup>24</sup> and death.<sup>25</sup>

Antipsychotics, in our opinion, are a restraint, and are used to control residents when the nursing home does not have the proper staff needed to provide direct care to residents. While this is not always the case, it happens far too often.<sup>26</sup>

### *Pressure Ulcers*

Pressure ulcers are one of the most important measures of quality according to the CDC.<sup>27</sup> Pressure ulcers are for the most part avoidable and research has shown that in the majority of cases pressure ulcers can be prevented.<sup>28</sup> If this is the case, then why is NY in the bottom 10 of the country?

We urge the Department to recommend minimum staffing levels in nursing homes to the level indicated in the HHS Study. At that point, nursing homes can staff based on resident needs and work on measures that improve care and financial benefits.

Money is saved when people are not harmed.

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<sup>22</sup> Lisa-Ann Fraser, Kuan Liu, Kyla L. Naylor, Y. Joseph Hwang, Stephanie N. Dixon, Salimah Z. Shariff, Amit X. Garg, "Falls and Fractures With Atypical Antipsychotic Medication Use: A Population-Based Cohort Study," *JAMA Intern Med.* 2015;175(3):450-452, <http://archinte.jamanetwork.com/article.aspx?articleid=2089230>.

<sup>23</sup> Y. Joseph Hwang, Stephanie N. Dixon, Jeffrey P. Reiss, Ron Wald, Chirag R. Parikh, Sonja Gandhi, Salimah Z. Shariff, Neesh Pannu, Danielle M. Nash, Faisal Rehman, Amit X. Garg, "Atypical Antipsychotic Drugs and the Risk for Acute Kidney Injury and Other Adverse Outcomes in Older Adults: A Population-Based Cohort Study," *Ann Intern Med.* 2014; 161(4):242-248, <http://archinte.jamanetwork.com/article.aspx?articleid=2089230>; <http://annals.org/article.aspx?articleid=1897100>.

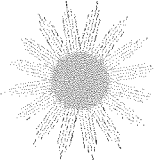
<sup>24</sup> Rajender R. Aparasu, Satabdi Chatterjee, Hua Chen, "Risk of Hospitalization and Use of First- Versus Second-Generation Antipsychotics Among Nursing Home Residents," *Psychiatric Services*, Vol. 65, Issue No. 6, 781-788 (June 2014), <http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201300093>

<sup>25</sup> Donovan T. Maust, Hyungjin Myra Kim, Lisa S. Seyfried, Claire Chiang, Janet Kavanagh, Lori S. Schneider, Helen C. Kales, "Antipsychotics, Other Psychotropics, and the Risk of Death in Patients With Dementia; Number Needed to Harm," *JAMA Psychiatry.* 2015; 72(5): 438-445, <http://archpsyc.jamanetwork.com/article.aspx?articleid=2203833>.

<sup>26</sup> See Kay Lazar and Matt Carroll, "A rampant prescription, a hidden peril," *Boston Globe* (April 29, 2012), [http://archive.boston.com/news/local/massachusetts/articles/2012/04/29/nursing\\_home\\_residents\\_with\\_dementia\\_often\\_given\\_antipsychotics\\_despite\\_health\\_warnings/?page=full](http://archive.boston.com/news/local/massachusetts/articles/2012/04/29/nursing_home_residents_with_dementia_often_given_antipsychotics_despite_health_warnings/?page=full).

<sup>27</sup> NCHS Data Brief, No. 14 (February 2009), which incorporates Pressure Ulcers Among Nursing Home Residents: United States, 2004. Available at [www.cdc.gov/nchs/data/databriefs/db14.pdf](http://www.cdc.gov/nchs/data/databriefs/db14.pdf) (PDF).

<sup>28</sup> Edsberg, L.; Langemo, D.; Baharestani, M.; Posthauer, M.; and Goldberg, M., "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313-334. Abstract accessed in February 2017 at [http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable\\_Pressure\\_Injury\\_State\\_of\\_the\\_Science.6.aspx](http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science.6.aspx). Henceforth Unavoidable Pressure Injury.



Need for Minimum Staffing Standards in WNY

Using information from CMS Nursing Home Compare Provider dataset, WNY’s 8 counties have 44 for-profit; 5 government, and 21 non-profit operated nursing homes.<sup>29</sup> While the ownership types (i.e. for-profit, government, and non-profit) all have a range of quality characteristics, the available data shows that for-profits, as a whole, provide lower overall quality of care. We see this using the health inspection data:<sup>30</sup>

	Avg Health Raw Score <sup>31</sup> (Median Score)	# deficiencies	Range Health Raw Score	Avg Total Staffing CMS Score (Range);(Median)	Overall Rating (Range);(Median)
WNY	26.89 (16)	5.2	0-138	2.73 (1-5);(3)	3.13 (1-5); (3)
For-Profit	30.36 (28)	6.0	0-138	2.51 (1-5); (2)	2.8 (1-5);(2)
Government	18.4 (16)	3.4	0-36	3.2 (2-4); (3)	3.4 (1-5); (4)
Not-for-Profit	21.48 (16)	3.8	4-87	3.1 (1-4); (3)	3.8 (1-5); (4)

Overall, the for-profit operated nursing homes performed worse on the Department’s inspections, and fall below the WNY average for staffing. This echoes the conclusion drawn by LTCCC’s recent reports. (Deficiencies stem from violations of the minimum federal requirements of participation. The higher the raw health score means the worse the facility(ies) did on inspection.)

Only 7 out of 71 WNY nursing homes met the expectations of study that each resident receives 0.75 hprd of RN care, in 2019 Quarter 1. 13 out of 71 WNY nursing homes had less than 0.25 hprd of RN care, in 2019 Quarter 1. 11 out of 71 WNY nursing homes met the expectation that each resident receives at least 4.1 hprd of total staffing care. 11 out of 71 WNY nursing homes had less than 3.0 hprd of total staffing care.<sup>32</sup>

WNY RN Staffing and Quality

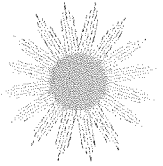
WNY Nursing Homes	Antipsychotic Medication Average	Antipsychotic Medication WNY	Pressure Ulcers	Pressure Ulcer WNY
>0.75 RN	9.57%	12.42%	5.61%	6.8%
<0.25 RN	13.51%	12.42%	8.28%	6.8%

<sup>29</sup> <https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py> Last accessed October 12, 2019

<sup>30</sup> Insert brief discussion why health inspection #s are used and not quality measures.

<sup>31</sup> The higher the health inspection raw score= the worse the facility did on inspection.

<sup>32</sup> Data from <https://nursinghome411.org/nys-nursing-homes-2019/> using CMS NHC.



WNY Total Staff and Quality

WNY Nursing Homes	Antipsychotic Medication Average	Antipsychotic Medication WNY Average	Pressure Ulcers Average	Pressure Ulcer WNY Average
>4.1 Total Staff	13.13%	12.42%	7.39%	6.8%
<3.0 Total Staff	15.07%	12.42%	8.55%	6.8%

When operators cut costs by reducing staff, residents suffer. This is seen not only when nursing staff are cut, or resources are not being effectively implemented into a facility, outlined in our September 20 2019 testimony. But also includes other staff such as dietary and housekeeping.<sup>33</sup>

*Every Person in NY should have Access to Quality Care*

The Buffalo News reported that NY’s “top nursing homes admit poor people at a lower rate than the state’s worst nursing homes.”<sup>34</sup> In addition, the Buffalo News reported at CMS Nursing Home Compare 1-star rated nursing homes, 14% of residents were Medicaid admissions, compared to 7% at 5-star rated nursing homes. Studies have shown that staffing disparities exist in nursing homes with high concentrations of minority residents.<sup>35</sup> Every resident in WNY (and the country) should have equal access to quality of care. However it is not happening.

Recommendations

In addition to implementing minimum staffing standards, we offer the following recommendations:

1. Increase the Department’s ability to properly enforce the minimum requirements of participation.

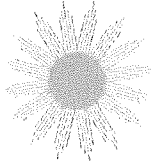
As detailed in our September 20, 2019 testimony, Safire South has been cited 5 times in a row for insufficient nursing staff. The most recent was on August 22, 2019, whereby the survey team determined “the facility did not meet minimum levels on 21 of 51 shifts.” As a result of the insufficient staffing, residents were not getting their medications on time (for example one resident didn’t get her morning medications until after 2pm) or being served their meals. An interviewed resident stated “the staff don’t get me [out of bed] because I need two people to get [out of bed], there is not enough staff and it happens often.”<sup>36</sup>

<sup>33</sup> For example, see *Salamanca Rehab STD SOD Aug 2, 2019, Event ID DCUO11*: “During an interview...the Diet Technician stated there used to be one cook and three to four dietary aids to prepare meals, but the staffing has been cut to one cook and two dietary aids...”

<sup>34</sup> <https://buffalonews.com/2019/07/14/new-yorks-top-nursing-homes-less-likely-to-admit-poor-than-worst-homes-data-shows/>

<sup>35</sup> See Mor V, Zinn J, Angelelli J, Teno JM, Miller SC. Driven to tiers: socio-economic and racial disparities in the quality of nursing home care. *Milbank Q.* 2004; 82 (2): 227-56.

<sup>36</sup> Safire Southtowns STD DOD August 22, 2019, Event ID 96KL11.



At what point does the Department (and CMS) say enough is enough? Plans of Correction are not working. The Department (and CMS) should use its full powers of enforcement. This includes assessing state fines for citations issued at the Greater than Minimal Harm Level (D-F) Rating.<sup>37</sup>

CELJ also supports legislation that would prohibit nursing homes from admitting new residents when they are understaffed. This would follow policy that has long been in place for hospital emergency rooms. If a nursing home does not have the staff or resources to provide care to its residents, why are they allowed to continue to admit residents?

2. Nursing Home industry must be creative and partner with the Department and Educational Institutions to address nursing home staff recruitment and retention, and improve every nursing home's access to technology.

There are many components to workforce development: recruitment and hiring, orientation, training (initial and ongoing), mentoring, and effective leadership and culture within a nursing home. Some nursing homes are making great headway regarding workforce development. However, others are not. For example, Safire Rehabilitation of the Southtowns, which has been cited for insufficient staffing 5 times in a row. The August 22, 2019 survey details the stresses on both resident and staff due to low staffing and staff turnover. Staff turnover is a major issue in nursing homes, and studies have found that facilities with higher staff turnover have worse quality.<sup>38</sup>

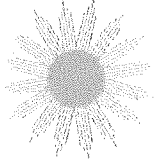
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<sup>37</sup> It should be noted that deficiencies for insufficient staffing are rare, and should be cited more frequently. For example, Salamanca Rehabilitation & Nursing Center, on August 2, 2019, August 2, 2019, ( SOD Event ID DCUO11) was cited under F 684 Quality of Care when a transcription error resulted in a resident with chronic kidney disease, received the wrong dose of a diuretic-medication for a month. The resident was hospitalized and died. While there were many breakdowns by staff and the physician, nursing staff were not monitoring the resident nor did they relay information to the physician accurately. While we do not know the questions the surveyor asked, we would want to know why the nurse did not monitor the resident or properly transcribe the orders. Was she/he rushed? Were they short staffed? We also question why this deficiency was not cited at harm when the resident died.

In addition, *See* Comprehensive Rehab & Nursing Ctr at Williamsville, SOD July 22, 2019 Event ID LP1511: where there was lack of supervision of 4 residents who were at risk for wandering. One resident, who was assessed as high risk, eloped undetected by staff from the building through a window. The SOD details that the window was "wide open, the screen was damaged and the stoppers were broken and damage." A high risk resident eloped. We question whether there were 'sufficient' staffing available to monitor him and others.

