

NYS Department of Health Staffing Study Engagement Session

September 20, 2019

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Vice President, Quality Advocacy,
Research, and Innovation and
Post-Acute/Continuing Care



Good morning. My name is Loretta Willis and I am the vice president of the Quality Advocacy, Research, and Innovation division and Post-Acute and Continuing Care at the Healthcare Association of New York State. HANYS is the statewide association for hospitals, health systems and continuing care providers across New York. Thank you for this opportunity to provide input to the Department of Health's healthcare staffing study.

I am a nurse by training. I have provided care in various settings across the continuum. I know firsthand how important it is to have the right care team with the right mix of experience, education and training to meet patient needs and provide high-quality care.

I am here today to stress that **HANYS and our members strongly oppose government-mandated nurse staffing ratios** that would impose rigid requirements for every New York hospital and nursing home. These would override the professional judgment of nurses and healthcare professionals and restrict access to care. These one-size-fits-all ratios would apply to all facilities – regardless of size, location or the needs of their patients.

Effective and appropriate staffing is critical to the provision of quality care in all healthcare organizations. Staffing decisions should remain with local hospitals, nursing homes and healthcare clinicians.

Delivering effective and reliable patient-centered care requires a full partnership with nurses working within a multidisciplinary team alongside physicians, medical assistants, care coordinators, aides, other allied professionals and with active patient and family engagement.

Hospitals and nursing homes develop staffing plans tailored to individual patient care needs. These staffing plans are determined by many factors that appropriately vary, starting with the condition of the patient and his or her needs. It also includes the experience, education and preparation of the staff; the use of technology; the physical layout

of the hospital or nursing home; and the number and competencies of clinical and non-clinical staff collaborating with nurses to provide care. HANYS and our members are committed to strengthening these efforts, provided they are grounded in evidence-based strategies.

Healthcare is about people taking care of people. Supporting the healthcare workforce is a top priority of HANYS and every hospital, nursing home and health system. Recruitment and retention at all levels of the healthcare workforce is critical to delivering the highest quality care.

HANYS supports workforce investment strategies such as:

- **Tuition assistance programs for Bachelor of Science in Nursing:** Research has linked a BSN-prepared workforce with better patient outcomes. Tuition assistance will help encourage individuals to pursue a BS in Nursing, which is now required for nurses.
- **Work and learn programs:** These programs provide flexible learning opportunities, often at the work site, for nurses to achieve a BSN.
- **Support for nurse residency programs:** Research has shown that nurse residency programs can improve recruitment and retention of registered nurses and can positively influence professional accomplishments and commitment to nursing.
- **New graduate and new hire mentor/preceptor programs:** To encourage nurse retention, many hospitals and nursing homes are offering mentor and preceptor programs to provide personalized support for nurses adjusting to a new work environment.

- **Programs to promote future workforce:** Programs such as high school “career days,” job shadowing and internships can encourage the entrance of new students into the nursing profession.
- **Permanent per diem and float pools:** Many hospitals and nursing homes have set up internal, specially trained nurse registries to respond to fluctuations in staff, patient volume and acuity need.
- **Formal “on-call” programs for specialized areas:** Specialized areas such as labor and delivery and the operating room routinely have highly-trained staff “on-call” to respond to expected fluctuations in those environments.
- **Staffing committees:** Organization-based committees with representation from all patient care stakeholders, including unit level nurses, can proactively address processes, procedures and staffing assignments on an ongoing basis to ensure patient and staff needs are met.

HANYS and our members are committed to improving quality and patient safety. We’ve made significant gains in recent years. For example, more than 175 hospitals across the state participate in a federal quality improvement collaborative, the New York State Partnership for Patients. Within the most recent NYSPFP contract period, this effort averted more than 11,800 harms to patients.

These outstanding clinical and patient safety improvements are happening as New York’s hospitals and health systems are expanding access to cutting-edge healthcare services, transforming operations to emphasize patient-centric healthcare, shifting care to the outpatient setting and educating the next generation of medical and health professionals.

In closing, HANYS is committed to working with state government and all healthcare stakeholders as we pursue our common goal: ensuring that the highest quality care is accessible and affordable to all New Yorkers. However, government-mandated nurse staffing ratios that would impose rigid requirements in every New York hospital and nursing home will not achieve that aim.

Again, thank you for the opportunity to provide input to the department's study. I'm happy to answer any questions you have.

HANYS: Always There for Healthcare

HANYS is committed to working with state government and all healthcare stakeholders as we pursue our common goal: ensuring that the highest quality care is accessible and affordable to all New Yorkers.

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Department of Health Public Meeting: RN Safe Staffing

Testimony of Nora Higgins, PEF Region 12 Coordinator & NICU RN at SUNY Stony Brook Hospital

September 20, 2019

Good morning, my name is Nora Higgins, I have been a nurse for 32 years. 31 of which with Stony Brook. Clinically 27 years spent in the OB/GYN field, and the last four were spent in the Neonatal Intensive Care Unit (NICU). I'd like to thank the Department of Health for the opportunity to testify today on behalf of the NYS Public Employees Federation (PEF) to provide our perspective on safe staffing for this study. PEF represents over 4,000 nurses working at the State's acute care facilities. Using professional judgement, if a nurse determines an assignment to be inappropriate, a Protest of Assignment form is submitted to hospital management and to PEF. I have chosen a couple of situations to give you an idea of what public sector nurses working at state facilities can face daily because of short staffing.

SUNY Stony Brook University Hospital – for reference is a 603 bed Tertiary Care hospital and Level One Trauma Center with the only State-owned Emergency Medical Services. On September 9, 2019 a nurse on the Surgical Intensive Care Unit (SICU) 18North, reported for the day shift. There were 8 RN's assigned and 2 Aides for 30 ICU patients. The nurse filled out a Protest of Assignment Form and stated:

“Previous shift had no aides on all night; pressing patient care issues required attention as soon as day shift came on the floor i.e.: toileting, episodes of incontinence, personal care issues. Two aides on the floor, many total care patients. Patient acuity high; unable to tend to patients needs and perform medical care (blood transfusions, phlebotomy, medications, charting, neuro checks, neurovascular checks) in a timely fashion. 2 patients impulsive and prone to climb over bed rails; if call bells not answered within 2-3 min of ringing, posing fall risk”.

Understaffed units can be seen all over this fast paced - high tech hospital.

Nurses work 12-hour shifts and are on their feet all day long. They don't have anyone to cover them while they take a break or try to sit down for a meal. Taking a bathroom break is a challenge. If they don't have to work overtime hours, they go home at the end of their tour with deep concern that something may have been missed. Those seriously ill and vulnerable patients may have received sub-standard care and are placed at greater risk for poor outcomes.

- Brooklyn Downstate University Hospital – a 376 bed facility that serves the needs of nearly three million people. On September 9, 2019 a protest of assignment form was filed:
- “Today I was floated to NS 32 along with Ms. ___RN, and Ms. _____ RN of NS 42 due to inadequate staffing on NS 32. I also had to function in the role of charge nurse on NS 32 to which I have never had to function before. I was very uncomfortable being placed as charge nurse on NS 32 (Labor and Delivery) which posed a risk to me and to the patients.

My focus as a registered nurse is first and foremost the patient's safety. I am committed to work within the scope of my training and practice, but today I was made to function that is not within my scope of practice. I felt vulnerable and at risk for loss of my license if a decision was needed by me that would put a patient at risk and something adverse happened. Myself, along with Ms. _____

Ms. _____ did not feel safe today working on NS 32.
This was a very unsafe environment that needs the attention of everyone.”

PEF also represents RN's at the following state hospitals:

- Upstate Medical Center. Holds a total of 735 beds between two campuses
- Roswell Park Comprehensive Cancer Center. A 133 bed center of excellent and innovative care
- Helen Hayes Sub-Acute Rehabilitation Hospital. Holds 155 beds, and is a national leader in physical rehabilitation, specializing in spinal cord & brain injury and stroke recovery.

Additionally, approximately 5,000 other PEF nurses work throughout the “O” agencies such as the Office of Mental Health, Office of People With Developmental Disabilities, Office of Alcoholism and Substance Abuse, the veteran's nursing homes, NYS Department of Corrections and Community Supervision, and smaller facilities. They are all experiencing recruitment and retention problems and PEF welcomes this DOH study, which we hope will finally lead to some solutions to address adequate safe staffing and quality care services.

PEF supports the staffing ratios below:

1. Proposed/preferred minimum staffing levels

- Trauma Emergency 1:1
- Operating Room 1:1
- All Intensive Care 1:2
- Emergency Critical Care 1:2
- Post Anesthesia Care 1:2
- Labor – 1st Stage 1:2
- Labor – 2nd & 3rd Stage 1:1
- Antepartum 1:3
- Non-critical Antepartum 1:4
- Newborn Nursery 1:3
- Intermediate Care Nursery 1:3
- Post-partum Couplets 1:3
- Post-partum mother – only 1:4
- Well-baby Nursery 1:6
- Emergency Department 1:3
- Step-down & Telemetry 1:3
- Pediatrics 1:3
- Medical/Surgical 1:4
- Acute Care Psychiatric 1:4
- Rehabilitation & Sub-Acute 1:5

We strongly urge the Department of Health to establish similar ratios for state facilities within “O” agencies such as OMH, OPWDD & DOCCS for which my colleague and Union Sister, Carolyn Cole will address. All ratios are minimums to be adjusted based upon patient needs.

With respect to workforce needs, we believe the state must prioritize reallocation to be competitive with private hospitals. This will improve the state's ability to recruit and retain a larger share of the nursing pool. Currently the entry Grade is a 14. PEF proposes it be increased to a Grade 20. When the BSN legislation was enacted, that created an additional education requirement for the profession, of which is just cause for reallocation to be considered. With recruitment and retention problems and the statutory increase in educational demands for all nurses to achieve a BSN, higher compensation is in truly order.

Regarding the use of On-Call in the context of safe staffing, we believe on call is best used as a supplement and not as a replacement for maintaining staffing levels. On-call should be meant for specific coverage for specific units and departments. The Emergency Department, Operating Room and Labor and Delivery unit are good examples of where on-call makes sense. RNs will fill in call for every shift of every day in a schedule. Picture a unit with 6 beds full of laboring patients and 4 RNs are working. An emergency C/section walks in the door. One RN is reassigned to care for and prepare the patient for surgery, the 6 patients are now cared for by 3 RNs, but someone needs to be sterile and hand off surgical tools to the Surgeon. On call RN comes in to scrub. When delivery is complete and mother and child are stable, the on call RN is dismissed of her duties. The on call RN is not meant to be supplemental staff is there is not an acute crisis.

Suggested compensation for nurses who remain available to return to work immediately within a specified period of time from a rotating roster should be 30% of

the daily rate of compensation for each 8 hours or part thereof. In the event the employees are actually recalled to work, they will receive appropriate overtime or recall compensation as provided by law.

By adopting the following measures, and consideration of additional compensation, quality care for patients will be consistent and human necessities for nurses will be met:

- Floats should be cross trained for the units they work on and must accomplish competency skills.
- Nurses assigned to be charge on a unit must also have training in that service.
- Scheduled coverage for breaks should be figured in when determining staffing minimums.

Workforce Development enhancements the state should consider include:

- Compensation for the cost of certifications and credentials with renewal
- Student loan forgiveness or full tuition remission for continuing education at SUNY academic institutions
- Childcare subsidies
- Quality of work/life such as guaranteed vacation, modest holiday time off with accrual use, and flexibility with scheduling (staffing ratios would allow for this)

All the state nursing services are experiencing difficulty attracting and retaining enough numbers of qualified staff; some more than others. This nursing shortage has reached a crisis level across the industry. PEF commends the Governor for

commissioning this study. We believe it will lead to adequate safe staffing, quality care services, and many lives saved. Thank for your time.

**Department of Health Public Meeting: RN Safe Staffing
Testimony of Carolyn Cole, PEF Council Leader & RN at OPWDD Facility
September 20, 2019**

Good afternoon, my name is Carolyn Cole. I am a Community Mental Health Nurse for the New York State Office of People With Developmental Disabilities (OPWDD). I would like to thank the Department of Health for giving the New York State Public Employees Federation (PEF) this opportunity to speak as a stakeholder in your study to examine 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. I am here today to advocate that New York State's "O" agencies, which employ thousands of public sector RNs across the state; that they be included in the safe staffing study as they are equally impacted by the current nursing shortage crisis. These "O" agencies include:

- the Office of People With Developmental Disabilities (OPWDD)
- the Office of Alcohol and Substance Abuse (OASAS)
- the Office of Mental Health (OMH)
- the Office of Children and Family Services (OCFS)
- the Department of Corrections and Community Services (DOCCS)

They are stakeholders as well. They provide essential services to the public and ensure a holistic approach to the needs of New York State's most vulnerable residents and must be included in this study and benefit from what will come out of it.

PEF represents close to 10,000 registered professional nurses employed at NYS facilities. Approximately 5,000 registered nurses work throughout these various "O" agencies and are plagued with the same recruitment and retention problems that hamper the State's acute care hospitals. It is

within these agencies that nurses work the most forced overtime, despite there being statutory protections prohibiting mandatory overtime for nurses (except for emergencies that are outlined) *in Labor Law Part 177 – Restrictions on Consecutive Hours of Work For Nurses.*

New York State has made a commitment to tackle the growing epidemic of opioid abuse, addiction and overdose deaths but the agency (OASAS) which the State relies on to fulfill this charge is unable to adequately meet their RN staffing needs. It has gotten to a point where one Addiction Treatment Center (ATC) had assigned social workers, to assist the nurse. RN's at OASAS, DOCCS and OMH facilities are made to work double shifts, are pre-scheduled to work mandatory overtime and in a lot of cases are mandated from home. PEF regularly receives reports from our RNs about being exhausted and feeling as though they have abandoned their spouses and children.

Mandatory safe staffing levels for these agencies will allow medication administration and treatments to be on time. The nurse will be able to do assessments, charting and therapeutic interactions. The nurse will have work/life balance and be able to spend time with their families. Evidenced based data shows that this will have a trickle down effect to the patients and the quality of care given by nurses. New hires will find this environment conducive to making a long-term commitment to working for New York State instead of the current situation of heavy turnover.

One extreme example of the staffing shortage reported to the union by members is when a DOCCS facility was forced to place an entire jail on lock down, in the event of any injury or sickness to an inmate or staff, simply because there were no nurses on duty that day.

The OMH patient population is seeing increased numbers of ex-convicts with dual diagnoses that has changed the in-patient dynamics of providing safe mental health care to the most volatile patients. Assaults and injuries on staff are increasing.

At OPWDD facilities, disabled consumers, many of which are struggling with mental health issues as well as other disabilities, are being discharged to different sites based on the availability -- or lack thereof -- of RNs at a particular site. At times, these transfers are to sites that are not appropriate to the consumer as well as further away from immediate family. These transfers can be highly stressful and disruptive to the entire family and to the caregivers who have become a second family.

Earlier this year, PEF assisted the family of Tony Otto -- a beloved, 51 year-old quadriplegic who had been living at a Central New York OPWDD residential home for over 25 years— in a fight to appeal his transfer. Tony's family has given the union permission to share his story at this hearing. OPWDD planned to move Tony out of the facility he had called home for over 25 years to a nursing home where he would only receive comfort care and is 1 ½ hour drive away from his family who live near his current facility.

Tony's family was told by OPWDD that they must choose a nursing home as OPWDD "can no longer support their son's nursing needs" as he requires 24-hour nursing care. OPWDD has been closing 24-hour nursing support residences, intensive Intermediate Care facilities and diminishing the services necessary for people to live in the least restrictive setting by outsourcing these individuals to nursing homes and other long-term care facilities.

PEF member Jodi Nettleton, a developmental disabilities policy developer at OPWDD, who took care of Tony for five years, said his situation is a result of short staffing of RN's at state facilities. "The state has trouble recruiting and retaining registered nurses. As a result, state-operated services throughout New York have diminished. The state has not allocated adequate funding to support

nursing titles to compete with the private sector, so it is reducing the footprint of services which is an injustice.”

Tony’s family appealed the discharge at a hearing on May 9th. On June 11th, Hearing Officer Peter Loomis, ruled in favor of Tony and his family against the discharge. Here are brief excerpts from the ruling, a copy of which we submit with our written testimony.

“It is clear from the record that OPWDD has made many different attempts to hire and retain RN’s in order to meet Tony’s needs, most of which have not been particularly successful....OPWDD must, in my opinion, notwithstanding the admitted difficulties, continue to investigate and pursue ways to increase the pool of RNs available to serve Tony.

I cannot in good conscience relegate Tony to life in a skilled nursing facility. He has physical limitations that I would expect few can understand, or imagine themselves enduring, but yet his mind is clear and living (at his current facility) has enabled him to be part of and participate in the community around him. Denying Tony these opportunities would, in my judgement, not be appropriate or reasonable based solely on what admittedly are onerous staffing problems.

I find it in Tony’s overall best interests to remain where he is, and which he considers his home, while OPWDD continues its efforts to hire additional staff. I therefore sustain the objection to discharge filed on Tony’s behalf.”

Tony Otto’s story is one many across the state. Most OPWDD residents do not have active families that have the time and resources to fight inappropriate placements. The real life, real people consequences of RN short staffing in these “O” agencies impact our most vulnerable residents and they deserve better!

There is no question safe staffing levels will improve patient outcomes and we strongly urge the Department of Health to include “O” agencies in this safe staffing study.

Thank you again for the opportunity to testify today.



Testimony for the Department of Health Staffing Study

Provided by

James W. Clyne, Jr
President/CEO
LeadingAge New York

Friday, September 20, 2019

Introduction

On behalf of the membership of LeadingAge New York, thank you for the opportunity to submit testimony on staffing enhancements to improve patient safety and the quality of healthcare service delivery. LeadingAge New York represents over 400 not-for-profit and public providers of aging services and senior housing, long-term and post-acute care, as well as provider-sponsored managed long term care plans.

New York is home to approximately 3 million residents age 65 and older, representing 15 percent of the population. By 2025, 18 percent of New York's population is projected to be age 65 or older, up from 14 percent in 2010. Both the number and percentage of older New Yorkers is expected to continue to rise over the next 20 years. This growth will drive a corresponding increase in the number of New Yorkers with cognitive and functional limitations who require long-term supports and services. However, by 2025, the availability of younger New Yorkers to care for seniors both informally and in the formal care delivery system will be at its lowest point in a decade and declining. In addition, with one-third of today's older New Yorkers living at or near the poverty level, it is reasonable to expect that a significant portion of our growing senior population will continue to rely heavily on public programs – principally the Medicaid program – to cover their service needs. Any staffing mandates must consider the reality of increased Medicaid costs and the current struggle to find qualified staff, which will be exacerbated in the years to come.

LeadingAge New York strongly opposes government-mandated nurse staffing ratios requiring inflexible nurse/aide-to-resident ratios in every New York nursing home, overriding the professional judgment of clinicians and potentially limiting access to care. Any one-size-fits-all ratios that would apply to all nursing homes, regardless of size, location, physical layout or the actual care needs of residents is contrary to quality patient-centered care. Imposing staffing ratios on nursing homes and hospitals could also further deprive home and community-based services agencies and other institutional alternatives (e.g., adult care facilities and assisted living) of the staffing they need at a time when the state is seeking to rebalance the long-term care system.

Availability of Nurses and Aides

The labor supply is already being outstripped by current demands, and future projections are daunting:

- High percentages of nursing homes in the State are currently reporting difficulty recruiting and retaining registered nurses (RNs) (47%); experienced RNs (59%); licensed practical nurses (LPNs)(56%) and certified nurse aides (CNAs) (58%).¹ Worker shortages are most commonly cited for the difficulty.
- Between 2015 and 2040, the number of adults over age 85 in New York State will double.
- A decline in the number of working age adults and large increase in the numbers of older adults will affect the availability of informal care and demand for formal services and caregivers.

¹ Martiniano R, et. al. The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; March 2018.

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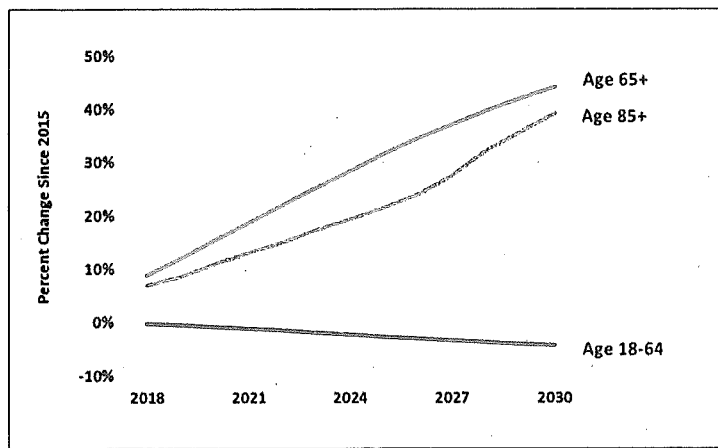
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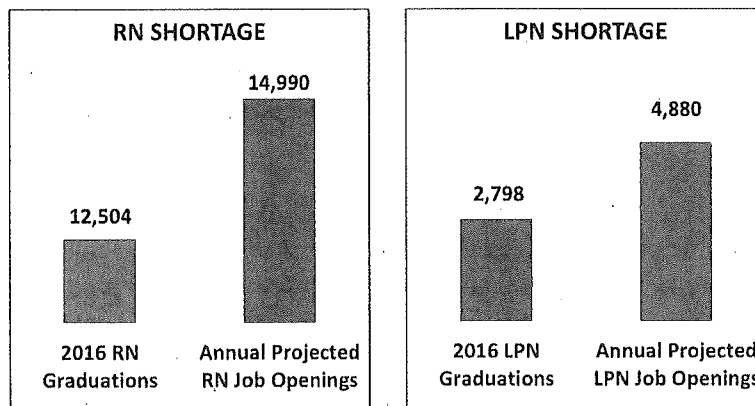
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NYS Aged Population Grows while Working Adult Age Group Declines



- As shown below, NYS nurse openings are exceeding graduations by over 4,500 positions annually.
- The NYS Department of Labor has identified home health aides (45%), personal care aides (31%) and nursing assistants (16%) as three of the top four sources of health care job openings between 2014 and 2024.

NYS Nurse Job Openings Exceed Graduations by over 4,500 Annually



Estimated Cost of this Mandate

The Safe Staffing for Quality Care Act (A.2954/S.1032) would require nursing homes to maintain staffing ratios of 2.8 hours of CNA, 0.75 hours of RN, and 0.55 hours of LPN time per resident per day. LeadingAge NY estimates that these requirements would require nursing homes to add 6,903 RNs, 461 LPNs and 10,300 CNAs at an initial annual cost of \$1,057,600,000.²

² LeadingAge NY estimated the need for additional staff by comparing the daily staffing ratios required by the bill to the reported hours worked from 2017 nursing home cost reports, and applied regional averages to homes for which data was not available. To estimate the cost, we multiplied facility-specific average RN, LPN and CNA wages including benefits by the number of additional hours required.

We believe this estimate is inherently conservative, as it does not consider wage increases subsequent to 2017 or wage growth likely to occur due to increased competition for staff if this legislation were to be enacted. Researchers of the impacts of mandated nurse staffing ratios in California found that wages for all RNs in the state rose faster during the period of implementation than they did in other states at the same time. For example, with hospitals in regions outside of New York City paying 9 – 22 percent more than nursing homes for RNs³, nursing homes could see steep increases in RN compensation if such a mandate were applied. There would be ripple effects on other providers that utilize nurses and aides including home care agencies, assisted living facilities and adult day services.