<sup>38</sup> *See* Thomas KS, Mor V, Tyler DA, Hyer K. The relationships among licensed nurse turnover, retention, and rehospitalization of nursing home residents. *The Gerontologist*. Apr 2013;53(2):211-221. *See also* Lerner NB, Johantgen M, Trinkoff AM, Storr CL, Han K. Are nursing home survey deficiencies higher in facilities with greater staff turnover. *Journal of the American Medical Directors Association*. Feb 2014;15(2):102-107





Nursing home operators choose to participate in Medicare and Medicaid. With this comes the legal obligation to ensure every resident that is admitted is provided with safe and proper care. This begins with ensuring the facility is properly staffed and staff are well trained. We understand that the current environment is challenging on operators. However, such challenges should not be passed onto residents.

We encourage the Department (and NYS) to continue its workforce investment program and expand it to the current workforce in order ensure every person who works in long term care has access to current trainings and opportunities for advancement. We encourage investments to: expand access to training programs in rural areas, scholarships for part-time students in nursing and aide programs, and other initiatives that will promote workforce development.

In addition, the process of certifying and recertifying CNAs and home health aides (HHAs) needs to be streamlined. For example, why does a CNA, in order to become a HHA, have to take a 75-hour HHA training course? Many of the skills needed to become a HHA are learned in order for an individual to become a CNA. In addition, while CNAs who have at least one year of hospital experience are eligible to take a competency exam instead of undergoing the training course, it is our understanding this is not afforded to CNAs who work in nursing homes.

In addition to improving the workforce, we encourage the Department and nursing home operators to explore and invest in technology that would improve communications between nursing staff, physicians, and residents, and also resident care.

In closing, we urge the Department to seriously consider recommending minimum staffing levels in NY nursing homes. Minimum staffing standards are an essential component to ensure every resident has access to safe, effective quality care. The minimum standards of 2.8 hprd CNA, 1.3 hprd LPN, and 0.75 hprd are the baseline requirements that are necessary to ensure every resident has access to safe care. Nursing homes can then staff above those levels based on resident acuity.

We look forward to working with the Department to improve the quality of care in our nursing homes. Every member of the community has the right to access quality and safe care in nursing homes.



## **Communications Workers of America Local 1126**

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My name is Dave Dunn, I am a resource radio operator at Mohawk Valley Healthcare Systems, in Utica NY. My job is to take reports from EMS Units(Ambulances). Frequently when we have ambulances coming into the Emergency Department there is a 30-60 minute wait because of short staffing. Often short staffing situations result in overburdening the charge nurse who has the responsibility of distributing the patients as evenly as possible. When a paid ambulance company has an ambulance out of service due to hospital delays it costs not only the ambulance company monetarily but the communities they serve in literally lives. The loss of a volunteer ambulance in a community is often way more devastating because it is often the only ambulance serving smaller communities and will only cost lives. The result is not only loss of life but increased wait times at emergency scenes often leaving patients in pain longer than they should be. The fact that a hospital is short staffed does not only affect the hospital and the patient, it has a far reaching effect on the whole community. Safe Staffing is not just a hospital problem, a healthcare problem, they are a community health problem and I implore the Department of health to implement safe staffing ratios for the betterment of the community as a whole.



## **Communications Workers of America Local 1126**

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My name is Raymond Vatalaro. Several years ago Faxton-St. Lukes healthcare, in Utica NY enacted a new policy called "no pass zone". This policy requires every staff member, regardless of their background to enter a patient room, where the patient is calling for assistance and assist the patient.

There is simply not enough healthcare workers to properly care for the patients. This policy is an unsafe attempt by the Mohawk Valley Healthcare System to fill the vacancies in the nursing staff, with unqualified employees. I have recently retired from the Faxton-St. Lukes campus as an Electrician, and I was required to assist patients under this new policy.

I have never seen a nurse manager follow this policy. You never see hospital administrators touring the patient care areas, if they did the administrators would be forced to follow their own policy. The administrators are only seen heading to the cafeteria for lunch.

I and so many other employees are not trained in patient care. I do not want to do something that could harm a patient. I would not know if they are on a restricted diet, being untrained in patient care i am unaware of the particular requirements or needs of any given patient. What do i do if i find a patient who has fallen out of bed, or needs medication, or worse not breathing. What if like the patient I am unable to locate a nurse because they are understaffed. This is a real fear for the ancillary staff of our campus.

We all need statewide safe staffing ratios in order to ensure our families and friends are safe and have qualified people caring for them, not an electrician, housekeeper, etc.

Respectfully,

Raymond Vatalaro



Memorial Sloan Kettering  
Cancer Center

October 21, 2019

Staffing Enhancements in Hospitals and Nursing Homes:  
New York State Department of Health Stakeholder Engagement Session

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Memorial Sloan Kettering Cancer Center (MSK) appreciates the opportunity to offer stakeholder feedback on how staffing enhancements and other initiatives can improve patient safety and health care quality, as well as to provide input on the associated fiscal implications. As the New York State Department of Health (DOH) studies this issue, we urge you to identify and consider how to promote staffing models that have contributed to demonstrated excellence in nursing, exceptional patient outcomes, and value-based care.

Promoting quality care through a professional practice model:

As the world's oldest and largest private cancer center, MSK is devoted to exceptional patient care, innovative research, and outstanding educational programs. Today, we are one of 50 National Cancer Institute–designated Comprehensive Cancer Centers, where state-of-the-art science flourishes side by side with clinical studies and treatment. MSK has ranked as one of the top two hospitals for cancer care in the country for more than 25 years running, and our patients have been shown to have a significant survival advantage across all major cancer types when compared with patients treated at other types of facilities.<sup>1</sup> Given our strong performance across a range of quality indicators, including Magnet<sup>®</sup> recognition granted by the American Nurses Credentialing Center (ANCC), we believe that the principles that guide our approach to the delivery of patient care can inform the DOH's study of how staffing enhancements can improve quality and patient safety.

One of the key tenets of our approach to health care delivery is an emphasis on multidisciplinary patient care, which includes the delivery of nursing care in a relationship-based professional practice model. Each patient care team at MSK is led by a physician and may include a range of provider types, including nurses, nursing assistants, patient care techs, physical therapists, genetic counselors, social workers, psychologists,

nutritionists, and others – many of whom specialize in treating a particular type of cancer. Our team members meet regularly to discuss patients' diagnostic and treatment information, meaning that each patient benefits from a wide range of expertise in their specific cancer.

The more than 4,000 highly skilled oncology nurses at MSK play an especially important role on these multidisciplinary care teams. As part of our professional practice model for relationship-based nursing care, MSK nurses collaborate with physicians and other members of the team to develop a treatment plan, and they provide a range of services – from administering therapies and monitoring for side effects to providing patient education and emotional support. Importantly, this professional practice model empowers nurses to make decisions about the nursing care a patient will receive and how it will be delivered. Our nurses work at the top of their license. The nurse/patient relationship is central to our professional practice model and drives team communication, management of the work environment, and work allocation – including staffing plans on hospital inpatient units.

More specifically, front-line nurse managers and direct care staff share responsibility for developing nurse staffing plans at MSK. These plans are based on projected patient volume and acuity, mode of patient care delivery, technology integration, and physical environment. Staffing is evaluated on a shift-by-shift basis with input from front-line staff and according to changing patient needs. The adequacy of staffing plans is also evaluated using data on nursing sensitive indicators; patient and staff satisfaction indicators; and outcomes reflecting the principles of relationship-based care. Unlike the rigid numerical staffing ratios that are often touted by safe staffing advocates, this flexible and responsive approach to nurse staffing decisions enables our multidisciplinary care model by appropriately accounting for the roles and contributions of other members of the care team, e.g., nursing assistants, patient care techs, social workers, and others.

This approach to nurse staffing also permits nurses at MSK to develop specialized skills and to contribute to organizational governance. For example, our nursing IV team oversees vascular access and venipuncture across inpatient units rather than being assigned to a specific nursing unit. We have similarly highly skilled chemotherapy and wound and ostomy nursing teams, as well as many specialized clinical trials nurses who enhance our patients' informed participation in clinical trials and support safety through the monitoring of protocol adherence. Nurses at MSK participate in organizational leadership, professional development, and nursing research. They significantly influence new program development and the establishment of organizational policies, procedures

and standards at MSK. Finally, they are also afforded numerous opportunities to take part in continuing education, staff development, and in-service training.

MSK's receipt of Magnet<sup>®</sup> recognition from the ANCC - the nation's highest honor for excellence in nursing – speaks to the quality of our nursing practice. Only about seven percent of hospitals nationally have achieved Magnet<sup>®</sup> recognition. Magnet facilities are expected to develop knowledge, innovation, and expertise to advance the delivery of nursing care globally. The program emphasizes the importance of transformational leadership; structural empowerment; exemplary professional practice; new knowledge innovation and improvements; and empirical quality results. These principles are evidenced in the Magnet program's evaluation of nurse staffing assignments at hospitals under consideration for Magnet recognition. The program standards assess whether clinical nurses collaborate with nursing leadership to address unit-level staffing needs using data analysis and evaluation, for example. The program also emphasizes outcomes, such as whether the care delivery system is designed to meet evidence-based care standards, national patient safety goals, affordable and value-based outcomes, and regulatory requirements.

#### Nurse-staffing ratios:

In contrast to the professional practice model of nursing described above, rigid nurse-staffing ratios fail to recognize the complex and fluid nature of patient care. Patient acuity can and does fluctuate substantially, and nurse-staffing ratios disempower nursing staff by removing their ability to tailor resources to patient care needs. Nurse-staffing ratios also ignore the contributions of other members of the health care team, e.g., nursing assistants, patient care techs, physical therapists, and social workers. These providers can decrease the demands on nursing, while ensuring the efficient delivery of care. Imposing nurse-staffing ratios, then, carries a significant risk of increasing the total cost of inpatient care without offering compelling evidence of improved patient outcomes.<sup>11</sup> This is contrary to promoting value-based care – an increasingly critical goal for hospitals and the health care system as a whole.

Nurse staffing ratios would also promote an inefficient distribution of nurses in the health care system. Skilled nurses are in limited supply, and they should be deployed in a manner that takes full advantage of their knowledge and training. At MSK we anticipate that we would have to reassign nurses from the outpatient setting to the inpatient setting to meet the ratios that have been proposed in legislation. As patient care, particularly for cancer care, has shifted in large part to the outpatient setting, this would make it difficult for MSK

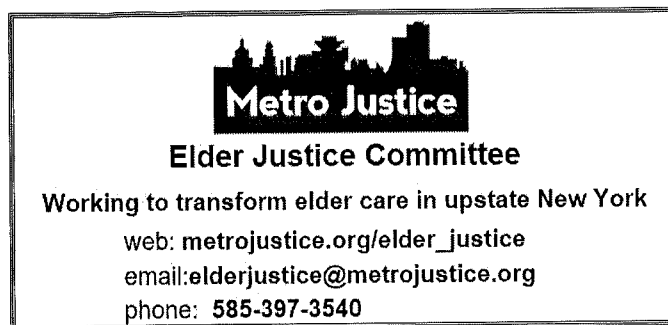
to adequately staff our hospital outpatient sites. More broadly, a redistribution of nurses from the outpatient setting to the inpatient setting would undermine the ability of nurses to promote wellness – a fundamental goal of nursing care. Nurses not only educate, they advocate for their patients to ensure their active and informed participation in their care, and they help patients to navigate an increasingly complex and fragmented delivery system. A shortage of nurses in the outpatient setting would make the goals of improving health outcomes and achieving efficiencies through value-based care far more difficult to achieve.