Lack of Evidence of Effectiveness

California is the only state in the US to mandate hospital-wide nurse staffing ratios. Researchers have not been able to establish a causal relationship between mandated specified ratios and quality of care.

Prior to implementing mandatory nurse staffing ratios in California, the California Department of Health Services (DHS) contracted with the University of California-Davis (Center for Health Services Research in Primary Care and Center for Nursing Research) to provide analytic and technical support. The report concluded that “. . . the literature offers no support for establishing minimum nurse-to-patient ratios for nursing units in acute care hospitals, especially in the absence of adjustments for case mix and skill mix.”

An analysis of the impact of ratios in a study published by the California Health Care Foundation (Spetz and Chapman, et al. 2009) found that while skill mix increased after the implementation of the California law, most quality measures analyzed were not directly affected by ratios. This study found that the overall level of average length of stay in California stayed the same since the ratios were imposed. Other nursing sensitive measures showed similar results. Similarly, Bolton, et al. (2007) found no significant changes in falls, falls with injury, hospital-acquired pressure ulcers, or use of restraints associated with California's nurse staffing ratios. Bolton determined: “. . . anticipated improvements in nursing-sensitive patient outcomes were not observed.”

In the October 2016 publication of the final regulation updating the Requirements of Participation for nursing homes, the Centers for Medicare & Medicaid Services (CMS) stated as follows: “We agree that sufficient staffing is necessary, along with the need for that staff to be competent in delivering the care that a resident requires. We also agree that all of these factors are associated with quality of care. However, we do not agree that we should establish minimum staffing ratios at this time. As discussed in the preamble to the proposed rule, this is a complex issue and we do not agree that a “one size fits all” approach is best.”

Nursing Home Staffing is Already Closely Monitored

Nursing homes are already required to have staffing plans tailored to individual resident care needs, and information on staffing as well as safety/outcomes is available to the public. Facilities are also required to comply with numerous regulations covering staffing adequacy, competence, processes of care and other areas.

- Under Federal posting requirements, nursing homes must record and prominently display current nurse staffing numbers by occupation for each shift, as well as the daily number of residents.

³ Source: LeadingAge NY analysis of 2015 RHCF Medicaid Cost Reports & 2015 Institutional Cost Reports from HealthData NY.

- During standard health inspections of nursing homes, DOH inspectors review quality of care and staff/resident interaction; including interviewing residents, family members and caregivers.
- CMS's Payroll-Based Journal (PBJ) requires nursing homes to collect staffing hours based on payroll data or other verifiable and auditable data and report this data quarterly.
- The PBJ data are, in turn, used to develop the staffing rating included in CMS's Five-Star Quality Rating System. Nursing Home Compare is an on-line resource for consumers, families and caregivers to review a nursing home's Five-Star rating for staffing, quality and compliance.
- DOH's Nursing Home Profile website also includes public information on staffing, quality and compliance.
- The federal Requirements of Participation include staffing adequacy determinations and a comprehensive facility assessment to help identify staffing levels, skill mix and competencies to address resident needs.
- DOH's Nursing Home Quality Initiative includes 14 quality measures derived from Nursing Home Compare, performance on potentially avoidable hospitalizations and three compliance components. Two staffing measures are included – a calculation of nurse staffing hours and the level of contract/agency staff use. Each facility's score is used in determining eligibility for an award from a \$50 million self-funded pool.

Invest in Recruiting New LTC Workers

Workforce is not a problem looming in the distant future – it is a crisis today. Nursing homes and other long term care providers face extraordinary challenges recruiting and retaining workers -- the pool of eligible candidates is small; access to required aide certification and nursing programs is limited; home care patients are dispersed over long distances, aides must have reliable vehicles and spend hours each day driving between patients' homes; and competition with other employers, such as hospitals and even fast food and retail establishments, is fierce.

Expanding the pool of LTC workers would help nursing homes and other LTC providers to more quickly fill vacant positions, thus increasing patient care staffing. The following should be considered:

- **Utilizing DSRIP 2.0 as a vehicle for recruiting new workers into the LTC field**, rather than focusing almost entirely on training/retraining *existing* workers. These investments should support:
 - Expansion of aide, LPN, and RN training programs especially in rural areas;
 - Subsidies and stipends for participating in aide certification and nursing programs;
 - Subsidies for car maintenance and day care for LPNs and aides;
 - Scholarships for part-time students in nursing and aide programs in community colleges;
 - Loan forgiveness programs for nursing graduates.
- **\$50 million in State funding to support initiatives to train, recruit, and retain the LTC workforce**, including programs that provide: (1) enhanced wages and benefits; (2) social supports for workers; (3) reimbursement of certificate training expenses; (4) on-the-job training; (5) high school pre-apprenticeship programs; (6) peer mentoring; (7) career ladders; and (8) additional staff to support direct care positions.

- **Civil Money Penalty (CMP) funds for CNA recruitment and retention:** The state's CMP account supports activities that benefit nursing home residents and improve quality of care or quality of life. Funding from this account should be used to create a New York Careers in Aging program, which would be used to cover the expenses of students to complete approved certified nurse aide (CNA) training and testing programs, provide CNAs with retention bonuses after 6 months of work, and fund a marketing and recruitment plan highlighting the benefits of working in a nursing home.

Programmatic Initiatives

- **Allow for advanced CNAs/medication technicians:** Enact legislation to allow CNAs with additional training to administer medications in nursing homes under the supervision of a registered nurse. The state is facing a significant nursing shortage, and many nurses express dissatisfaction with the repetitive task of routine medication administration. Meanwhile, aide-level workers are leaving health care to pursue other jobs due to wage restrictions and job satisfaction. Allowing these additional responsibilities can provide increased job satisfaction, allow for wage increases, a career ladder, and improved staff retention.
- **Modify training required of paid feeding assistants:** New York regulations require feeding assistants who support nursing home residents at meals to undergo more extensive training than federal regulations require. As a result, many nursing homes continue to use CNAs to assist some residents at meals who might otherwise be fed by a paid feeding assistant. If State regulations were aligned with the federal requirements, nursing homes could expand their use of feeding assistants and allow CNAs to focus on higher level tasks.
- **Facilitate cross-certification, streamline in-service training requirements, and promote the availability of competency exams of direct care workers:** Streamline the certification and re-certification of CNAs, home health aides (HHAs), and personal care aides. Currently, CNAs that seek to become HHAs must either take the 75-hour HHA training course or take a competency exam in lieu of training. However, only CNAs with one year or more of hospital experience are eligible to take the evaluation in lieu of the course. Veterans trained by the US military as medical technicians or medics are also eligible for competency evaluations in lieu of training. CNAs who work in nursing homes do not appear to be eligible for competency evaluations in lieu of the full course. Expanding access to competency evaluations and streamlining or aligning training and in-service requirements would expand the pool of aides and reduce duplicative in-service requirements.
- **Facilitate cross-training and lateral transfers across health and LTPAC settings:** Providers of health, LTC, behavioral health, and developmental disability services and unions should join together with regulators and educational institutions to explore cross-training and inter-disciplinary service opportunities in order to alleviate workforce shortages. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.
- **Support informal caregivers:** The state should offer expanded respite benefits, direct financial assistance, greater tax incentives, training programs, and education and community outreach programs for informal caregivers. This would help consumers and their families to reduce their reliance on formal caregivers and delay the need for Medicaid covered LTC costs.
- **Expand efforts to recruit young adults and "young" seniors for LTPAC careers:** Support programs like MercyCare in the Adirondacks which is successfully utilizing younger senior volunteers to provide supportive services to other seniors in need. In addition, assist providers to replicate career exploration programs in secondary schools and institutions of higher education, like the Geriatric Career Development Program of The New Jewish Home which provides academic and career

development assistance to at-risk New York City youth, through an in-depth, work-based learning program in a geriatric long-term care setting.

- **Support relevant federal legislation:** The Nursing Home Workforce Quality Act (H.R. 1265) would grant CMS greater flexibility in reinstating providers' CNA training programs; making suspension of a training program a discretionary remedy available to survey agencies. In addition, nursing homes subject to a lockout would regain their authority to train CNAs once the deficiencies for which they were cited are corrected. The Geriatric Workforce Improvement Act (S. 299) would address the widening gap between the number of health care providers educated and trained to meet the special needs of people as they age, and the rapidly growing population of people aged 65 and over. The bill would reauthorize the Geriatric Workforce Enhancement Program for another five years, with authorized funding increased to \$45 million per year.

LeadingAge NY remains committed to partnering on the *Department of Health and Nursing Home Associations Collaboration to Improve Nursing Home Quality* on other initiatives aimed at addressing workforce issues, regulatory flexibility, and quality measurement and enhancement.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven, and public continuing care including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs, and Managed Long Term Care plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.



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Testimony on Staffing Enhancements

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<http://www.chwsny.org/>

- My name is Jean Moore and I am Director of the Center for Health Workforce Studies.
- We are a research center based at the University at Albany School of Public Health.
- Established in 1996, our mission is to provide timely, accurate data and conduct policy-relevant research on the health workforce to support health workforce planning and policymaking
- Thank you for giving me the opportunity to present testimony regarding staffing enhancements in hospitals and nursing homes.
- In order to assess the feasibility of implementing minimum staffing ratios, we need information about the supply and distribution of the state's nursing workforce, as well as production of new graduates, especially in light of new RN licensing requirements (BSN in 10).
- I'd like to share with you what we know and don't know about the current nursing workforce and the production of new RNs in the state, as well as available data sources.
- Perhaps most importantly, I want to tell you what I think we need to know prior to implementing mandatory staffing ratios.

There are limited data on RN supply and distribution, as well as educational and practice characteristics of the state's active RNs.

- We have analyzed American Community Survey (ACS) data in the past when conducting nursing workforce research and found it to be a useful source of information about RNs at state and regional levels.

- There are, however, a number of limitations associated with using the ACS:
 - Data in the ACS are self-reported and there is some evidence of misclassification. (e.g. reporting the wrong occupation or educational attainment)
 - While health care employment settings are reported, they are too general for meaningful analysis, e.g., one cannot distinguish inpatient from outpatient hospital jobs
 - The ACS question on educational attainment asks about highest degree earned but not highest nursing degree, so there is no way to estimate the percent of active RNs in the state who hold (BSNs)
 - The sampling frame used by ACS is not sufficient for local area analysis, particularly in the state's rural areas.
- We recently evaluated data collected by the National Council of State Boards for Nursing on the state's nursing workforce. Our assessment indicates that the data are limited due to small sample size and are only useful for state level analyses.
- We have also used data drawn from the National Sample Survey of Registered Nurses, a federally supported data collection effort on the nursing workforce using a nationally representative sample of RNs. Our experience using these data indicate that due to sample size limitations, they are only useful for state level analyses.

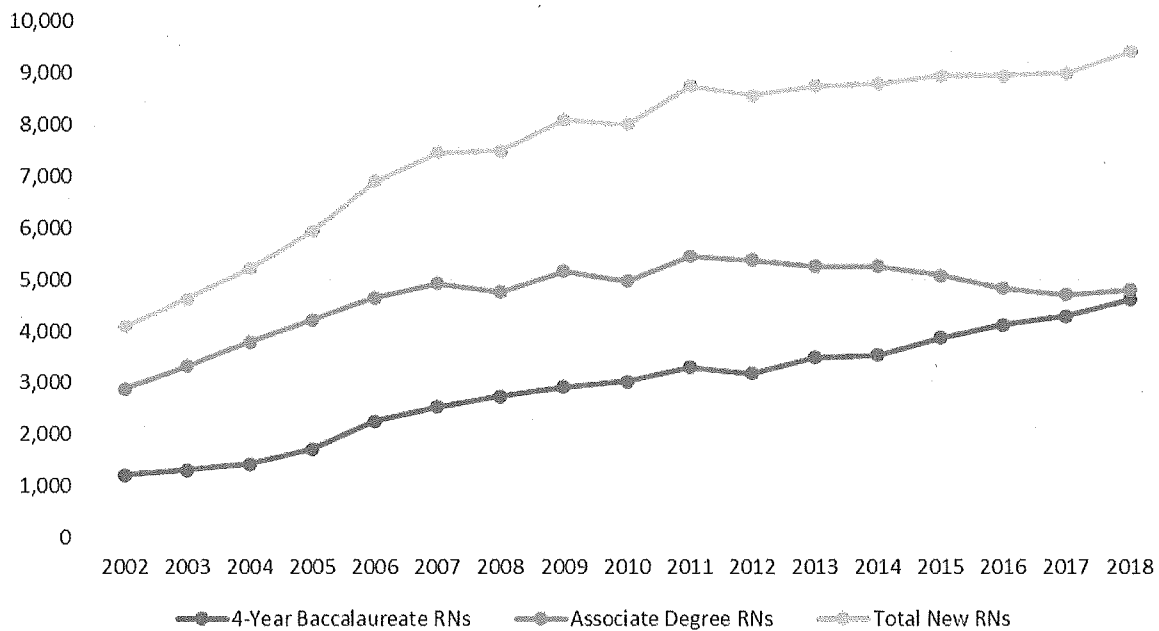
With regard to RN production in the state....

- Since 2002 the Center has conducted an annual survey of the deans and directors of New York's registered nurse (RN) education programs.
- The survey asks about nursing program applications, admissions, and graduations as well as respondents' assessment of the local job market, and barriers to expanding program capacity.
- Key findings from this research are described below

The annual number of graduates from the state's RN education programs continues to rise.

Since 2002, the number of new RN graduates from the state's nursing education programs has consistently increased. However, in recent years, growth has slowed. We've also seen that graduations from BSN programs continue to increase, while graduations from ADN programs have seen declines since 2011.

Annual Number of New Graduates from NY RN Education Programs by Degree Type, 2002 – 2018

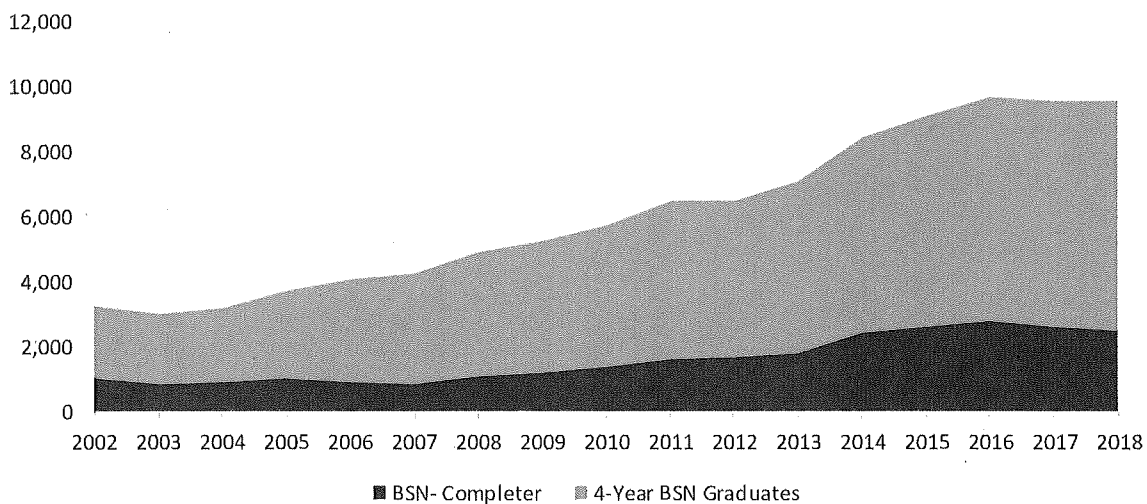


Note: BSN completers are those RNs with ADNs or RN diplomas who go on to earn BSNs.

Source: Center for Health Workforce Studies

BSN-completer graduations as a percentage of total BSN graduations declined between 2014 and 2018.

BSN-completer graduates, as a percentage of total BSN graduates, grew steadily between 2007 and 2014, increasing from 26% to 41% (Figure 2). Since 2014, however, BSN-completer graduates as a percentage of total BSN graduates declined to 35%.



Source: Center for Health Workforce Studies

What we don't know

- We don't have much information about the state's active RN supply and I am concerned that maldistribution of the nursing workforce (much like physicians) could hamper efforts of providers to implement staffing ratios.
- We don't know either short-term or long-term impacts of the BSN in 10 legislation passed in 2017 on the current supply of RNs working in the state and potential new entrants into the nursing profession.
- Thus, we don't know whether the current supply of RNs is adequate (either in size or distribution) to meet staffing ratio goals, nor do we know whether the production of RNs in the state is adequate to maintain those goals.

What we need

We need better data on the current supply of active RNs – demographic, educational, practice characteristics to understand who they are, where they are and what they do.

There currently is a model for collecting the data needed for such workforce monitoring efforts. Currently, workforce data are collected from the state's nurse practitioners through a mandatory survey tied to license renewal.

Moreover, if the state collected data that supports the ongoing monitoring of the nursing workforce, we could better understand the adequacy of the supply of nurses in relation to demand for them under minimum staffing ratio guidelines.



**NYS Department of Health Testimony of Nurse and Caregiver-to-Patient Ratios in NY
Hospitals and Nursing Homes
Friday, September 20, 2019**

The New York State Nurses Association represents over 42,000 registered nurses and is the largest union representing registered nurse in New York state.

As a union representing registered nurses, we advocate universal, equal, high quality health care for all New Yorkers regardless of ability to pay.

We strongly support legislation and regulations that will allow nurses and other direct care health workers to provide care for our patients and communities in compliance with professional standards, with guaranteed minimum staffing levels, and under safe and fair working conditions. Universal studies demonstrate that this policy is fiscally prudent and helps hospitals and nursing homes save money.

The FY19-20 Executive Budget included a proposal directing the Department of Health to conduct a study that will examine ways to implement staffing enhancements to improve patient safety and the quality of care in our hospitals and nursing homes.

The Governor's proposal recognizes the inherent authority of the DOH to regulate hospitals and nursing homes to ensure patient safety. It further directs the DOH to engage health care industry stakeholders to conduct a study on (a) the need for staffing enhancements and other methods to improve patient care; (b) the costs and financial impacts of improved staffing, and (c) the impact of improved or enhanced staffing regulations on patient safety and the quality of care.

NYSNA and a range of other labor and community advocates strongly support expanding mandatory safe staffing standards or floors to ensure that hospital and nursing home patients have enough registered nurses, licensed practical nurses, nurse's aides, patient care technicians, and other direct patient care workers and professionals who are part of an inter-disciplinary team to deliver safe high quality patient care.

We believe that minimum staffing ratios covering registered nurses, licensed practical nurses, nursing aides, patient care technicians and other members of the inter-disciplinary team of direct care staff will be found to be the most effective approach to improving patient safety and the working conditions of direct care workers.

This conclusion is supported by a well-established body of research and the actual experiences of New York, California and other jurisdictions that have successfully implemented minimum staffing ratios.

Setting a floor on the number of patients that registered nurses, licensed practical nurses, nursing aides, patient care technicians and other direct care staff can be assigned to care for is safer to patients, safer for direct care workers and in the end more cost effective than short-sighted management efforts to cut corners and pinch pennies by skimping on patient care.

New York has already established safe staffing standards for certain types of patients by statute and regulation. New York's approach to safe staffing standards was a correct response to documented patient safety concerns for certain types of units. With the intensification of patient acuity throughout hospitals and nursing homes, it is now time to expand the application of staffing standards to every patient care unit in furtherance of safe patient care and to be consistent with New York's long standing approach to regulating hospital and nursing home staffing.

Research shows that the more patients assigned to a nurse and other direct care staff, the worse the quality of care that is received by those patients. Poor staffing increases patient mortality rates, reduces patient health outcomes, increases the incidence of co-morbidities, complications and length of stay, reduces patient ratings of their care experience, lengthens patient recovery times, and leads to higher rates of readmission and unnecessary health care utilization.

Poor staffing also negatively affects the working conditions of direct care workers and the experience of patients. Inadequate staffing increases wait times for care, is a trigger for workplace violence and assaults on patient care staff, leads to increased workplace injuries and illness, depresses workplace morale and leads to higher rates of staff burnout and turnover.

The adverse effects of poor staffing also have serious costs and financial consequences for bottom lines of hospitals, nursing home and other health care providers. High rates of turnover of direct care staff pose a huge and increasing cost for employers in the form of direct recruitment and training costs and indirectly in the form of lost experience and productivity. Unnecessary patient admissions and readmissions impose significant costs on the health care system and result in reduced provider reimbursement and other monetary penalties under current federal and state policy. Poor staffing is a major contributing factor in assaults and work-related injuries, leading to increased labor back-fill and employee health care costs to employers. Poor staffing also increases liability costs for malpractice and

patient harm lawsuits. Poor patient care outcomes also impose a macro-economic cost in the form of lost work time, decreased quality of life and higher total health costs in the broader economy.

NYSNA strongly supports the expansion and establishment of enforceable staffing ratios beyond where they already exist to all areas of hospitals and nursing homes, applicable to nurses and to other direct care workers, as a necessary measure to ensure the health and safety of patients and workers.

Hospitals Face a Patient Safety Crisis in New York

Over the past few years, New York has consistently been ranked lower than other states when it comes to patient safety in hospitals.

The Leapfrog Group's hospital safety rankings placed New York near the bottom at 48th out of 50 states. According to the latest Leapfrog ratings, only 5.84% of New York hospitals received an "A" grade (compared to 29.1% of California hospitals). At the other end of the spectrum, 17.5% of New York hospitals received a "D" or "F" ranking (compared to only 7.8% of California hospitals).

U.S. News and World Report's latest rankings placed New York's health care providers at 38th.

In addition, Medicare's Hospital Compare, which is a tool that measures hospital quality of care data and patient satisfaction scores, gives NY hospitals very poor ratings. Of the 151 hospitals receiving scores, only 17 received a 4 or 5 star rating (11%), while 95 received the lowest 1 or 2 star ratings (62.9%). In California, by way of comparison, 89 hospitals (30.5%) received the highest 4 or 5 star ratings.

New York must act to improve quality of care, patient safety and the safety of its hospital workforce. Implementing safer hospital workforce staffing levels will be one of the ways we can achieve these much-needed improvements.

DOH Currently Regulates the Provision of Health Care Services, Including Minimum Standards of Nursing Care, Development and Implementation of Staffing Plans and Minimum Nurse-to-Patient Ratios

DOH has already enacted regulations imposing minimum staffing levels of registered nurses in New York hospitals and residential health care facilities, many of which have been on the books for decades.