In reporting on how staffing enhancements and other initiatives can improve patient safety and health care quality, as well as the associated fiscal implications, MSK urges the DOH to reject rigid numerical nurse-staffing ratios. This approach would disempower nursing staff by removing their ability to use professional judgement about patient acuity and the optimal delivery of patient care. This development would run directly counter to the pivotal 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, which emphasizes that nurses should pursue higher levels of education; practice to the full extent of that education and training; and engage in interprofessional collaboration to transform health care and improve quality. Nurses have ranked as the most trusted profession in the Gallup poll on honesty and ethical standards in each of the last 17 years. Any staffing enhancements designed to improve patient safety and health care quality should empower, rather than disempower, nurses to make decisions about optimal patient care. We urge the DOH to focus on identifying and promoting practices, such as formal collaboration with leadership, that enable nurses to deliver relationship-based, patient-centered care as part of professional practice model.

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<sup>i</sup> David G. Pfister et al., [Risk Adjusting Survival Outcomes in Hospitals That Treat Patients with Cancer Without Information on Cancer Stage](#), *JAMA Oncology* 1(9):1303-10 (2015).

<sup>ii</sup> See for example: Thomas A. Lang et al., [Nurse–Patient Ratios: A Systematic Review on the Effects of Nurse Staffing on Patient, Nurse Employee, and Hospital Outcomes](#), *Journal of Nursing Admin* 34(7):326-337 (2004).



## Staffing Study Meeting Testimony to NYSDOH - October 22, 2019

### Elder Justice Committee of Metro Justice Safe Staffing Bill's Cost-Benefits

Leading Edge, a nursing home lobby, appears to be the source of the repeated claim that the cost to nursing homes of the Safe Staffing bill will be \$1 billion. Their claim is based on their false contention that "the legislation would require more than an hour of additional staff time per resident per day when compared to current staffing levels." Elder Justice committee's calculations of additional staff time of only 22.8 minutes per resident per day was obtained from CMS' Nursing Home Compare website's on October 21, 2019. CMS reported total NYS average nursing hours as 3.72 hours per resident per day. The calculation is simply the bill's proposed 4.1 hour minimum minus the current 3.72 NYS average hours = 0.38 hours (22.8 minutes).

#### Incremental Nursing Home Direct Care Cost

We calculated a total added cost of **\$277 million vs. \$1 billion** as follows:

100,000 NYS nursing home residents x 0.38 hrs./day x 365 days x \$20/hour = \$277 million [using a \$20 weighted average hourly NYS nursing wages of \$40 RN, \$21 LPN and \$13 CNA.]

#### Benefits from Passage of the Safe Staffing bill

A reduction in: pressure ulcers, use of dangerous antipsychotic drugs, falls and injuries, urinary incontinence issues, malnutrition, dehydration, and avoidable hospitalizations. Additional considerable cost savings benefits will accrue to nursing home owners/administrators of reduced direct care staff turnover and consequent lower hiring and training costs, fewer staff injuries and lower workers compensation claims, fewer costly lawsuits, increased employee job satisfaction, fewer NYSDOH fines for deficiencies, and of course healthier and happier residents, resulting in improved nursing home quality and fewer vacant beds!

**One Example: Savings from Fewer Resident Falls** [using data from Consumer Voice's: *The High Cost of poor Care: The Financial Case for prevention in American Nursing Homes* by Lani G. Gallagher 4/2011]

100,000 NYS nursing home residents x 75% fall once per year x 25% of these falls are preventable, and 17.5% of these falls result in fractures or lacerations with the average added cost of health care being \$19,440. Multiplying these numbers together yields the annual NYS preventable falls cost savings of \$64 million.



Testimony of Mary Ann Sprung, RN before NYSDOH in Regard to the Safe  
Staffing for Quality Care Act  
October 22, 2019

I am Mary Ann Sprung, an RN with 40 years of experience in New York hospitals. We traveled here today from Rochester because we passionately believe that this bill should become law. We are members of the Elder Justice Committee of Metro Justice Rochester, an organization which champions human rights. I watched the webcast from the September 20th hearing in Albany. Several health care professionals, union representatives, and industry lobbyists pleaded their cases both for and against the legislation. I was appalled at the individuals who called themselves nurses who were opposed. I wondered when they had last cared for patients on a busy hospital or nursing home unit. Did they fear repercussions if they didn't speak on behalf of their employers or the hospital associations rather than patients?

At the conclusion, I wondered if you had heard from the most important stakeholders of all: patients in hospitals and nursing homes. They are the most vulnerable members of our society who rarely if ever have the chance to voice their testimony about how they suffer from inadequate staffing. So we want to make sure that we bring their voices to this table today. And to emphasize that these stakeholders, these people, these human beings are not only suffering but dying because wealthy health care institutions value money over what is moral.

From my first day on a medical-surgical floor at a highly regarded hospital, I knew that something was very wrong. I couldn't begin to give the kind of competent, compassionate care I was taught to give. There were simply not enough nurses to go around. I saw nurses cutting corners and neglecting good infection control practices as simple as washing their hands for sheer lack of staff and time.

Throughout the years, this did not change. No matter where I was employed, there was never enough staff. The opponents say that it would cost too much money to

Eleven months ago I fell, badly breaking an ankle. Upon release from the hospital where I had surgery, I spent 3 weeks in the nursing home in Rochester which was then rated number one by the Center for Medicare and Medicaid Services. Within 2 hours of my admission, I needed to use the bathroom but had been warned not to try to get up alone as I could not bear weight on my leg. I pressed my call button which, as in most nursing homes, only turns on a light on above the door, unlike the call buttons hospitals have which allow the patient to say what help is needed.

So, I waited and waited, pressing the button several times before finally shouting “Help” out into the hallway. I nearly wet myself. Later, I asked for help with a shower, not having had one while in hospital for 1 week. I was told that my turn for a shower would come in another week since there was not enough staff to help with showers more than once a week.

That night in pain, I pressed the call button and waited 45 minutes for someone to come to my door to ask what I needed. The nurse left and came back 30 minutes later to tell me that my pain meds had not arrived yet from their off-site pharmacy because they were short-staffed the shift before, and the nurse did not have the time to make sure my prescriptions had been filled. I waited 12 hours in severe post-operative pain for medicine which I should have been receiving every 4 hours.

I felt lucky that I had the strength to raise my voice and call out for help. My heart broke for my neighbors who were too elderly or weak to shout out. Many waited silently in their soaked beds and in pain for their care to arrive. Today I am here to call out again, on *their* behalf.

When did our Health Care System become a Health Care Industry? I say shame on those who unethically and immorally become rich by taking advantage of the sick and elderly—the very people for whom they pretend to care. I implore you to be champions for the weakest members of our society. Do not be swayed by the fear-mongering or well-paid lobbyists for the health care industry. Go back to



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**TESTIMONY FOR A PUBLIC MEETING ON:  
NURSING HOME STAFFING, PATIENT SAFETY, AND THE  
QUALITY OF HEALTHCARE DELIVERY**

**PRESENTED BEFORE:**

**THE NEW YORK STATE DEPARTMENT OF HEALTH**

**PRESENTED BY:**

**TANYA KESSLER  
SENIOR STAFF ATTORNEY  
MOBILIZATION FOR JUSTICE, INC.**

**OCTOBER 22, 2019**

Mobilization for Justice, Inc.'s mission is to achieve social justice, prioritizing the needs of people who are low-income, disenfranchised or have disabilities. Our Disability and Aging Rights Project provides legal services and advocacy to individuals living in adult care facilities and nursing homes.

### **Poor Care and Diminished Quality of Life**

On our intake line for nursing home residents, we receive many calls related to quality of care problems. From our experience advocating for residents of nursing homes, we know that a host of problems stem from understaffing.

When nursing homes are understaffed, the risk of pressure ulcers increases,<sup>1</sup> the risk of infection increases,<sup>2</sup> the risk of falls increases,<sup>3</sup> and the risk of medication errors increases.<sup>4</sup> Staff improperly use chemical restraints<sup>5</sup> when there are insufficient staff to use non-medication interventions to help patients with dementia who are in distress. Our clients have suffered debilitating effects from being prescribed anti-psychotic medications to control their behavior,<sup>6</sup> despite the Food and Drug Administration's black box warnings against prescribing such drugs to elders with dementia.<sup>7</sup>

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<sup>1</sup> See, e.g. Johnson-Pawlson J, Infeld DL. *Nurse staffing and quality of care in nursing facilities*. J Gerontol Nurs. 1996;22(8):36–45; Horn S, Buerhaus P, Bergstrom N, et al. *RN staffing time and outcomes of long stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care*. Am J Nurs. 2005;105:58–70; see also Edsberg, L, et al., *Unavoidable Pressure Injury: State of the Science and Consensus Outcomes*, J.Wound, Ostomy & Continence Nurs. July/August 2014: 313-34 (noting that the vast majority of pressure ulcers are avoidable).

<sup>2</sup> See, e.g. Matt Richtel and Andrew Jacobs, *Nursing Homes are a Breeding Ground for a Fatal Fungus*, N.Y. Times, Sept. 11, 2019 (noting that poor staffing levels contribute to escalating levels of drug-resistant infections in nursing homes).

<sup>3</sup> McKnight's Long Term Care News, 'Staggering' 75% of nursing homes almost never meet expected RN staffing levels, study finds', July 1, 2019, available at: <https://www.mcknights.com/news/staggering-75-of-nursing-homes-almost-never-meet-expected-rn-staffing-levels-study-finds/> (noting that falls and medication errors are likely more frequent when nursing homes are understaffed)

<sup>4</sup> See *id.*

<sup>5</sup> See 42 C.F.R. § 483.45(d) and (e) (prohibiting the use of unnecessary drugs and restricting the use of psychotropic medications); see also 42 C.F.R. § 483.12 (freedom from abuse, neglect and exploitation includes freedom from unnecessary physical and chemical restraints)

<sup>6</sup> Maust DT, *Antipsychotics, other psychotropics, and the risk of death in patients with dementia: number needed to harm*, JAMA Psychiatry, 2015 May;72(5):438-45 (noting increased mortality in elderly patients with dementia who are prescribed antipsychotics); see also Human Rights Watch, "*They Want Docile*": *How Nursing Homes in the United States Overmedicate People with Dementia*, Feb. 5, 2018, available at: <https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia> (noting that the lack of minimum staffing regulations is a key concern underlying the use of antipsychotics on people with dementia in nursing homes).

<sup>7</sup> Jun Wan, *FDA Extends Black Box Warning to all Anti-psychotics*, Psychiatric News, July 18, 2008, available at: <https://psychnews.psychiatryonline.org/doi/10.1176/pn.43.14.0001>

We recently assisted a nursing home resident in a Brooklyn nursing home, Ms. M. Ms. M. is an elderly person with dementia who had suffered multiple problems that stem from understaffing, while residing at the nursing home. She had untreated abscesses on her skin, pressure ulcers, unwashed hair, an unexplained black eye, had been placed on two anti-psychotic medications, and had been physically restrained in a wheelchair. Aside from the disturbing use of physical restraints, it is important to note that Ms. M did not need a wheelchair and was able to walk without assistance.

Ms. M's family member described severe understaffing at Ms. M's nursing home. Nursing Home Compare confirms this assessment: the facility currently has a one-star rating for staffing. (This rating is published by the U.S. Centers for Medicare & Medicaid Services.) The facility has been cited in recent years for inappropriately prescribing anti-psychotic drugs for residents with dementia. And yet New York State allows this nursing home, like many others with poor staffing ratios, to continue to house hundreds of vulnerable adults.<sup>8</sup>

### Unnecessary Institutionalization

Understaffing results in poor care and a diminished quality of life, but also in unnecessary institutionalization. Patients who enter a nursing home for a short stay, as Ms. M did, may experience preventable medical complications that prolong their institutionalization unnecessarily and sometimes permanently.