- 10 N.Y.C.R.R. Section 405.5 requires the following minimum staffing and patient care standards in all hospitals:
 - There shall be a director of nursing services who is a licensed RN;
 - RNs, LPNs and other personnel shall be employed in sufficient numbers "to provide nursing care to all patients as needed;"
 - Supervisory and staff personnel shall be provided "for each department or nursing unit to ensure, when needed in accordance with generally accepted standards of nursing

practice, the immediate availability of a registered professional nurse for bedside care of any patient;”

- The nursing service shall “monitor and evaluate the quality and appropriateness of patient care and the resolution of identified problems.”
- 10 N.Y.C.R.R. Section 415.13 requires the following minimum nursing services in residential health care facilities:
 - The facility shall have “sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care;”
 - The facility shall assure that each resident receives treatments, medications, diets and other health services in accordance with individual care plans;
 - The facility shall provide services by sufficient numbers of RNs, LPNs, certified nurse aides and other nursing personnel “on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;”
 - The facility shall designate a registered professional nurse or licensed practical nurse to serve as a charge nurse on each tour of duty who is responsible for the supervision of total nursing activities in the facility, or “as necessitated by resident care needs, the facility may designate one charge nurse for each tour of duty on each resident care unit or on proximate nursing care units in the facility provided that each nursing care unit in the facility is under the supervision of a charge nurse;”
 - The facility shall use the services of a registered professional nurse for at least eight consecutive hours a day, seven days a week;
 - The facility shall designate a registered professional nurse to serve as the director of nursing on a full-time basis.
 - If the facility has an average daily census of more than 60 patients, the director of nursing may not act as a charge nurse and another licensed nurse must be on duty to perform charge duties;
- 10 N.Y.C.R.R. Section 405.29(d)(3) requires that cardiac surgery centers shall be staffed on a 24 hours basis by at least one RN in charge of coordinating care of post-surgery patients and in charge of staffing levels for the unit; in addition, there shall be “registered professional nurses, licensed, practical nurses and nursing assistants in such ratios that are commensurate with the type and amount of nursing needs of the patients;
- 10 N.Y.C.R.R. Section 405.29(e)(1) requires that cardiac catheterization labs shall provide care to adult and pediatric patients by clinical personnel trained in critical care and complex cardiac conditions and available on a 24 hour basis;
- 10 N.Y.C.R.R. Section 405.22(a) requires that all critical care units are to be staffed “for patients requiring care on a concentrated or continuous basis,” shall be “provided with a concentration

of professional staff and supportive services that are appropriate to the scope of services provided...in accordance with generally accepted standards of medical practice” and that written policies for patient care meeting these requirements are developed and implemented by the nursing service;

- 10 N.Y.C.R.R. Section 405.22(b) requires pediatric intensive care units to maintain one in-house physician on a 24/7 basis, a qualified physician, physician assistant or nurse practitioner assigned to the unit on a 24/7 basis, an attending physician exercising oversight of the unit, and that the hospital “shall provide registered professional nursing staff sufficient to meet critically ill or injured pediatric patient needs, ensure patient safety and provide quality care;”
- 10 N.Y.C.R.R. Section 405.22(d) establishes minimum nurse-to-patient ratios for burn units, requiring one registered nurse for every two intensive care patients at all times and one registered nurse for every three non-intensive care patients at all times;
- 10 N.Y.C.R.R. Section 405.31(p)(5) establishes minimum nurse-to-patient ratios for liver transplantation services, requiring one registered nurse for every two ICU/PACU patients and one registered nurse for every four non-ICU/PACU patients;
- 10 N.Y.C.R.R. Section 405.19(d)(2) establishes minimum nurse staffing levels in emergency services facilities which require one supervising RN to be present on the unit on a 24 hour basis and additional registered nurses depending on the average volume of patients, with at least 1 RN if the average ER census is 25 or less, an additional RN if the average census is more than 25, and “as patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet patient care needs;”
- 10 N.Y.C.R.R. Section 405.18(d) requires that spinal cord injury programs have at least one registered nurse available assigned to the unit at all times;
- 10 N.Y.C.R.R. Section 405.21 requires that perinatal services units that each maternity patient “when present in a labor, delivery, birthing room or birthing center shall be under the care of a registered professional nurse available in accordance with the patient’s needs” (See also: 10 N.Y.C.R.R. Section 721.7 which requires that nursing care for all mothers and newborns be supervised by a registered nurse and that “assessment and monitoring activities shall remain the responsibility of a registered nurse or advanced practice nurse in obstetric-neonatal nursing, even when personnel with a mixture of skill are used;”
- 10 N.Y.C.R.R. Section 405.12 requires the operating room shall be supervised by a registered professional nurse or physician, that nursing personnel “shall be on duty in sufficient number for the surgical suite in accordance with the needs of patients and the complexity of services they are to receive,” and that a registered nurse be present as the circulating nurse in all operating rooms where surgery is being performed for the duration of the surgical procedure;

The DOH authority to regulate minimum standards of patient care extends to all units and departments within hospitals and 10 N.Y.C.R.R Section 405 regulates the standards for provision of care and services that include minimum standards and qualifications of administrators, medical staff, nursing staff (including RNs, LPNs and assistive personnel), housekeeping, quality assurance, infection control, surgical services, anesthesia services, respiratory care services, radiology and nuclear medicine

services, laboratory services, pharmaceutical services, rehabilitation services, emergency services, outpatient services, perinatal services, critical care services, food and dietetic services, hospital environmental health services, utilization review services, and social services. In each case, the DOH establishes minimum standards for the provision of these non-nursing services, and in many cases establishes minimum staffing requirements that such services be provided in a manner consistent with patient care needs.

DOH regulations concerning non-nursing personnel working in New York hospitals have been upheld by New York appellate courts when challenged and there is no legal basis to question the power of the DOH to regulate these non-nursing hospital function, particularly as they affect quality of patient care and safety. For instance, in *Hosp. Ass'n of New York State*, the court upheld DOH regulations limiting the work hours of postgraduate trainee physicians, finding that the regulations "rationally relate primarily to patient care." 164 A.D.2d at 527; *see also Pukin v. New York State Dep't of Health*, 224 A.D.2d 107, 109 (1996) (upholding regulations restricting physicians from certain foreign medical programs from performing residencies in New York hospitals).

In addition to the direct regulation of staffing and patient care across the spectrum of hospital departments and services, hospitals are also currently required to create and maintain nursing staffing plans that effect the minimum standards imposed by DOH regulations.

Pursuant to 10 N.Y.C.R.R. Section 405.5, the RN director of nursing services is required to develop and implement on a daily basis a nursing plan "for determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital." In the context of the prior review of minimum standards of patient care and staffing of nursing and other personnel, it follows that the nursing plan must ensure sufficient numbers of staff to meet these standards.

In addition, pursuant to PHL Section 2805-t, all hospitals are required to track the actual numbers of nurses and assistive personnel providing direct patient care on each hospital unit and each shift, the actual registered nurse-to-patient ratios on each unit and shift, the numbers of non-nurse assistive personnel and the number of hours of patient care provided by such assistive personnel and the ratio of registered nurse to non-RN assistive staff (expressed as a percentage). PHL Section 2805-t further requires that this information be made available to the public upon demand.

Pursuant to 10 N.Y.C.R.R. Section 400.25 regulating the disclosure of nursing quality indicators, all hospitals are required to track and publicly disclose "(1) the total number of productive hours of care provided by patient care staff per patient day for each unit, and the number and percentage of productive hours of care provided by registered nurses, licensed practical nurses and unlicensed personnel each; and (2) the average registered nurse and licensed practical nurse to patient ratio for each unit and on each shift."

In addition, Section 400.25 also requires that hospitals provide a copy of the nurse staffing plans (as required by Section 405.5) as they relate to "the procedures and processes used for determining and adjusting staffing levels based on patient case mix and acuity."

If hospitals and nursing homes are required by PHL Section 2805-t and 10 N.Y.C.R.R to track and disclose their nurse-to-patient ratios, and to disclose their nursing plans for determining and adjusting staffing levels based on patient case mix and acuity, it follows (a) that hospitals are required to plan and actually schedule sufficient numbers of staff to provide proper care and (b) that the DOH has the

power to regulate these nursing functions by setting minimum standards of care expressed as minimum ratios of staff to patients, including both registered nurses and non-RN assistive personnel.

Based on the foregoing, the DOH has the legal authority to regulate the operation of hospitals and the legislature has given the department broad power to implement specific technical and scientific standards of hospital care to ensure high quality care, protect patient safety and maintain minimum operational standards for the qualifications, training and staffing levels of patient care personnel. In some cases the enacted staffing standards are generic (i.e., they require levels of nursing and other personnel necessary to provide “proper care” in accordance with accepted “standards of care”). In most cases, however, the existing regulatory framework requires concrete minimum staffing requirement, expressed in nurse-to-patient ratios or setting minimum requirements for types and numbers of staff assigned or on duty in particular units.

DOH thus has broad authority to issue regulations to ensure the quality of health care in New York and to make sure that Medicaid funds are spent on high quality services. Pursuing that statutory mandate, the agency has a longstanding history of issuing regulations that include nurse-to-patient and non-RN-to-patient ratios or other concrete minimum staffing requirement across all units and departments of hospitals and residential care facilities. These regulations, applied in the health care industry and followed by hospitals and other health care facilities, concern both adequate staffing of registered nurses and the development of staffing plans by hospitals having a direct bearing on patient care and the quality of healthcare in New York. The formulation and implementation of minimum nurse to patient ratios is thus within DOH’s core authority as an administrative agency.

Experience and Data from California’s Minimum Nurse-to-Patient Regulations

While there are several states that have various degrees of mandated staffing ratios on particular units, currently there is only one state with a comprehensive law mandating minimum nurse staffing levels in its acute care hospitals, California. The law was passed in 1999, with full implementation beginning in 2004. In the interim period, the California Department of Health contracted with the University of California, Davis Medical Center to conduct a comprehensive study (see attached results) that culminated in the creation of the current regulatory ratios through a scientifically rigorous process that involved several stakeholders. CDHS was able to project the total number of necessary licensed hires after completing an extensive staffing survey of hospitals that took into account the existing levels of assistive personnel, and the outcome was a standard that reflected an exhaustive and comprehensive process.¹

Patient Outcomes Improved

Patients in California hospitals following the implementation of the staffing law saw some notable improvements in care and in health outcomes in hospital settings. On average, nurses care for fewer patients than they did prior to the legislation being passed, and they care for fewer patients than nurses in other states. The best improvements were in hospitals with the lowest and highest pre-mandate staffing ratios.² Failure to rescue rates improved in California hospitals relative to states

¹ <https://escholarship.org/content/qt53j6496x/qt53j6496x.pdf>

² L. Aiken, et al, “Hospital Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction,” JAMA 2002;288(16):1987-93.

without a staffing law. Most importantly, emergency room wait times fell after the new requirements were put into place. Patients going to the emergency room waited less to be seen, and fewer patients left the emergency room without being seen by a health care provider.³

In addition, as nurse workloads decreased, patient mortality rates dropped and nurse job satisfaction rates increased.⁴

There is thus ample technical and scientific data and research to establish a reasonable conclusion that the implementation of minimum nurse-to-patient ratios and other minimum standards for assistive personnel staffing will play a key role in improving patient safety and health outcomes while also improving the working conditions, health and safety of RNs and other nursing care providers.

Economic Impact on Subjects of the Proposed Regulation

The purpose of, necessity for and benefits derived in terms of the health and safety of patients and of nursing care staff are discussed above. The proposed regulation will further state objectives and the purposes of the DOH to improve community health, provide the quality of care in hospitals and nursing homes and improve the care received by residents who participate in government funded medical assistance programs.

The proposed regulation will directly affect hospitals and residential health care facilities, which will be required to hire RN and other assistive staff to comply with the minimum staffing requirements.

The exact numbers of nurses and other assistive personnel to be hired remains in need of further research and calculation.

Hospital and Residential Health Care Facility Cost Claims Are Likely Exaggerated

The hospital and residential health care facility trade associations have provided estimates that claim a total cost of compliance of \$2 to \$3 billion. These estimates are not provided in any detail and do not seem to be supported by any analysis or factual basis.

There is no doubt that hospitals and nursing homes will have to add RNs to comply with the proposed regulations.

It should be first noted that many hospitals are closer to meeting the proposed standards on many units and would not have to add as many staff as others might.

In California, which implemented similar staffing ratios regulations, studies found that the number of RN hours increased from 6.03 per patient per day in 2003 to 7.11 in 2008 after implementation of the staffing ratios regulations.

³ T. Chan, et al, "Effect of Mandated Nurse-Patient Ratios on Patient Wait Time and Care Time in the Emergency Department,"

⁴ See: <https://innovations.ahrq.gov/profiles/state-mandated-nurse-staffing-levels-alleviate-workloads-leading-lower-patient-mortality?id=3708>

It should be noted however that RN staffing in California at that time was extremely poor and much worse than current staffing levels in New York due to the encroachment of for-profit corporate hospital chains and other factors.