Unnecessary institutionalization results from not only understaffing of certified nursing assistants and nurses, but also understaffing of social work staff. Many nursing homes have insufficient staff to perform adequate discharge planning. In our representation of nursing home residents facing involuntary discharge, we invariably see an egregious lack of discharge planning, with few social services staff available to perform that function. Even large nursing homes often employ only one or two social work staff to address residents' various psychosocial needs. Clients who could live in the community with the appropriate supports obtain little or no assistance from the nursing home when they seek to be discharged to a more independent setting, despite regulatory requirements that nursing homes engage in comprehensive care planning, including proper discharge planning.<sup>9</sup> As a result, nursing homes are retaining people who could be living in the community, if only they had the support to move. When the nursing homes eventually decide to discharge residents, the discharge plans are often to inappropriate settings that lack needed services, such as homeless shelters. **In 2017, the number of individuals new to shelter who were discharged from nursing homes to the shelter system was 1,187.**<sup>10</sup> This failure to do proper discharge planning puts residents at risk of a cycle of re-hospitalization and institutionalization in a nursing home once again.

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<sup>8</sup> Virginia Jeffries and Jackie Jeffrey-Wilensky, NY's Nursing Home Staffing Shortages Raise Concerns About Quality of Care, City Limits, August 26, 2019, available at: <https://citylimits.org/2019/08/26/nys-nursing-home-staffing-shortages-raise-concerns-about-quality-of-care/> (noting that "New York City's most understaffed nursing homes have lower health ratings and almost twice as many citations for health hazards as the best-staffed facilities.")

<sup>9</sup> 10 N.Y.C.R.R. §§ 415.3(h)(1)(i),(vi) and (vii); 42 C.F.R. 483.21(b)(iv) and (c).

<sup>10</sup> N.Y. City Department Social Services, Local Law 117 of 2017 [report on medical health services in shelters] submitted to N.Y. City Council, Sept. 17, 2018, at 11.

Unnecessary institutionalization of people with disabilities is one of the forms of discrimination prohibited by the Americans with Disabilities Act (“ADA”), which applies to public entities, such as the State of New York.<sup>11</sup> Section 504 of the Rehabilitation Act (“RA”) “prohibits programs and activities receiving federal financial assistance from excluding, denying benefits to, or discriminating against, ‘otherwise qualified’” individuals with a disability.<sup>12</sup> Both the ADA and the RA incorporate an “integration mandate,” requiring that “when a state provides services to individuals with disabilities, it must do so ‘in the most integrated setting appropriate to their needs.’”<sup>13</sup>

New York State has recognized the importance of complying with the federal integration mandate, and included goals for transitioning nursing home residents to the community and reducing the “long-stay population” in nursing homes in its Olmstead Cabinet report.<sup>14</sup> However, among other problems, the lack of adequate staffing by nursing homes undermines this laudable goal.

### **Conclusion**

In order to protect nursing home residents’ health and safety, ensure their quality of life, and realize the goal of integrating nursing home residents in the community, New York State must address its staffing shortage.

Thank you for the opportunity to address the critical importance of addressing the staffing crisis in New York State nursing homes.

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<sup>11</sup> 42 U.S.C. § 12132.

<sup>12</sup> 29 U.S.C. § 794a.

<sup>13</sup> *Disability Advocates, Inc. v. Paterson*, 653 F.Supp.2d 184, 192 (E.D.N.Y. 2009), citing *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999); 28 C.F.R. § 35.130(d).

<sup>14</sup> New York State/Governor Andrew Cuomo, “Report and Recommendations of the Olmstead Cabinet: A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting,” at 15, (October 2013), available at: [https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead\\_Final\\_Report\\_2013.pdf](https://www.ny.gov/sites/ny.gov/files/atoms/files/Olmstead_Final_Report_2013.pdf).

Good morning,

I am coming before you today to speak in support of establishing statewide minimum nurse to patient staffing ratios. Simply put, too many hospitals are understaffed, nurse to patient staffing ratios directly implicate patient safety, allowing a patchwork of different staffing ratios in hospitals leads to disparate care, and requiring a statewide minimum staffing ratio would help to protect patients' lives.

Studies show that fewer patients die when the nurse-to-patient staffing ratio is higher, and that conversely, the odds of a patient dying increases for each additional patient that a nurse handles at any one time. Studies also show that when staffing is increased, the number of adverse events falls. Hospitals with lower staffing ratios have higher rates of pneumonia and other events that lead to longer hospital stays and higher mortality rates, while hospitals that have additional staffing see fewer medical malpractice lawsuits, fewer hospital acquired infections, and fewer readmissions.

Thankfully, we already have evidence of how to improve patient safety. Nursing homes have instituted safe staffing standards, and this has improved the facilities' quality scores and patient satisfaction rates. This isn't just a government score. Not only are patients better able to access care, but nurses are more likely to stay in facilities with adequate staffing, both of which have a direct impact on patient care and safety.

The only argument that I have heard in opposition to safe staffing ratios is that it would be too heavy of a financial burden on hospitals. This is not true. Over the same period of time when California implemented safe staffing ratios, hospitals saw their revenues rise dramatically. This requirement doesn't remove flexibility from hospitals, they are still free to determine staffing needs, they just can't staff a unit with less than the minimum safe level of nurses.

In my career, I have seen how hard nurses work to provide care to patients, and I believe that this proposal would ensure that patients receive the best and safest care possible.

Thank you.

Angélicque Moreno  
President  
New York State Academy of Trial Lawyers



**Office of the State  
Long Term Care  
Ombudsman**

TESTIMONY FOR MEETING ON  
NEW YORK STATE DEPARTMENT OF HEALTH STAFFING STUDY  
ENGAGEMENT SESSION

STAFFING ENHANCEMENTS AND PATIENT/RESIDENT QUALITY  
IMPROVEMENT INITIATIVES IN HOSPITALS AND NURSING HOMES

OCTOBER 22, 2019

PRESENTED BEFORE:

THE NEW YORK STATE DEPARTMENT OF HEALTH

PRESENTED BY:

CLAUDETTE ROYAL

NEW YORK STATE LONG TERM CARE OMBUDSMAN



Good morning, I am Claudette Royal the New York State Long Term Care Ombudsman. Thank you for the opportunity to provide comments at this event which is being held for the purposes of examining how staffing enhancements and other initiatives can be used to improve patient safety and the quality of health care delivery in hospitals and nursing homes.

The Long Term Care Ombudsman Program (LTCOP) program provides federally mandated advocacy services to all residents of long term care facilities. Our services are provided in nursing homes, adult homes, assisted livings and family type homes. The program operates through 15 regional programs throughout the state, which are comprised of 45 staff and 450 certified volunteers who provide a regular presence in facilities advocating on behalf of residents by identifying, investigating and resolving complaints brought forth in these facilities. The program's mission is to assist residents in protecting their rights and preferences and helping them maintain their quality of life and to receive the highest quality care, while residing in a long term care facility. Ombudsmen are an impartial party who acts directly based on the resident's wishes.

I will be providing a general overview of what the ombudsman program observes while providing their service to the residents of their assigned facilities. Please note Richard Mollot, the Executive Director of the Long Term Care Community Coalition and Lindsay Heckler a Supervising Attorney from the Center for Elder Law and Justice will both be providing testimony with more detailed information related to their specific understanding of workforce and staffing issues from their agencies perspective. Both of these individuals are directly involved with the Ombudsman Program, as Mr. Mollot's agency is the sponsoring agency for the Long Term Care Ombudsman Program in the Hudson Valley region and Ms. Heckler's agency is a subcontractor to our sponsoring agency in the Buffalo region. She is also a certified ombudsman.

Ombudsmen provide regular visits to their assigned facility where they have the opportunity to make observations over a longer period of time, allowing for the ability to recognize trends and concerns. During a visit to a facility, ombudsmen speak with residents and their representatives as well as staff regarding concerns they may observe during their visit. Many of these observations are related to the difficulties they see, or residents' expressions of concerns related to the staffing in the facility.

Our staff and volunteers often express facility staff are making their best efforts to provide residents with the care they need, however it appears personnel is inadequate to provide care to all residents when needed. For example, in a facility in Steuben County there are several examples of concerns related to staffing that have been expressed to the program. One of the floors in the facility has many dementia residents, and due to shortage of staff they wander without proper supervision. Some of these residents have behavior management concerns and may enter other residents' rooms engaging in verbal or physical altercations. In one instance a resident wandered into an alert and oriented resident room, attempting to take belongings and throwing items, prompting the resident to use the call light for help, however no one came for 45 mins to assist. By that time, the other resident had already left the room. Another time an ombudsman was performing a routine visit late in the day and there were only 2 aides on the floor. Both were assisting another resident with care needs. A resident with cognitive impairments was following the ombudsman to the elevator. The ombudsman did make attempts to re-direct the resident to other activities, but due to inadequate staffing the ombudsman stayed with the resident for 45 minutes because of safety concerns until staff were available. In this facility short staff in the evening and weekends is also common. We have received complaints

reporting there are only one to two aides per 40 residents. Some residents have expressed they will sit with their call light on for 2-3 hours before someone comes to assist them. All of these examples have become commonplace. It should also be noted in Steuben County specifically residents are fearful to make complaints on their own regarding this, as they do fear retaliation.

The Long Term Care Ombudsman Program has seen a continued increase in overall complaints over the past 3 years, noting a 150% increase in complaints received from 2017 to 2019. Although not all of these complaints are directly reported as shortage of staff in the data reporting system known as the National Ombudsman Reporting System, many of them can be linked to staffing concerns, such as those reported under the categories of requests for assistance, pressure sores, pain management, medication concerns, personal hygiene, and toileting. As we continue to see an increase in these categories, and an overall increase in complaints generated by residents and their representatives, it is a strong indicator for the need of better staffing ratios to be implemented. The direct observations of the ombudsman in facilities is also a relevant indicator that staffing is a major concern for our program and the residents we serve.

In relation to the examples provided from Steuben County, the Ombudsman Program has the potential to provide relevant information and observations to the Department of Health when they are conducting a survey of a facility. An article published in the Journal of Post-Acute and Long Term Care Medicine in March of 2019 reported the positive impact of involving the ombudsman in the survey process. Having a regular presence in facilities allows for more detailed information to be available that could be share with a survey team. LTCOP stands ready to assist DOH survey teams in more effectively working together to identify staffing issues, quality of life issues, and any other pertinent observations that volunteers and staff may have.

Staffing ratios are in great need of evaluation to ensure residents receive the highest level of quality care. LTCOP staff and volunteers are well positioned to assist the DOH in achieving its goals through the direct observations each visit as they interact with residents and staff of facilities. I look forward to continuing to be part of the team and provide information to the Department of Health to assist in determining what actions can be taken to address this crisis and improve the lives of all residents residing in nursing homes.

Intro

*Hello.*

Good morning. My name is Wendy Braithwaite and I am employed by Montefiore Medical Center, as a staff nurse on a surgical unit which includes providing care for medicine patients, as well.

Today, I will be addressing the need for safe staffing levels from the perspective of someone working at the bedside. When I first started, I was assigned 7 to 8 patients per shift, which is then doubled for break coverage, further increasing the workload. Over the years, there have been some improvements, where the nurse is now assigned 5 to 6 patients. This is again doubled for break coverage. Saying that there are improvements, although much needed, does not give the true depth of what it means to have 5 or 6 patients.