Based on these factors, including our assessment that staffing levels in the non-profit, academic and tertiary care medical centers in New York today are better than the for-profit dominated hospital industry in place in California at that time, we believe that the numbers of nurses needed in New York to comply will be substantially lower than was the case in California.

The DOH Can Determine the Actual Costs of Compliance by Analyzing Nursing Quality Indicator Data Currently Required by PHL Section 2805-t

As was previously noted, PHL Section 2805-t requires all hospitals to maintain records of their actual RN and assistive nursing personnel staffing and the actual nurse-to-patient ratios for all units and all shifts.

The DOH could request representative sample data covering defined time periods from all hospitals and nursing homes to provide a statistical “snap shot” of actual staffing in NY hospitals and nursing homes. This baseline data could then be compared to the proposed staffing regulation to determine the shortfall and the number of nurses that each facility would need to add to comply with the regulations.

The Relative Costs of Compliance with the Staffing Regulations Are Low

Even if we accept the \$2 billion to \$3 billion cost of compliance claimed by the hospital and nursing home industry trade associations, it should be noted that the relative cost, in the context of gross hospital expenses, revenues and net profits, is relatively minor.

According to data compiled from the most recent institutional cost reports by the American Hospital Directory, gross patient revenue for all NY state hospitals was \$211 billion.⁵

The \$2 to \$3 billion cost of adding RNs claimed by the industry associations thus amounts to only 0.9% to 1.4% of total revenues. Compliance with the proposed regulations would thus entail a very small relative share of total revenues and current costs.

Compliance Can Be Attained Without Additional Expenditures By Shifting Existing Spending To Direct Patient Care

According to a review of IRS form 990 data for a sampling of hospitals, managerial expenses account for 18% to 25% of total hospital expenses. The categorization of management expenses on the IRS forms varies widely, however, and we believe that many managerial expenses are improperly included in direct patient care accounts or as directly related to “program expenses,” thus making the actual expenditure on non-care functions are much higher.

⁵ See: https://www.ahd.com/state_statistics.html

Numerous studies have established that US hospital managerial expenses account for 25% or more of total healthcare expenses, more than double the rate in Canada and significantly higher than any other developed nation.⁶

A review of hospital IRS 990 returns shows that substantial sums are expended on such non-patient care categories as “key employee” salaries and benefits (i.e., executives and high level managers), advertising, occupancy, travel, office expenses, dues to industry associations, lobbying, and other similar expenses. In addition, hospitals are increasingly utilizing multiple layers of management and supervisory personnel at all levels of their operations, including at the patient care unit and department levels. These excess managers do not provide direct patient care and are not necessary to the operation of patient care units.

Managerial and executive salaries in the industry are often excessive and add to the bloated administrative expenditures. Of the approximately 200 hospitals in NY State, the top 412 executives alone receive compensation of \$339 million.⁷ Of the 5 major private hospital networks in New York City alone, 108 top executives earned more than \$1 million, and the combined salaries of these 108 executives totaled \$234 million.⁸

The hospital industry could thus fund the \$2 to \$3 billion it claims would be necessary to comply with minimum nurse-to-patient ratios entirely by reducing its current administrative costs from by 10% (from 25% to a still high 22.5% administrative cost rate). This could be accomplished by 1) reducing executive salaries, 2) eliminating excess layers of management throughout hospital operations, 3) reducing or eliminating advertising and other similar wasteful spending, and 4) streamlining managerial and other non-patient care functions.

A shift of a small amount of administrative expenses from non-patient care to direct patient care activities would thus entirely pay for compliance with the staffing regulations and not require any additional funding.

Better Nurse Staffing Will Offset the Costs of Compliance By Producing Cost Savings In Other Areas

Our hospitals have concerns about the cost of implementation of higher nurse staffing and assistive personnel workforce staffing levels in our hospitals.

The costs of compliance, however, cannot be viewed as a static analysis. Increasing staffing levels will result in changes in quality of care and improved working conditions which will generate offsetting efficiencies and cost savings and reduce the net costs of compliance. These cost offsets will be beneficial to hospitals, and these generated savings will be important to maintaining staffing levels in the facilities.

⁶ See e.g.: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1327>;
<http://www.commonwealthfund.org/publications/in-the-literature/2014/sep/hospital-administrative-costs>;

⁷ See: Paying for What Doesn't Count, How Exorbitant Executive Compensation and Frivolous Advertising Hurts New York Hospital Patients, Memorandum, Communication Workers of America District One.

⁸ See: https://www.nysna.org/sites/default/files/attach/419/2017/09/RestructuringH+H_Final.pdf

Studies show increasing nurse staffing levels reduces length of stay and overall costs. The value of lives saved per thousand hospitalized patients was 2.5 times higher than the increased cost of one additional RN per patient day in intensive care units, 1.8 times higher in surgical units, and 1.3 times higher in medical units.⁹

In addition, there will be added savings in improved workforce stability. Hospital administrators are acutely aware of the high cost and expense of nurse turnover and retraining. Studies currently price the cost of turnover for nurses between \$37,000 and \$58,000. Hospitals can stand to lose between \$5.2 and \$8.1 million annually due to nurse turnover. Nurse burnout is also on the rise nationally over the last decade, contributing to the high cost of turnover.¹⁰ A study in Pennsylvania showed an increase of one patient per nurse increased burnout by 23% and job dissatisfaction by 15%. 43% of nurses that reported high burnout were intending to leave the profession. There is evidence that safer nurse staffing mitigates some of these burnout conditions in nursing workforces, particularly evident in California where they have passed legislation regulating minimum nurse staffing levels. A study conducted in 2010 showed that higher staffing led to lighter workload, which improved recruitment and retention of nurses.¹¹

Improved staffing will also generate savings or reduced costs resulting from higher patient satisfaction scores and other metrics that result in bonus payments under Value Based Payment programs, reduced staff absenteeism due to fatigue, illness, injury or depressive disorders, fewer injuries and disability claims caused by accidents and fatigue, fewer workplace violence incidents as patient wait times are reduced and patients and family members receive more staff attention, and other quantifiable savings and cost reductions.

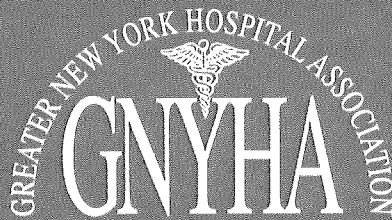
⁹ T. Shamliyan, et al, "Cost Savings Associated with Increased Staffing in Acute Care Hospitals: Simulation Exercise," *Nursing Econ* 2009 Sep-Oct;27(5):302-14, 331.

¹⁰ See: <https://avanthealthcare.com/pdf/NationalHealthcareRNRetentionReport2016.pdf>

¹¹ L. Aiken, et al, "Hospital Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," *JAMA* 2002;288(16):1987-93.

New York State Department of Health Staffing Engagement Study

September 20, 2019 | Albany, New York



Lorraine Ryan, Senior Vice President for Legal, Regulatory, and Professional Affairs

GREATER NEW YORK HOSPITAL ASSOCIATION

Introduction

My name is Lorraine Ryan, Senior Vice President for Legal, Regulatory, and Professional Affairs at the Greater New York Hospital Association (GNYHA). GNYHA's members include hospitals throughout New York State and in New Jersey, Connecticut, and Rhode Island. On behalf of GNYHA, thank you for the opportunity today to contribute to the New York State Department of Health's (DOH) Staffing Study. GNYHA and its member hospitals and health systems appreciate DOH's efforts to fully understand the processes that go into safe staffing, and the importance of considering how staffing enhancements and other initiatives can improve patient safety and the quality of health care delivery.

GNYHA—and myself as a nurse—have the deepest respect and admiration for our registered nurses (RNs), but we strongly oppose forced, inflexible nurse staffing ratios and a law that would mandate unit-based ratios, at all times, in all hospitals in New York State.

My responsibilities at GNYHA include oversight of clinical quality improvement initiatives and programming. I can say without reservation that New York's health care providers are deeply committed to providing safe, high-quality care that leads to the best possible health outcomes. But no hospital or nursing home is exactly alike, and no single staffing formula works in every situation. Legislation mandating nurse staffing ratios belies the proven ability of hospitals and unions to agree on staffing plans on their own through good-faith contract negotiations, as was done earlier this year by several New York City hospitals and the New York State Nurses Association (NYSNA).

GNYHA and its members agree that more nurses are needed in our hospitals, but the approach to how staffing plans are developed and implemented must be left to nursing leadership, with input from frontline staff. Forced nurse staffing ratios would crowd out other essential members of the health care team, undermine real-time patient care decisions, and deny hospitals the workforce flexibility they need to respond to emergencies. Health care delivery has never been more complex, and we have learned that the best way to ensure optimal outcomes of care is through a multidisciplinary approach that involves not only nurses and physicians, but also physical therapists, dietitians, clinical pharmacists, lab technicians, social workers, environmental, transportation and food service workers, and others. Mandatory nurse staffing ratios that must be met at all times would force hospitals, many of which already operate with scarce resources, to eliminate these other essential team members.

It would cost New York's hospitals a staggering \$2 billion annually to comply with the nurse staffing ratios bill—money they don't have for a mandate they don't need. Many of these financially struggling institutions would be forced to reduce services, lay off staff, or even close their doors for good, impacting access to care for those with the most need. Our principal objections to this deeply misguided legislation are described below.

Quality Care Is About Teamwork

A high-performing health care team is widely recognized as an essential tool in the delivery of patient-centered, coordinated, effective health care.¹ In a 2019 evaluation by the Centers for Medicare & Medicaid Services (CMS), New York ranked second among all CMS Partnership for Patients contractors on reducing

¹ Mitchell, P, et al., "Core Principles and Values of Effective Team-Based Health Care," *Institute of Medicine of the National Academy of Sciences* (October 2012).

hospital-acquired conditions and readmissions.² This is because of New York hospitals' multidisciplinary, team-based approach to health care delivery, which includes physicians, nurses, pharmacists, physical therapists, dietitians, environmental services workers and others. By working together, these teams have delivered tremendous results for patients. DOH's 2017 *Hospital-Acquired Infections Reports* documents reductions ranging from 2% to 21% in surgical site infections, catheter-associated urinary tract infections, and Methicillin-resistant *Staphylococcus aureus* (MRSA).³ These and other improvements are the result of multidisciplinary teams of health care professionals working together to implement evidence-based best practices. The use of multidisciplinary teams in hospitals can limit adverse events, improve outcomes, and add to patient and employee satisfaction.⁴

Forced nurse staffing ratios will crowd out other essential members of the health care team and compromise high-quality patient care. That is one of the reasons the RN who chaired President Obama's National Health Care Workforce Commission called staffing ratios a "bankrupt idea."⁵

In November 2018, Massachusetts voters, by a resounding margin of 70% to 30%, rejected a ballot initiative to impose nurse staffing ratios on Massachusetts hospitals. They determined that nurse staffing ratios would be cost prohibitive, lead to hospital closures, eliminate high cost-service lines, increase wait times, reduce non-health care workforce staffing, and compromise access to care.

Leave Staffing Decisions to the Experts

Chief Nursing Officers (CNOs) and their experienced leadership teams are responsible for ensuring that appropriate staffing plans are in place on all units, and at all times, in their hospitals. Nurse staffing ratio legislation would eliminate that invaluable expertise and replace it with rigid, arbitrary staffing levels that must be maintained at all times, even during breaks, depriving these professionals of the flexibility necessary to respond, in real time, to the needs of their patients.

Hospitals and CNOs need the flexibility to prepare for and manage the unexpected—unplanned absences, natural disasters, power failures, other emergencies, etc.—and adjust staffing accordingly. Weather-related emergencies, seasonally related disease onset (e.g., influenza), the recent uptick in emergency department (ED) visits caused by measles, and other emergency situations often require special units to isolate patients and prevent the spread of disease, as well as reassign staff to deal with unique circumstances. Forced nurse staffing ratios would make it very difficult for hospital leaders to respond effectively to these situations.

2019 contract negotiations between NYSNA and several hospitals in New York City resulted in a commitment to maintain the number of nurses per unit, per shift via agreed-upon staffing plans. The ratified contracts also include a provision giving hospital nursing leadership and RN staff the flexibility to allocate patients among nurses according to their professional determination of appropriate patient care.

² Mathematica Policy Research, Program Evaluation Contractor, "Formative Feedback Report, Submitted to the Department of Health and Human Resources, Centers for Medicare & Medicaid Services" (April 2019).

³ New York State Department of Health, "Hospital Acquired Infections in New York State, 2017 Report, Summary for Consumers" (October 2018).

⁴ Ebstein, N.E., "Multidisciplinary in-Hospital Teams Improve Patient Outcomes: A Review," *Surgical Neurology International* (August 2014).

⁵ Douglas, K., Kerfoot, K. M., "A Provocative Conversation with Peter Buerhaus," *Nursing Economics* (July-August 2011).

In addition to recognizing the need for flexibility in staffing, the hospitals and NYSNA agreed to fill vacant positions and hire additional RNs who will be included in staffing plans, resulting in an increase in the nursing workforce at each hospital. With the input of RN staff, the additional nurses will be allocated as necessary by a drop or increase in patient census or acuity affecting patient and staffing needs.

Many of these hospitals also agreed to create RN float pools to respond to sick calls, leaves of absence, and other unplanned staffing needs, retaining the flexibility for nursing leadership and RN staff to allocate patients among nurses according to their professional determination of appropriate patient care. The hospitals and NYSNA also agreed to the enforcement of staffing guidelines to address systemic failure to meet the guidelines, and use of a third-party mediator and dispute resolution procedures, when and if necessary.

Studies: Ratios Don't Improve Care

California is the only state in the nation that imposes RN staffing ratios on every unit of every hospital, but more than a decade after the law was implemented, there is no credible evidence that patient care has improved.

In 2009, the California Healthcare Foundation assessed the impact of nurse staffing ratios on hospitals and patient care and found the desired outcome of staffing legislation—improved patient outcomes such as decreased pressure ulcers, post-surgical complications, deep vein thrombosis/pulmonary embolism, pneumonia mortality, and post-operative sepsis—did not appear to have been met.⁶ Similarly, a 2013 study in *Medical Care and Research Review* noted, “California’s minimum nurse-to-patient staffing regulations were intended to improve the quality of patient care, but to date there is only mixed evidence that they achieved this goal.” The study concluded with a warning that “policy makers should tread cautiously as they consider new nurse staffing regulations.”⁷

Even after more than a decade of nurse staffing ratios in California, several national databases show comparable hospital quality in New York and California, and some show New York hospitals performing better than California hospitals. A 2013 study describes the impact of the California law on patient level outcomes as mixed, and the findings suggest the positive impacts have not been as significant as predicted.⁸ In 2015, Dave Regan, president of SEIU United Health Workers West in California, said ratios “have not improved patient care” and have “forced hospitals to downsize.”⁹ The bottom line: there is no reliable evidence that nurse staffing ratios improve patient care.

⁶ Spetz, J., Chapman, S., Herrera, M.A., et al, “Assessing the Impact of California’s Nurse Staffing Ratios on Hospitals and Patient Care” *Issue Brief, California Health Care Foundation Issue Brief* (February 2009).

⁷ Spetz, J., Harless, D.W., Herrera, C.N., Mark, B.A. “Using Minimum Nurse Staffing Regulations to Measure the Relationship between Nursing and Hospital Quality of Care” *Medical Care Research Review* (2013).

⁸ Serratt, T., “California’s Nurse-to-Patient Ratios, Part 3: Eight Years Later, What Do We Know about Patient Level Outcomes?” *The Journal of Nursing Administration* (November 2013).

⁹ Goldberg, D., “Health Union Split Complicates Nurses Jobs Push” *Politico* (March 30, 2015).

Ratios Will Cost Billions, Threaten Jobs, and Damage Labor Peace

It would cost New York's hospitals an estimated \$2 billion annually to comply with nurse staffing ratios. Hospitals would have no choice but to cut costs. Fewer positions would remain for non-RN members of the care team, and RNs would be forced to perform more and more non-clinical tasks ordinarily done by other care team members, such as transporting patients and administrative work. Many financially struggling institutions would be forced to cut non-RN positions.

That is exactly what happened in California. After forced nurse staffing ratios went into effect in 2004, significant tension between unions representing nurses and those representing other types of health care workers emerged over fear of job losses. Nurse staffing ratios will create tension in New York between and among caregivers who must work together to improve quality and reduce costs.

Ratios Would Increase ED Wait Times, Impact Access and the Distribution of Nurses

Compliance with forced 24/7 nurse staffing ratios would lead to increased wait times in EDs.¹⁰ This could force hospitals to go on diversion for ED arrivals in the event of a mass casualty event or other high patient volume emergencies. The cost of complying with forced nurse staffing ratios could preclude hospitals from taking steps to reduce ED wait times such as hiring additional primary care doctors and specialty physicians, upgrading existing infrastructure, and investing in new or expanded facilities. This is particularly problematic because hospitals are currently working to reduce avoidable ED visits as part of the State's Delivery System Reform Incentive Payment (DSRIP) program. As part of DSRIP, hospitals collaborate with ambulatory care and other community-based providers to reduce avoidable hospital use and expand outpatient services.

Inflexible nurse staffing ratios would also promote an inefficient distribution of nurses in the health care delivery system. Health care services, especially cancer care, have shifted in great part to the outpatient setting, allowing patients to receive necessary treatment and return home, which is not only preferred by patients and families, but often more effective and efficient. Inflexible inpatient staffing ratios would require hospitals to move nurses from the outpatient to the inpatient setting, threatening the ability to hire an adequate number of nurses to treat patients in the outpatient setting.

Forced nurse staffing ratios would undo the work that hospitals and other providers have already done to ensure that their communities have greater access to health care services in the most appropriate settings.

Staffing Rules Already Exist

Forced nurse staffing ratios are unnecessary because multiple staffing rules are already in effect. New York State regulations require the director of nursing services to develop a staffing plan, approved by the governing body, for determining the types and number of nursing personnel and other staff necessary to provide nursing care for all areas of the hospital. Federal authorities survey hospital staffing as part of CMS's Conditions of Participation, and New York State law requires the disclosure of staffing plans and quality indicators—information that is available to anyone upon request.

¹⁰ Weichenthal, L., Hendey, G.W., "The Effect of Mandatory Nurse Ratios on Patient Care in an Emergency Department," *Administration of Emergency Medicine* (February 2009).

Developing the Workforce of Tomorrow

We recognize that more nurses are needed in hospitals across the State and that nursing leadership and RN staff need to retain the flexibility to allocate patients among nurses according to their professional determination of appropriate patient care. New York's "BSN in 10" law requires RNs to complete a bachelor of science degree in nursing within 10 years of initial licensure, ensuring that nurses are prepared to practice to the full scope of their license as recommended by the Institute of Medicine in its *The Future of Nursing* report. Notably, a recent study suggests that hospitals with higher proportion of nurses with a BSN and lower nurse workloads have better outcomes for patients following in-hospital cardiac arrest¹¹. Higher education for RNs is a means to developing a more capable workforce, which is essential to managing the complexities of an ever-evolving, highly technical work environment.

Other staffing enhancements to consider include funding for nurse residency programs to build competencies in new graduates and improve hospitals' ability to recruit and retain nurses; a transition to practice programs with adequate preparation and protected time for nurse preceptors; and permanent RN float pools to respond to sick calls, leaves of absence, and other unplanned staffing needs.

Conclusion

Staffing levels are best made in real time by expert, experienced clinicians. This is why the American Nurses Association, the American Organization of Nurse Executives, and the New York Organization of Nurse Executives and Leaders oppose forced nurse staffing ratios.

For these and many other reasons, GNYHA strongly opposes forced nurse staffing ratio legislation. We remain deeply committed to the well-being of all New Yorkers, and we stand ready to work with Governor Cuomo, the State Legislature, and DOH to ensure that all health care workers provide the highest quality patient care possible.

I am happy to answer any questions you may have.

¹¹ Harrison, J.M, Aiken L.H., Sloane, D.M., Brooks, Carthon, et al, "In Hospitals With More Nurses Who Have Baccalaureate Degrees, Better Outcomes for Patients with Cardiac Arrest," *Health Affairs* (July 2019).

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My name is Ann Harrington, I am a registered nurse with 40+ years of experience in hospital clinical and leadership roles. Currently I am Executive Director of the New York Organization of Nurse Executives and Leaders, Inc. I am accompanied by Claire Murray, registered nurse and Executive Director Emeritus of NYONEL. Today we represent NYONEL's 700-members who are nurse leaders at all levels – Chief Nurses, Nursing Administrators, Managers, Leaders -- in all areas where nursing is practiced: hospitals, primary care, home care, schools, long term care, and in education and research.

There is no organization that is more committed to safe nurse staffing than ours. As nurse leaders we are ultimately responsible for ensuring quality patient outcomes and patient satisfaction. Safe staffing is integral to doing so. And as nurses we have the education and skill to design and manage safe staffing systems in our organizations.

We appreciate the opportunity to testify to the discussion points suggested in the invitation.

The first discussion point invites recommendations for plans for minimum staffing levels and other enhancements in hospitals and nursing homes. Ours are as follow:

- Healthcare organizations should have nurse-led staffing committees that include >50% staff 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 the needs of the patient population and the education/competence of the nursing staff within that organization.
- 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 team should consider inclusion of 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 among others.
- Once designed and deployed, 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.

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The next discussion point requests consideration of 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) will enhance workforce retention, because of buy-in. Retention then leads to staff advancement within their individual roles, and job security. Clinical/career ladders are proven to improve staff satisfaction and retention. And in the case of non-professional staff, they will contribute to feeding the pipeline to provide future registered nurses.
- Well-designed staffing structures will facilitate position-appropriate task assignments, nurses working to the top of their licensure, and reserving lower-level tasks for non-licensed personnel. Nurse job satisfaction and potential retention will result.
- 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%) separation¹, and reduce the costs associated with RN turnover (>\$37,000)².
- 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.
- Workforce retention must remain a top consideration. Positive outcomes will result from investment in existing staff by implementing career ladders, and financial support for continuing academic education, preparing for specialty certification and other advancement opportunities. Beyond strengthening the workforce knowledge base, care outcomes will improve as will staff satisfaction, patient satisfaction and patients' willingness to recommend the organization as a site for care.

To address discussion about the California experience:

California has had mandated nurse staffing ratios since 2003. From published studies that evaluate intended outcomes, no definitive conclusions can be reached. Experientially they report frequent unit closures due to inability to staff to ratios 24 x 7, Emergency Department diversions due to closed inpatient beds, and smaller community/rural hospital closures, none of which do justice to the communities served. Studies report inconsistent care outcomes, and staff and patient satisfaction levels.

More recent studies of nurse staffing in general – as past ones have – reinforce the correlation between higher RN staffing levels and improved patient outcomes and nurse satisfaction.

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However, they do not identify either a specific number of patients per nurse nor do any of them recommend constant, inflexible ratios.

In their 2009 statement, the International Council of Nurses – an influential global health organization- cited a number of factors critical to achieving evidence-based safe nurse staffing. They include the following, most of which have been highlighted in our comments.

- Real time patient needs assessment
- Local assessment of nurse staffing requirements to provide a service
- Nursing and interdisciplinary care structures that enable nurses to work to their optimal scope of practice
- Good human resources practices to recruit and retain nurses
- Healthy work environments and occupational health and safety policies and services that support high quality professional practice
- Workforce planning systems to ensure that the supply of staff meets patient needs
- Tools to support workload measurement and its management
- Rostering to ensure scheduling meets anticipated fluctuations in workload
- Metrics to assess the impact of nurse staffing on patient care and policies that guide and support best practices across all of these³.