Patients in the acute care setting are now much sicker than ever before, demanding more nursing care hours. On my unit, we have patients on ventilators with multiple IV infusions needed to maintain life. There are patients requiring wound care that utilizes nursing care hours for assessment, cleaning, and dressing of these wounds. We are assigned patients with mental and polysubstance abuse illnesses. These patients can at times become verbally and physically abusive, adding to an already untenable situation. Then we have our surgical patients. These patients sometimes require pre-surgical care, involving preps and education. The patients will then need post-surgical and other care, for example: drain care, blood transfusions, bladder irrigations, IV antibiotics and supplements such as electrolytes. Additionally, there's the documentation that's required. Over the years, required documentation has increased dramatically, causing a marked shift from actual hands-on care to time spent documenting on the computer. Staff huddles and rounding, IDT and the occasional in-service, all this separate from patient care and teaching, as well as medication administration, embodies the day to day routine of a bedside nurse.

Many studies have shown a direct correlation between improved patient outcomes and satisfaction, based on staffing levels.

These studies show that the readmission rates also decreases with higher nurse to patient ratios. Reimbursement is now based on patient outcomes, satisfaction and rates of readmission. Staff retention and morale can be directly linked to staffing levels, as well. I believe that on a Medical-Surgical unit a nurse should

be assigned no more than 5 patients, at any given time. This level should be adjusted for higher acuities. Meanwhile, standards or guidelines should be set to objectively measure patient acuity. Bedside nurses should be involved with the formulation of these standards or guidelines. The amount of documentation that is required by nursing should also be reassessed, in an effort to allow for more direct care.

In closing, as nurses we are required to be an advocate for our patients. This entails providing education along with high quality care for our patients, which in turn improves the quality of life and decreases the need for admissions. To do this, we need resources and support. Resources is not limited to more nurses, but ancillary staff, equipment and ongoing education with skills training, as well. An increased value should be placed on the input and ideas, we provide. Since reimbursement is now based on outcomes and satisfaction, staffing levels should be safe and adequate to ensure that the patients needs are met ALWAYS.



# *Testimony*

to the  
**NYS Department of Health Commissioner,  
Howard A. Zucker, M.D.**

on  
**Staffing Enhancements in Hospitals and  
Nursing Homes**

**October 22, 2019**

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*Testimony of  
Andrew Pallotta  
President, New York State United Teachers  
to the  
New York State Department of Health Commissioner,  
Howard A. Zucker, M.D.  
on  
Staffing Enhancements in Hospitals and Nursing Homes  
October 22, 2019*

Commissioner Zucker and distinguished staff from the New York State Department of Health, I am Andrew Pallotta, President of New York State United Teachers (NYSUT). NYSUT represents more than 600,000 education and health care workers statewide. NYSUT's Health Care Professionals Council (HCPC), overseen by UFT Vice-President of Private Sector, Anne Goldman, consists of representatives of NYSUT's 16,000 professional registered nurses and other health care professionals working in public and private health care settings statewide. Our members work in hospitals, clinics and through home health care agencies. Additionally, our members include physicians, visiting nurses, therapists, lab personnel, school psychologists and registered professional school-based nurses throughout New York State. In addition, NYSUT represents over 160,000 retirees, many of whom use the state's health care system. On behalf of the HCPC and NYSUT, we greatly appreciate the opportunity to submit testimony today on the New York State Department of Health's 2019 hearing on the very important topic of staffing enhancements in hospitals and nursing homes.

We were happy to see that, in the 2019-20 Enacted New York State Budget, Governor Cuomo and the New York State Legislature directed the department to conduct a study to examine how staffing enhancements and other initiatives can be used to improve patient safety and the quality of health care service delivery in hospitals and nursing homes. As you are aware, the study will analyze the range of potential fiscal impacts of staffing levels, as well as other staffing enhancement strategies and patient quality improvement initiatives.

We thank you for convening today's hearing on this important topic and allowing various stakeholders the opportunity to express their views and concerns. We all have a shared goal of providing the best quality health care to patients, and I believe we can find consensus on this issue. At its core, safe staffing ratios are about ensuring patients are best served by health care professionals.

NYSUT has long supported the enactment of the Safe Staffing for Quality Care Act — S.1032 (Rivera)/A.2954 (Gunther) — that would require acute care facilities and nursing homes to implement certain direct care nurse-to-patient ratios in all nursing units and imposes penalties for violations of these ratios. Over the years, the sponsors of this bill have largely been health care professionals from health care unions. Included in my testimony, I will provide you with a first-hand account from a dedicated hospital RN who will illustrate how difficult it can be to preserve patient safety due to inadequate and unsafe staffing ratios.

The safe staffing legislation establishes satisfactory minimum nurse-to-patient staff plans in both hospitals and health care facilities and will protect patient safety, ensure the delivery of quality health care and improve working conditions for health care professionals. Licensed nurses constitute the highest percentage of direct health care staff in acute care facilities and have a central role in the delivery of health care. Currently, many health care settings have inadequate and poorly monitored nurse staffing practices, which jeopardize the delivery of quality health care services and adversely impact the health of patients who enter acute care facilities. This can and has resulted in dangerous medical errors and patient infections.

With the emergence of sophisticated medical technology, new life-saving/sustaining equipment, electronic medical record requirements and strict hospital regulations, the role of a registered nurse in the hospital setting has and will continue to evolve. The mastery and application of these advances and policies, while essential, takes valuable time away from direct patient care.

The rapid changes in medical technology and the way we care for the sick and infirmed underscores the need for hospitals to implement adequate staffing ratios. Our patients deserve nothing less.

Staffing in many of our hospitals has been cut to dangerously low levels, and there is currently no recognized standard for appropriate staffing levels in hospitals and other facilities that provide nursing services. The enactment of this legislation would help ensure that patients receive safe, appropriate and high-quality health care.



There is a clear connection between the amount of nurse staffing hours and the quality of care that patients receive. A growing body of evidence has shown that the rate of mortality in acute care settings decreases as the number of registered nurses-to-patients increases. Further, the rate of injury and infection decreases as the number of licensed nursing staff increases. A recent study released by Columbia University School of Nursing, concluded that hospital understaffing increases the risk of health care associated infections in patients and increases the number of days patients spend in the hospital, adds billions of dollars to health care costs annually and compromises patient care and nurse wellbeing. Similar research, dating from as far back as the 1980s, has shown that appropriate nursing interventions can reduce the length of stay in acute care settings and improve the quality of life in long-term care settings.

The real life consequences of not having the appropriate number of registered professional nurses to care for patients in acute care facilities and nursing homes are outlined below, in an account from a Registered Nurse. This nurse noted that recently, a patient was admitted to an acute care urban hospital in New York City. This facility is a designated Trauma Center, Stroke Center, and STEMI Center. The patient had a vascular procedure to restore blood flow in the leg and was admitted to the Surgical Intensive Care Unit. The care required for this patient included hourly vascular blood flow checks to assess the patient's leg to maintain patent blood flow after the surgery. The attending nurse also had a stroke patient who required hourly neurological assessments. These are typical assignments in an intensive care unit; however, because the unit was not scheduled with the proper amount of staff, the nurse received an additional Level 1

critical trauma patient. The trauma patient was bleeding and required massive transfusions of blood products to stabilize the patient. The nurse was struggling over a period of time to keep the trauma patient alive and was unable to assess the other two patients. It was during this event that the original patient who had a vascular procedure on his leg lost blood flow to the leg and ultimately lost his limb.

As illustrated in the preceding account, establishing staffing standards for licensed nurses in acute care facilities and nursing homes in New York State would ensure that these facilities operate in a manner that guarantees the safe delivery of quality health care services.

We must also consider preventative care for patients with regard to implementing safe staffing policies. Practicing preventative medicine by educating our patients, pre-discharge, can significantly serve to prevent the high incidence of re-admission. Early recognition of pending or possible complications can produce positive patient outcomes. Continuous assessment of the patient, which can only be done by a registered nurse, would reduce the health system's cost by decreasing length-of-stays and decreasing avoidable complications through early detection and subsequent early intervention.

For the state's uninsured population, the hospital is often the only access to medical care and, therefore, hospitals must be mindful that once a patient is discharged there may be no follow-up medical care available to them. NYSUT believes it is imperative that RNs are provided

sufficient time to educate their patients on how best to care for their injury or disease so as to avoid re-admission. Due to the existing disproportionate nurse-to-patient ratios, there is simply not enough time for proper patient discharge education.

We respectfully disagree with the use of staffing committees and labor management committees as a way to address the chronic short staffing in acute and long-term care facilities. That process requires an agreement between labor and management, and it is clear that hospital management has not demonstrated a willingness to adequately address this troubling issue. This is vitally important to pass the Safe Staffing for Quality Care Act. Accordingly, we are asking for the department's full public support of the enactment of this legislation.

Our goal, as health care professionals, is to improve patient outcomes for everyone in our state, without exception. Registered nurses play a critical role in this endeavor, however, with current staffing levels, this is nearly impossible. The government requires motorists to use seatbelts, and places limits on the amount of time a truck driver can spend behind the wheel before taking a mandatory break (this is essentially a work/rest ratio). If such protections were enacted in the interest of public safety, why then when it comes to our health care should we have less of a standard? No one should receive a lower standard of care because a health care institution refuses to provide the number of registered nurses required to deliver a high standard of care.

In closing, we once again ask for the New York State Department of Health's full public support of the enactment of the Safe Staffing for Quality Care Act to help ensure better outcomes for our patients. Our patients deserve nothing less.

Thank you for your consideration of this important matter.

CB/JG/AB  
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# STATE WIDE

**New York StateWide Senior Action Council, Inc**  
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Good morning, my name is Luciana Rougier. I am a member of NY StateWide Senior Action Council and a Retired Member of 1199 /SEIU. I live in the Ditmas Park section of Brooklyn.

In 2010, I retired from St. Vincent's Hospital where I worked as a dietary and transportation aide for 23 years. To this day, St. Vincent's is a facility that has not been replaced and much needed in the community.

As far as my experience with the health care system, as an employee at St. Vincent's, I was responsible for transporting patients to different testing areas, and when the staff was overwhelmed, I would help transport the patients to the Operating Rooms.

Many times the patients were delayed in getting to their testing areas because there wasn't enough staff to help transfer the patients from their beds to the gurneys.

In addition, if the families or loved ones were not present at feeding time, many of the patients would not eat their meals on time. This means that if a patient lacked the support of friends or family that would regularly visit, their nourishment might have been irregular.

That was between 10 and 23 years ago.

At that time, there was a policy of *“doing more with less”*. And I can tell you that if patients were not getting enough services at that time, they are receiving even less now.

Currently, nurses and health aides in my union are complaining that they are short staffed and need more help in order to carry out proper care.

I am glad that I have not been in need of hospital services so far, but when the time comes, I hope that the services will be there.

Hospitals and nursing homes are visited more and more by people who are 65 years of age and over. We are one of the largest parts of the community that use health care services. So we need to make sure that proper care is in place for this incoming group.

Thank You.

# STATE WIDE

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**Tuesday, October 22, 2019**

**Staffing Study Meeting**

**90 Church Street**

**New York City**

**María Alvarez**  
**Executive Director**  
**NY StateWide Senior Action Council**

Commissioner Zucker & Esteemed Members of this Panel:

Thank you for holding this panel to hear the input of consumers and advocates on this vital issue.

New York StateWide Senior Action Council operate 3 helplines in New York State: Managed Care Counseling Assistance, Patients' Rights, and Medicare Health Fraud Prevention. Our services are free, unbiased and open to the public. In addition, our staff and volunteers make countless community presentations achieving outreach to communities that are not easy to reach due to language, cultural, geographic, and physical barriers. In addition, we conduct media and traditional community outreach methods.

I can tell you that we have a laundry list of complaints ranging from fraudulent activities, to billing errors, and lack of access to health care and prescription drugs.

Many of these complaints stem from patients in distress simply not getting enough attention from the hospital personnel and having their health deteriorate to a point where they would require more medical or rehabilitative attention, or worse – they die.

The painful part of all of this is that more and more, patients, caregivers, and families are being stripped of their rights to appeal, have complaints reviewed in a timely manner or to get satisfactory results due to the

"overburdened system" – to put it in the words of Department of Health personnel.

As a consumer advocate, we see how the rules are constantly changed and reassessed and the results invariably end up "blaming the victim". Most of the time the burden of being informed, taking actions that result in months of appeals, and just basically asserting patient rights falls on a patient who in many cases is too sick to speak out, too medicated to sign a release form, or uninformed to know that they have the right to medical attention from hospital staff and an appropriate discharge plan so as not to land back in the same situation with a more chronic disease.

Instead, many patients languish in nursing homes and hospital beds waiting for their meals, meds and a trip to the bathroom because the hospital or nursing home lacks the appropriate staffing to handle the patients on hand.

And the people who have it worse are those who do not have families or friends to keep an eye on them while staying in these institutions. I have heard many stories about how the loved one has had to advocate for the patient to make sure that they get their meals, medications, or are transported to the toilet. Like they say, the squeaky wheel gets the oil.

We are also getting reports that vacancies are not being filled. It seems that some of the nursing homes are content to hire part time workers so that they do not have to pay them benefits. So this situation can get worse.

Many of StateWide's members are retired health care workers. They have lived these injustices as employees, and now what they all tell me is: "I want to make sure that if I ever wind up in one of these facilities there is more personnel that when I was there."

**Safe Staffing Ratios: Saves Lives, Improves Patient Outcomes, Saves the Hospital, Money in Unnecessary Readmissions, Improves the Quality of Care, and Improves Access to Care.**

I would be glad to answer any questions.



**NYS Department of Health Public Meeting: RN Safe Staffing**

**Testimony of Joan Rosegreen, PEF Council Leader & RN at SUNY Downstate Hospital**

**October 22, 2019**

Good morning, my name is Joan Rosegreen I am a Council Leader for the Public Employees Federation and I have worked as an RN for 25 years. I would like to thank the Department of Health for the opportunity to speak on behalf of the PEF represented nursing staff at SUNY Downstate Medical Center.

I represent 600 PEF nurses employed at SUNY Downstate. The facility is a 324 bed unit that provides specialized care such as pediatric dialysis, neonatal ICU and pediatric ICU among other critical care services. Downstate is located in a community of color with existing health care disparities in both services and patient outcomes.

DOH should be aware of the current conditions as it relates to staffing at the facility and I have selected 2 scenarios to present to show how short staffing has affected our staff and the care they provide to the patients.

The acuity of the patients that we care for requires nurses who are skilled in what they do, however because of the ongoing shortage, staffing on the units are compromised and results in nurses being overworked on a daily basis.

Recently on the mother baby unit a mother who delivered her baby felt it was necessary to kidnap her baby from the unit and made use of the opportunity when she realized there was not enough nursing staff on the unit to monitor her activity. On this particular day there were only 2 nurses on the unit who were occupied with the care of their patients and despite the unit being a locked unit the mother was clever enough to realize that she could leave with her baby because there was no staff member in view to see what she was doing. Luckily this situation was diffused when a non-

nursing staff member observed the mother leaving with the baby and alerted the security. Had there been adequate nursing and ancillary staff the above issue would not have occurred.

Nurses at Downstate utilize protests of assignment to indicate the working conditions. Over the past 3 weeks; I have received protest of assignments from the labor and delivery units and the step-down units where nurses are being floated to other units and asked to perform duties that they are not trained to perform. For example, most days in the Labor & Delivery unit there are only 5 nurses to care for the patients. Of the 5 nurses, 2 have to go to the OR for C sections which leave 3 nurses to operate the unit. Similarly, on the step-down unit where the ratio should be 1 RN to 2 critical patients, there is one often 1 RN with 4 patients and no ancillary staff. Both units are affected greatly by the lack of nursing staff and nurses are often left to provide care in the critical care unit without the assistance of the ancillary staff where there is also a shortage.

Working daily with inadequate staffing has resulted in an increase in nursing staff being injured or ill and unable to report to work like they normally would. Nurses are also regularly asked to work double shifts or fill in on their off days leading to exhaustion and loss of time with their families.

SUNY Downstate is unable to retain the nurses they hire primarily due to the volume of work they have to perform caused by short staffing, which if not done properly can result in nurses being brought up on disciplinary charges.

On behalf of the RNs at SUNY Downstate, I strongly urge DOH to help diffuse the nursing shortage crisis at SUNY hospitals by establishing safe staffing ratios that will allow RNs to be able to take breaks during their shifts, take vacation when needed. and create a working environment that is safe to work in and free from hostility and disciplinary actions which results from inadequate staffing . Nurses go above and beyond to provide the best care to their patients, however they are at the point where they are burned out, inadequately paid and left feeling vulnerable because they believe their practice and license are at risk.

Thank you for your time.

# STATE WIDE

## **New York StateWide Senior Action Council, Inc**

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**Tuesday, October 22, 2019**

**Staffing Study Meeting**

**90 Church Street**

**New York City**

**Mario C. Henry, President  
Board of Directors**

**NY StateWide Senior Action Council**

Commissioner Zucker & Esteemed Members of this Panel:

My name is Mario C Henry. I am a senior citizen, President of the Board of Directors of New York StateWide Senior Action Council, a membership grassroots organization directed and governed by consumers. For these reasons I am in support of Resolution 396 calling upon the New York State Legislature to pass, and the Governor to sign, legislation requiring the New York State Department of Health to establish safe staffing ratios to ensure all acute care facilities and nursing homes meet minimum safe staffing standards for nurses and all direct care staff.

Senior citizens by the very nature of their age spend more time in medical facilities. Seniors consume 2/3 of all health care services provided, making them statistically more vulnerable to the adverse effects of not having proper care in hospitals and nursing homes. Seniors are at greater risk for more frequent and more severe adverse reactions to medications. Seniors are at greater risk of contracting pneumonia. They are at greater risk of getting pressure sores. They are at greater risk of falls and fractured bones.

They, more than any other age group need adequate numbers of nurses present to monitor their conditions and alert Physicians Assistants and Doctors to problems in a timely fashion. The periodic visit by a Doctor or Physicians Assistant will not be enough to assure a timely response to an unanticipated change in a medical condition. By the time a Doctor or Physicians Assistant sees a problem the senior might very well be dead. Nurses are the first line of defense for patients and sometimes the difference between life and death.

Senior citizens have a right to know that in their so-called golden years they will receive proper care in a timely manner. Seniors have a right to know that when they are most vulnerable they will not be neglected.

The New York State Nurses Association has shown, based on publicly available documents, that the additional cost of adequately staffing medical establishments is not prohibitive. The cost of adequately staffing would be only 1.25 % of the total revenues of the New York State hospitals and only 6.25 % of the money hospitals spend on non-patient care. I do not think that is too much to ask to avoid neglecting our senior citizens when they are most vulnerable.

Thank you.

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**Testimony of Sean Clarke, FAAN, PhD, RN  
Executive Vice-Dean, NYU Rory Meyers School of Nursing**

to

**NYS Department of Health  
Stakeholder Engagement Session on Staffing Enhancements to Improve Patient Safety**

*October 24, 2019*

As the New York State Department of Health is reviewing staffing enhancements in relation to patient safety and the quality of healthcare service delivery, I write to share my expertise in this subject and highlight relevant research on this topic. I am a nurse researcher and currently serve as Executive Vice-Dean and Professor at the New York University (NYU) Rory Meyers College of Nursing. As of this year, I have been involved in research on nurse workforce and patient safety issues, as well as specifically nurse staffing matters, for two decades. I was the lead data analyst and first coauthor on one of the most influential research papers on staffing in the literature (published in *Journal of the American Medical Association* in 2002). At this point in my career I have authored and coauthored dozens of articles and given dozens of invited talks on staffing research and policy related to staffing.

Anyone with first-hand experience of health care has always known that nurse staffing matters. When patient loads are excessive, nurses can become unable to deliver high quality care. These perceptions have some backing in research, beginning with the first modern-era study of the associations between outcomes and nurse staffing in US hospitals published by my NYU colleague, Professor Christine Kovner in 1998. No one argues anymore that nurse staffing makes a difference in patient outcomes: much of the daily work of nurse managers and executives in health care organizations across the state goes into ensuring that there are enough of the right nurses in the right places to ensure safe care.

That being said, there are many misunderstandings about the research literature in this area. While all agree that a considerable number of studies have suggested a connection between nurse staffing and outcomes, not all published articles in this area show this link. Furthermore, there is debate and disagreement about how large the effects are, and to what extent the effects found, reflect the importance of ratios *per se* in the actual work of nurses as opposed to related factors. If other factors linked with staffing explain some of the effects that researchers have seen, it is quite possible that increasing staffing alone won't improve patient safety. It should also be highlighted that the literature does not speak directly to the question of what levels of staffing from shift to shift are safe, probably because institution, unit and patient variables are so important to making a certain staffing level appropriate, too lean, or wasteful. Finally, as others have stated, evidence to date has been contradictory (and mostly negative) on the question of whether the California initiative has produced benefits for patients in that state.

I would urge the NYS Department of Health and others weighing the question of regulating nurse staffing ratios to be cautious about assuming who within the profession supports and who does not support strict regulation of staffing. Front-line or direct care clinicians are divided, as are academics and scholars, regarding their beliefs on the appropriateness of this policy strategy and whether the benefits outweigh costs. I would similarly urge that any decisions about the regulation of nurse staffing be informed by an understanding of the extensive "grey zones" in the research literature, particularly where the lines between safe and unsafe staffing levels lie. I would further recommend detailed consideration regarding where in the state reimbursement rates are likely insufficient to cover for staffing at proposed levels, as well as what outcomes will actually be improved in relation to potential decreases in availability of services, especially if tight controls are proposed.

I thank the Department for the opportunity to provide feedback on the research conducted around nurse staffing issues and would welcome any questions the Department has throughout their review. (Please contact Jennifer Pautz, Senior Director of Government Affairs for NYU, [Jennifer.pautz@nyu.edu](mailto:Jennifer.pautz@nyu.edu)).

## Staffing Study Meeting

October 22<sup>nd</sup> 2019

90 Church Street

New York City

Honorable members of the New York State Department of Health,

Ladies and gentlemen,

I have come to testify about my personal experiences at hospitals and nursing homes for the past 22 years.

My name is Gilbert Sabater, a resident of Manhattan. I have been involved (as a volunteer, proxy, caregiver and friend)) in nursing homes for the past 22 years. In my professional career, I worked as a consultant to major corporations for 10 years, a director in a Fortune 500 company for 3 years, and as an entrepreneur for the past 52 years.

I began my involvement in nursing homes when I was 15 years old. I was in school in Kingston, Ontario. The Jesuits made us an offer we could not refuse. Work in a nursing home every Saturday and get all day Sunday off after breakfast, no study periods and no high mass. I volunteered; it was one of the most rewarding experiences in my life! That was in the early 50's; the love that I experienced in that facility was not available in school.

Fifteen years later, during the 1960s when grandma (my wife's grandmother) entered a nursing home in Brooklyn, the label nursing home was a gross misstatement. It was a snake pit full of stenches, dirt, and tears; it was horrendous just visiting there. My wife and I decided to take grandma home until her family found out and took her away from us. What a disillusionment that was after my idyllic work in Kingston. I had made Dante's journey, only backwards and ended up in hell! Thankfully, today, as a result of new laws and regulations, we find ourselves somewhere in between.

Then in 1997 my aunt Blanche, whom I had been caring for since 1959 when she had a nervous breakdown, had to go into a catholic nursing home in Orlando Florida. My experience there was totally different than the reality when I brought her home to New York. Since then, I have cared for 19 individuals including my aunt and my mother which provided me with many opportunities to become familiar with hospitals (NYU, Bellevue, Veterans, Mt. Sinai, Cornell, St. Claire's/St. Vincent, St. John's, North Shore, Jewish Hospital and Montefiore/Einstein), as well as nursing homes (Kateri/Riverside, Dewitt, Mary Manning Walsh, Terence Cardinal Cooke, Henry J. Carter, Jewish Home, in Manhattan, Coler & Goldwater in Roosevelt Island, St. Vincent De Paul in the South Bronx, and Marcus Garvey, Concord, C.A.B.S, Veterans in Brooklyn.

I believe that combining the staffing needs in hospitals and nursing homes presents a challenge. What is the mission of hospitals vs. nursing homes? Are they similar or are they comparable? How about functionality of RN's in hospitals vs. nursing homes? I am no expert but I observe and experience; the RN in the hospital is the linchpin for my quick recovery and safe discharge home. She is the one always available to speak and explain in plain terms, the patient condition. Even in the Emergency department,

despite all the available doctors, it is usually the RN that translates or reads the charts to relatives; doctors are too busy to divert their attention from patients to family.

The function of the RN in the nursing home is totally different than hospitals. Usually family members are aware of the resident condition, they do not need to be told the health progress of their loved one; so the RN deals with wounds (LPN's are not trained to treat wounds) as well as the safe delivery of meds. In the past five years, due to financials, RN's have become members of wound-care teams while the few RN's on units are dispensing medicines. They have no time in an 8-hour shift to attend to any other duty or responsibility. Theoretically they are supposed to supervise the LPN's and CNA's, but they are overwhelmed with the meds. Experienced CNA's know what to do once they receive their assignment.

So we are now discussing apples and oranges and coming to conclusions that the applesauce we have created can be used indiscriminately. I disagree. My experience tells me different. We have a desperate need to staff enough RN's in hospitals to make sure the patients receive the proper care to get them home quickly and safely. My question is whether that need for RN's in nursing homes translates to the same results? Does having more RN's in nursing homes provide a safer, comfortable life for the resident (not a patient but a **resident**)? I don't believe so.

When nursing homes were staffed with CNA's on an 8:1 ratio in a regular long-term unit, residents received adequate care; they were cleaned when needed, they were toileted when requested and they were fed regularly without delays. When nursing homes changed the ratios to 10:1, the care decreased to some degree, but it seemed adequate at the time. But now when the standard seems to have increased ratios to 13:1 the quality of life as well as care leaves a lot to be desired. We now experience more pressure ulcers, a longer wait-time to get cleaned from #1 & #2, hurried inadequate meal times, more infections, etc. This is all based on my observations. And that is provided that the Administration adheres to the agreed PAR levels for staffing; what happens when scheduled employees call sick on weekends and holidays? Then CNA's are left on some units with a 17:1 ratio; is that acceptable? Can any human being attempt to care for that many people in a 7-hour shift (there are two 15 minute breaks and one half hour lunch break on each 8 hour shift)?

This is only a consumer's point of view; I leave to the professionals to use statistical models that will prove the same point that the higher the staffing in facilities the lesser the number of deficiencies found.

As my last comment on this issue, I believe CNA's are important, they provide "quality of life" for the individual being cared for. The function they serve is one of "family," not just "hired hand." All the people who work in the trenches are important. It has nothing to do with college degrees, postgraduate work or great knowledge of medicine. It has everything to do with compassion, caring, and love for the individual they are looking after.

Peter Drucker, the great management guru, put it very simply by comparing teams (sports, dancing, music, etc.) to corporations. He asked how a successful baseball team should be managed? Who are the people important to the success of the team? Obviously all the players are important, but if the team has weak pitching or batting they will go nowhere. The hospital is a baseball team, and some individuals—the doctors—are more important than others. A hierarchy makes sense!



The nursing home does not have the need for great surgeons or other specialties, but they need enough CNA's to perform the tasks required for the quality of life of each individual. There is no need for a hierarchy; the doctor is no longer the most important person on the team, but perhaps the CNA is. Why? Coming back to Peter Drucker, the nursing home is like an orchestra; every instrument is important to the delivery of beautiful music. Are the strings more important than the winds or percussion? Should the CNA be treated the same as the aide in the hospital? Do they perform the same tasks?

To return to our mission today...

What would be my recommendation based on my experience of the past 22 years? There should be RN's on staff to provide the wound care required in any health care institution, but I would suggest the State should set CNA ratio guidelines for nursing homes. The term "adequate staffing" called for in the Federal regulations is meaningless. Nursing home operators can make their own rules and interpret the term, which is more attuned to their pocketbook not to the residents' needs.

Thank you for taking the time to listen.



Staten Island  
Performing Provider System

Submitted: Wm. D. Myhre, Sr. Director Workforce Transformation/HR SI PPS

wmyhre@statenislandpps.org

NYS DOH – October 22, 2019

Public Comments:

Staffing Study Meeting

The Staten Island Performing Provider System and our more than 70 partners have engaged in a productive Workforce Transformation which has been a key to improving healthcare outcomes across Staten Island. During the past year the Staten Island PPS and key employer, labor and higher education stakeholders designed and launched the first in NYS... Federally Approved Registered Apprentice earn and learn program for Nursing Homes. This program was developed with an enhanced curriculum to address what the stakeholders noted as needed skills for new hires like Motivational Interviewing, Team Based work, Conflict Resolution. Our first class completed a combination of classroom and on the job learning in a four month period. All 9 students passed their state exams and the 3 credit college course in Sociology tailored to the Nursing Home environment. The success of this first program has led to the request for additional Apprentice classes to teach an additional 35-40 Certified Nursing Assistant Apprentices. In addition we are building another career ladder option, LPN Registered Apprentice earn and learn.

*and staffing*

The Apprentice model is concrete proof that multiple employers can come together under the convening model of the SI PPS to build best in practices learning and break down the old single employer approach to silo learning. In addition internal staff are selected as Mentors to the Apprentice learners. These Mentors are paid an hourly stipend to measure, mentor and guide the progress of the Apprentice learners. The Mentor program also provides a boost in employee morale when the front line staff are part of the solution.

In addition the Apprentice program <sup>offered</sup> permitted Home Health Aides a new career pathway. This new pathway with both the NYS CNA certification and a Federal DOL certificate created a new hiring pipeline for the Nursing Home partners engaged with the Staten Island PPS.

The Apprentice program is unique for its combination of classroom and on the job learning. Another additional resource is the instructor who helps students with their reading, writing and study skills further ensuring greater chances at success. The addition of a college credit course is also the first exposure to many of the Apprentice students to higher education.

This partnership between Nursing Homes, Organized Labor, College of Staten Island and the Staten Island PPS represents a new, collaborative model devoted to strategic skills assessment, modernized curriculum development, new recruitment pipeline development, creating upward common career pathways among multiple Nursing Home employers.

Additionally, the Staten Island PPS has multiple job titles pending review with the US DOL to expand the concept of earn and learn.

In closing I wish to also note that Cornell ILR studied our Workforce Transformation efforts and published them in October 2018. I have attached a copy to my remarks. I will end my remarks with some excerpts from the study:

“Central to the restructuring efforts led by the SI PPS is a profound change in how front line healthcare employees are working supported by extensive training and a broadening in the roles that employees play.”

“Where organizational and clinical integration is taking root, there is strong evidence that this integration produces benefits in patient care and, with the exception of integration between facilities and occupations, benefits for workers. As such public investments in efforts to increase clinical and organizational integration can lead to significant improvements in patient care and employee outcomes.”

**Findings of the Cornell Research Team Regarding DSRIP Promoted Change in the SI PPS**  
**Harry Katz, Ariel Avgar, Phoebe Strom, John August, and Adam Litwin**  
**Oct. 10, 2018**  
**ILR School, Cornell University**

This report provides a summary of the insights we, a team of researchers from Cornell University, have reached about the progress and accomplishments of the DSRIP restructuring taking place in the Staten Island Performing Provider System (SI PPS). We base our observations on an array of interviews with employees and managers in a variety of jobs and at a number of reporting levels within the SI PPS affiliated organizations and a survey of front-line healthcare workers in the SI PPS (primarily hospital and nursing home employees).

The factors assessed in the employee survey include: attitudes toward and familiarity with DSRIP; the degree of integration in the work of front-line healthcare employees and the effects of work integration on healthcare outcomes including patient care and safety culture; the training received by front-line employees; and the consequences of workplace change on employee well-being. More complete findings from the survey are provided in the power point slides and employee survey report that accompany this report. The survey data provides a snapshot of a system that has undergone dramatic transformation with an emphasis on greater clinical and organizational integration within and between facilities. As such, this data helps identify workplace patterns that can inform public policy efforts around healthcare integration and clinical improvements.

### **Research Overview**

A key objective of the NY state-wide DSRIP program is to improve patient care and reduce healthcare costs by stimulating more integration in healthcare provision. Integration in clinical and behavioral care is sought, for example. For this and other types of integration in

healthcare services to occur the work of front-line healthcare employees would have to correspondingly become more integrated. The survey went to great lengths to measure various forms of integration in the work of front-line healthcare employees including integration in work within units, between units, between facilities, between occupational groups and in clinical practices. An example of occupational integration would take place if nurses and CNA's communicated more effectively and actively. This could produce improved patient outcomes in nursing homes as CNA's would be better able to respond to and understand patient needs as nurses informed those CNA's more fully about the potential side effects of particular medication. Similarly, better communication between hospitals and nursing homes (another form of work integration) when patients are being transferred between those units could improve how the receiving unit responds to patient needs. Our survey sought to examine the implications associated with the different types of integration.

The employee survey data was collected during the spring of 2018, when various DSRIP projects had been underway for up to nearly three years in the SI PPS. It should be kept in mind that the survey does not allow assessment of how conditions and outcomes in 2018 compare with either prior conditions nor do we know how SI compares to other Performing Provider Systems. A variety of types of front-line employees completed surveys including a large number of CNA's and a number of nurses, technicians, and doctors. A total of 671 employees completed the survey (see Slides 2-4).

### **DSRIP Objectives**

The DSRIP reform of the New York State Medicaid system articulated key objectives including the reduction in the use of emergency rooms, greater coordination between clinical and behavioral care, greater use of primary medical care, and reductions in hospital re-entries. Each

of these objectives is sought through the establishment of a specific project designed to promote coordination and focus across the system. Progress in the DSRIP projects is measured by various performance data. The regular collection and continuous assessment of data itself is a noteworthy change brought by DSRIP.

**Key Finding #1 – Breadth and Depth of Organizational Restructuring and Workforce Transformation**

Our research reveals evidence of a myriad of benefits associated with the implementation of the SI PPS. We are particularly impressed by the depth and breadth of the restructuring occurring in the provision of healthcare on SI. Central to the restructuring efforts led by the SI PPS is a profound change in how front line healthcare employees are working, supported by extensive training and a broadening in the roles that employees play. Also noteworthy are core changes in the way medical services are paid for – a shift from fee-for-service to value-based rewards is underway and other financial incentives that are encouraging workforce transformation.

The workforce transformation underway at the SI PPS is supported and facilitated by the following:

1. The promotion of work task integration within and between the 70 organizations that comprise the SI PPS.
2. Data and analytic-based decision making that is used to evaluate and reward performance.
3. Extensive workforce preparedness providing both soft and hard skill development and career opportunities. SI PPS supported training is particularly valuable to small

organizations and their employees who previously lacked the scale and resources to develop training internally.

4. Monetary incentives and penalties justified by objective performance data.
5. The clear conveyance of expected system citizenship reinforced by monetary incentives.
6. Repeated communications across the PPS conveying the desired depth of change and the fact that changes induced by DSRIP are inevitable given broader changes underway in healthcare provision in the US including a shift to value –based payments.

At the same time, we believe there are even more profound changes taking place in medical care provision as a consequence of the SI PPS that may well come to outshine the initial key DSRIP performance objectives. These deeper and potential more consequential changes include:

1. A reorientation in workplace culture to a recognition of the importance of, and an acceptance of, the need for continuous performance measurement and improvement.
2. The spread of team working in various forms that replaces a previously highly fragmented and sometimes contentious relationships between the many occupational types involved in patient care.
3. An acceptance of, and support for, continuous learning and training including training that opens career opportunities to diverse individuals in the SI community who previously had faced upward mobility barriers.
4. A spirit of risk taking and openness to change.
5. Coordination, integration, and cooperation across the system in an effort to advance overall population health objectives including for example, clinical best practices integration (supported by an array of learning modules).

Examples of specific program innovations that promote the continuous learning mentioned in item 3 above include scholarships and new certificate, credit, and degree programs. Activities that encourage the spirit of continuous process improvement mentioned in item 1 above include lean training and patient education training encouraging “the right healthcare at the right time.” The important role played by training in the promotion of a workplace transformation is discussed below.

### **Key Finding #2 – The Breadth of Organizational and Clinical Integration**

A key objective of the NY state-wide DSRIP program is to improve patient care and reduce healthcare costs by stimulating more integration in healthcare provision. Integration in clinical and behavioral care is sought, for example. For this and other types of integration in healthcare services to occur the work of front-line healthcare employees would have to correspondingly become more integrated.

Our interviews revealed that there are a variety of types of integration being promoted in the work of front line employees in the SI PPS including the following:

1. Integration of information systems.
2. Occupation integration involving greater communication between different occupational groups, such as physicians and nurses.
3. Integration of clinical practices within a facility.
4. Within unit integration
5. Between unit integration
6. Inter-facility integration across different organizations



Each of these types of integration are central to the central DSRP goals and objectives advanced by SI PPS activities. Among these, inter-facility integration has received considerable attention as a central mechanism through which to improve system level outcomes. An example of greater coordination between providers through inter-facility integration is found in the integration taking place between hospitals and the nursing homes that requires a great deal of detailed and difficult monitoring. This integration has contributed to the nursing homes' success in reducing the length of stay or frequency of transfer to the hospital. Integration is also expanding between hospitals and community based organizations. This seems particularly successful in the addiction counseling realm.

Another example of effective inter-facility integration underway within the SI PPS is the sharing of information, experiences, and best practices that is now taking place in working groups involving various providers such as nursing homes. We observed some of the meetings of these groups and came away impressed by the mutual learning that was occurring, a learning pattern that apparently did not exist in the past across healthcare providers on the island.

A final example of enhanced organizational coordination are the handoffs occurring in hospital emergency department to addiction counseling. This differs from the past experience of social workers where they would see the same patients over and over in the past, but now see impactful intervention and fewer "frequent fliers."

### **Key Finding #3 – Positive Outcomes from Organizational and Clinical Integration**

The employee survey reveals that there are a number of positive outcomes from various forms of organizational and clinical integration are taking place in the SI PPS. As mentioned above, the survey went to great lengths to measure various forms of integration in the work of front-line healthcare employees including integration in work within units, between units,

between facilities, between occupational groups and in clinical practices. Our survey sought to examine the implications associated with different types of integration.

**The benefits of integration.** Perhaps the most important finding in our analysis of the survey data is that various forms of clinical and organizational integration are associated with frontline worker perceptions of better patient care (along a number of dimensions of care) and an enhanced safety culture (see Slide 29 in the attached). Certain types of clinical and organizational integration are also associated with improved employee well-being, although integration between units and between occupations does not (see Slide 30). These findings overall provide strong support for the basic rationale guiding SI PPS initiatives.

**Prevalence of integration.** While our survey data documents the benefits associated with clinical and organizational integration, we also find that integration is not yet as prevalent across facilities as it could be (see slides 19-22). In particular, employee perceptions of the level of coordination of care is not as high as one would hope given that care coordination is so central to many of the SI PPS initiatives. This evidence highlights the need for continued efforts to promote clinical and organizational integration and the need for efforts to embed this integration within and between facilities.

#### **Key Finding #4 – The Role of Training in Workforce Transformation**

For the SI PPS to achieve its core objectives front-line healthcare employees will have to work more effectively and to do so they will have to acquire and make use of a variety of advanced skills. To promote skill broadening and deepening the SI PPS has engaged in an extensive and highly commendable amount of training in part through the elaboration of

consortiums involving in-house training and educational programs provided at community colleges.

1. Through a variety of training initiatives including the CRPA, CHW, Sepsis, and INTERACT projects the SI PPS has introduced a global approach to training and moved away from the traditional silo approach. This has helped create common skills and approaches and lowered training costs.
2. The SI PPS had made use of a “convener model” which has helped coordinate training across the system and thereby served as an important linchpin to training initiatives.
3. The SI PPS has developed working partnership between the PPS, community partners, unions, and community colleges, here again departing from the traditional more silo approach.

Our qualitative research, for example, documented the impressive investments that SI PPS has made in apprenticeship and skill development through a unique partnership with 1199’s TEF and the College of Staten Island. While our survey data focuses on immediate workplace outcomes, it is likely that there will be long term benefits from the training and skill development that is being provided in Staten Island.

It is noteworthy that the SI PPS has been recognition by the National Fund for its innovative approach to, and depth of training provided to, front line healthcare workforce. The SI PPS also has been asked by the NY State DOH and DOHMH to help others imitate their approach.

One of the ways training can lead to improved patient outcomes is by helping employees make use of new technology. Training may have contributed to the finding in the employee survey that the hours saved using new technology correlates with greater improvements in patient care (see Slide 17). Our survey also demonstrates a link between training and employee

perceptions regarding access to DSRIP information. Training was also correlated to the employees' ability to answer DSRIP related questions correctly (see slide 12).

**Key Finding # 5 – The Importance of Strong Leadership**

In our view, in the SI PPS, as in other workplaces, organizational improvement is facilitated by effective and trusted top-level leadership. At the SI PPS we see much evidence of the required leadership, innovation and coordination. We are particularly impressed by the central role that the SI PPS has played in providing the necessary organizational infrastructure, knowledge base, and support for a sustained and ongoing effort to transform healthcare delivery on Staten Island. We believe that these efforts have led to fundamental changes across the affiliated healthcare organizations both at the leadership and front-line levels.

**Key Finding #6 – Employee knowledge of DSRIP**

For DSRIP to lead to meaningful changes in workforce behaviors and ultimately, patient care one would expect that it would be helpful for front-line employees to understand DRIP's objectives. Our employee survey asked a variety of questions about the extent and source of knowledge about DSRP. We find that a sizable proportion of frontline workers in the SI PPS have considerable knowledge of DSRIP, though there is room for improvement on this front (see Slide 13). Furthermore, our survey data indicate that the unions who represent front-line healthcare employees are a valuable vehicle for educating employees about DSRIP and its core features (see Slides 11 and 12).

**Key Finding #7 – The Influence of SI Structural Advantages and Barriers to Change**

The SI PPS has several structural advantages that likely contribute to its success including the fact that the island and its history provide an underlying sense of community, familiarity, and

common purpose across healthcare providers. This “island” culture, in our view contributes to the sharing of information and sense of common purpose that had been further spurred by the establishment of the PPS.

At the same time, the SI PPS faces several structural impediments such as the fact that share of Medicaid patients/revenues in the two hospitals on the island, is modest, only about 30% of the totals for these organizations. The effect of this is that while parts of these hospitals are fully engaged in one or another DSRIP project, sizeable parts of the hospitals are not similarly engaged. As a result, for example, in interviews several hospital employees observed that DSRIP reforms, such as the shift to value-based pricing, did not effect a sizeable share of the hospitals patients and revenues, In some ways this led to the existence of two different healthcare systems in the hospitals, one side closely linked to DSRIP restructuring and another side that was largely operating in traditional mode. One reason it is worthwhile to note these advantages and disadvantages is because the presence or absence of these factors in other PPS systems throughout New York State likely critically affects the operation and success of those systems.

Organizational change of the depth being attempted in the DSRIP reforms inevitably runs into barriers to change of the sort found in other change efforts. We’ve seen signs of such barriers including the fact that not all front-line employees in the SI PPS seem to fully understand why or how their work needs to change to support the goals of DSRIP. We’ve also heard some employees complain that they feel left out of the processes used to determine performance metrics. These employees can point to some unrealistic and inappropriate performance targets with the rightful claim that broader employee involvement in the design of those targets may have led to fewer problems.

It is also the case that some individuals in the SI PPS seem to be operating under the assumption that sooner or later the DSRIP reforms will go away and they'll be able to return to the "good old days" of a fee-for-service system where providers operated in a disjointed and fragmented manner even though those individuals admit that many problems were endemic in the old system. And not surprisingly, even in the face of the progress made by the SI PPS, there remain periodic workplace conflicts including distrust between some employees across different organizational levels.

### **Key Finding #8 – Employee Well Being**

Since front-line employees are at the center of efforts to integrate work processes and other workplace changes induced by DSRIP, it is critical that employee well-being be considered. Our employee survey assesses the following aspects of well-being: stress, job performance, turnover intentions, and job satisfaction. Our survey reveals positive effects of certain types of work integration on job satisfaction and job performance (see Slides 29 and 30). However, it is important to note that there is evidence that employees are feeling substantial stress (in some cases stress is induced by new technology) and a large proportion of employees report intentions to voluntarily leave their facility within the next 12 months (see Slides 18, 25, 26, and 30). Given the central role that employees play in the integration of patient care, high levels of employee reported stress and turnover intentions are likely to hinder such efforts. Notably, the survey also shows that unionized employees are more satisfied with their jobs as compared to unorganized employees. Unions also helped employees accurately learn about DSRIP (see slide 12) and we learned from our field interviews that unions helped promote and develop training opportunities.

Employees reported a relatively high level of facility reliance on temporary and part time workers (see slide 28). As with employee stress and turnover intentions, these practices may undermine some of the integration efforts put in place given the implications for workforce stability and consistency.

### **Key Finding #9 - Policy Implications**

Our field interviews and analysis of our survey data has a number of clear policy implications. First, where organizational and clinical integration is taking root, there is strong evidence that this integration produces benefits in patient care and, with the exception of integration between facilities and occupations, benefits for workers. As such, public investments in efforts to increase clinical and organizational integration can lead to significant improvements in patient care and employee outcomes. Second, reported levels of integration are still not as high as they could be and there is evidence of sizable variation across the different types of integration. Given the documented benefits of integration, this evidence suggests the need for continued efforts, like those initiated by DSRIP, to expand the diffusion of integration organizational and work practices. Third, problems that lead to poor employee attitudes and unsupportive staffing practices and patterns will hinder the diffusions of integration efforts. Investments in greater levels of integration consequently should include resources designed to address potential workforce issues, such as a reduction in precarious work arrangements, increased attention to employee perceptions of job insecurity, and efforts to address employee stress and burnout. Finally, unions appear to serve as an important source of information about DSRIP and SI PPS initiatives and help promote training. This evidence points to the benefits associated with union involvement in DSRIP.