We are leaving several documents with you today:

- A comprehensive discussion paper describing potential downstream effects that would result from the well-intended Safe Staffing for Quality Care bill -- A2954 (Gunther)/S1032 (Rivera) -- currently in the legislature;
- A bibliography of peer-reviewed articles on safe staffing (included within the above document);
- Position statements from NYONEL and AONL in opposition to mandated ratios;
- NYONEL's "Safe Staffing Always" Toolkit which we recommend for use as an organizational guide;
- A paper copy of this testimony;
- Our contact information.

Thank you for your time and attention, and for the opportunity to testify today.

We are willing 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. International Council of Nurses (2009) Evidence-based safe nurse staffing; position statement available at <https://www.icn.ch/positionstatements/> C. Socio-economic welfare of nurses



Position Statement

A2954 (Gunther)/S1032 (Rivera) Safe Staffing for Quality Care Act

The members of NYONEL, Chief Nursing Officers, Nursing Administrators, Managers and leaders of nursing across New York State, support the need for measures to assure safe staffing in all health care settings. The mandate for nurse staffing ratios and the reporting of these in hospitals and healthcare agencies as required by the “Safe Staffing for Quality Care Act” (A2954/S1032 **are not the relevant strategies to use to achieve this**). As the individuals ultimately responsible for safe patient care, nursing leaders believe that these well-intended but inappropriate requirements have negative consequences. Incorporating specific ratios into the regulations would impose arbitrary and inflexible parameters on the care of patients and clinical management. There are no evidence-based best practices, standards, or research that support the use of set ratios. This approach constitutes an unfunded mandate and the proposed reporting requirements are duplicative of existing regulatory requirements.

The variables that are most relevant to achieve safe staffing are well known (ANAs Principles for Safe Nurse Staffing, 2nd ed., 2012). For these strategies to have an impact, nursing leaders in clinical care must have the authority – endorsed by the entire agency leadership team – to empower RNs to implement safe staffing plans. All members of the agency leadership bear this responsibility for patient safety and quality outcomes.

Holistic Team Approach

While nurses are a vital part of the care team and an invaluable agency resource, the entire hospital leadership team must be accountable for providing the staffing necessary to assure positive patient outcomes. The CNO of any hospital is a nurse first and foremost, and has achieved a level of expertise to understand all facets of patient care. However, the allocation of resources is not – and should not be – the sole responsibility of CNOs. The judgment of professional nurses must be accepted as essential to safe staffing. It is imperative that the multiple factors that affect the need for nursing care be considered in the development of individual agency staffing patterns. Nursing staff, nurse leaders, and hospital leaders including administrative and financial should all be responsible and accountable for appropriate staffing to provide consistent and reliable care and optimal patient safety.

As with all patient care, a team approach renders the best results. Therefore, NYONEL **recommends that every agency be mandated to establish staffing committees** that include at least 50% direct care nurses, and CNOs. These nurses are familiar with the variables that affect standards of care and the care needs of specific patient populations that must be included in staffing plans. **The multi-disciplinary team must be led by the professional nurse. The two most important metrics should be the total nursing hours per patient day (not solely RN hours of care per patient) and skill mix.**

It is in the best interest of all healthcare agencies that the care needs of all patients are met or exceeded to ensure safe environments and optimal patient outcomes. This is especially important because the State has embarked on transforming the healthcare system’s delivery of services and payment structure. The

“pay for performance” model requires the team to focus on optimizing patient and population outcomes, delivering high value care, and improving long term financial sustainability. In addition, the literature suggests that nurse staffing levels have an impact on nurse satisfaction and patient mortality. CNOs and their leadership teams are better equipped to determine nursing practice issues including staffing. Direct care nurses have a right and responsibility to participate in those decisions.

RNs, Other Important Members of the Care Team and Patient Needs

The likely outcome of mandated RN ratios as proposed by the bill, will be reduction of other members of the care team that will be necessary to offset the cost of higher numbers of RNs. When other members of the care team such as unit secretaries, transporters, dietary assistants, LPNs and patient care technicians are cut, the resulting ancillary functions will be imposed on the RN and will not result in the anticipated additional nursing care hours intended to be gained from the mandated RN ratios. The recommended strategy, to empower agency-based staffing committees that include at least 50% of direct care nurses who can assess the variables including intensity of patient needs and acuity, would achieve safe staffing levels. Giving RN staffing committees the **responsibility and authority** to establish staffing models that take into account the dynamic needs of patients is essential. The numbers of team members caring for patients will need adjustment in response to changing patient needs, to achieve the desired agency-specific outcomes.

To this end, **we urge legislators to think critically about more effective and data-driven approaches to achieve the goal that all healthcare providers share: safe staffing that results in safe, high quality care.** A coalition of professional nursing organizations stand ready to collaborate with all stakeholders to determine optimal strategies. The following points are important to consider:

All patients are not equal.

- Set ratios per patient type assumes that all patients are the same. Even patients with the same diagnosis require different levels of care, and often needs change rapidly without warning.
- Patient needs by medical service or department vary from one type of facility to another and different departments within the same agency may have significantly different staffing needs.
- High levels of acuity among many patients place a greater burden on the clinicians caring for them, given shorter lengths of stay.

Like patients, all organizations are not equal.

- Supplemental resources, ancillary staff, physical layouts, and support systems vary greatly and have a major impact on the time requirements and types of staff needed in individual departments.
- Data released publicly will not be valid for comparison between units or agencies. Variables related to patient need, organizational characteristics, and care giver competencies are too complex to streamline. Such a mandate would be impossible to evaluate.

All registered nurses are not the same.

- To arrive at safe staffing levels, the educational level, experience, specialization, competency, and certification status of nurses must be considered. Averages do not account for these.
- In organizations that utilize expert nurses floating between departments to provide specialty care, the legislation would not allow their time with patients to be counted as part of the regulated ratio.
- Patient unit staffing standards (and mandated ratios) are based on the average combined needs of patients. Unit activity varies significantly and has more to do with patient condition than patient numbers.

The California Experience

While the legislation may be well-intentioned, the lack of improved patient outcomes in the only other state to implement ratios is worth highlighting.

Earlier studies showed lessons learned from the implementation of regulated staffing ratios in California:

- Ratios legislation has not improved patient outcomes.
- California's workforce numbers are at the low end of national statistics. The number of nurses to 10,000 population has not improved as predicted.
- Lack of access to care has resulted in diversion of patients and discontinuation of services. Diversions increased from 24.6% - 31% in the first quarter of implementation; 963 surgeries were postponed in the first 6 months; and 12 hospitals closed.
- The Medical Society and nurses have voiced complaints about lack of autonomy.
- Studies in 190 medical-surgical units in 63 hospitals demonstrated that while the percentage of RN hours per patient day increased by 15.9%, the number of RN hours dropped by 25.6%.
- In 60 stepdown units in 42 hospitals, there was a similar change of RN hours per patient day of 7.7% with a drop of 15.1% RN hours. This indicates that nurses were doing non-professional duties. Since studies have demonstrated that outcomes did not improve in a statistically significant way, the change resulted in increasing the non-nursing duties that higher paid RNs must perform (Donaldson, et. al., 2005)

As of 2006, only one MSA of California had a report rating care for the number of RN positions per 100,000 population above a C, with 19 of 24 ranging in scores from C- to F, or 0.5-1.0 below the national value (Lin, et al., 2006).

Further studies have demonstrated inconsistent outcomes.

The Cal-Noc studies demonstrated inconsistent results. Growth in Licensed Nurse was associated with improvement in only one Patient Sensitive Indicator (PSI) and reduced length of stay (LOS) for one PSI. Higher nurse staffing per patient day had a limited impact on adverse events in California hospitals. (Spetz et. al., 2013, Using Minimum Nurse Staffing Regulations to Measure the Relationship Between Nursing and Hospital Quality of Care)

Further international research by Dr. Linda Aiken and colleagues compared institution's established staffing standards and attempted to control for compounding variables rather than a discrete mandatory staffing ratio. The studies compared the number of shifts at or below the agency staffing plan. Results indicated that when two consecutive shifts were below the standards, outcomes were negatively affected. An agency's standards are determined by obtaining the mean or median over a lengthy period of time and that again provides an average. The result of additional RN staff improving the outcomes may be positive BUT the research did **not** generate a recommendation for a set number or ratio. Agency standards should be developed that allow for flexibility to staff at any moment based on the actual situation at hand, including: consideration of variations in patient populations across hospitals and departments; variations in individual patients' needs; the work environment; and staff competence or experience. To do otherwise will have significant unintended consequences.

Conclusions:

The adequacy of staffing should be measured on the outcomes produced. **Therefore, NYONEL recommends strategies such as those described in our "Safe Staffing Always" Toolkit (attached) rather than mandated ratios.**

If the current legislation as written were to be signed into law, the cost increases and lack of corresponding improvements in patient outcomes experienced in California would be duplicated in New York. With the hardship and the unprecedented economic challenges New York hospitals are facing, **NYONEL strongly urges the implementation of strategies other than mandated staff ratios and mandated reporting requirements.**

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Submitted to the New York State Department of Health 9/20/19

No organization is more committed to safe nurse staffing than the New York Organization of Nurse Executives and Leaders. Safe staffing is integral to nurse leaders' responsibility to ensure quality patient outcomes and patient and staff satisfaction. We oppose the well-intended Safe Staffing for Quality Care Act *A2954 (Gunther)/S1032 (Rivera)* as written. Summarily, the bill language attempts to simplify nurse staffing, which is an extremely complex issue that is not amenable to a "one size fits all" approach that the bill offers.

Some of the complexities that must be considered in making nurse staffing decisions are illustrated as follows.

First, no two hospitals are the same. The staffing numbers in the bill would apply to metropolitan academic medical centers and to critical access hospitals. Clearly the patient populations in these two hospital types are not comparable. Therefore, they should not be subject to the same staffing requirements.

No two patients are the same. Even with the same diagnosis, varying comorbidities, cultural and physical and behavioral limits demand very different care. And patient needs can change very suddenly without warning. The bill assumes an environment of "averages" and allows no ability to move staff to where patient needs are greater, from areas where needs are not as great. Nurses are educated to assess patient needs and provide the care and resources to meet those needs. As needs change, we adjust the resources accordingly. The rigidity of the bill language takes away all flexibility to apply nursing judgement and do so.

No two nurses are the same. Without detailed discussion I am sure you can appreciate the differences in abilities of a 6-month new graduate Associate-degree prepared nurse and a 20-year Baccalaureate prepared nurse with professional certification in his/her clinical specialty. The bill language would not allow for differentiation in assignments, and assumes "a nurse is a nurse." Nothing is further from the truth.

The bill's prescribed "24 x 7" staffing requirement is ill-advised for a couple of reasons. First, patient care and unit activities vary at different times of the day and night. The flow of admissions, discharges, transfers, testing, treatments and procedures all need to be considered in making staffing decisions. Staffing needs vary over times of day and days of the week. On one hand, "24 x 7" could be wasteful when needs are lower and on the other, insufficient when needs are higher. Further, "24 x 7" requires that nurses leaving a unit for break or meals be relieved by another nurse. This is ill-advised on two points: first, it requires a handoff report when the nurse departs and returns. Handoffs are proven by evidence as a potential area for miscommunication and can result in errors in care. In addition, relief requirements will necessitate hiring a cadre of "extra" nurses for relief, causing potentially incredible increased hospital expenses.

Hospitals have worked hard – again, under the guidance of expert nurse leaders, direct care nurses and other clinical staff – to create patient care teams that are structured to meet the

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needs of that particular organization's patient population, and that take into account the education, competencies and composition of the organization's clinical staff. Teams are composed of nurses and other caregivers whose skills complement one another's, and are organized around the care needs of that patient population. Care team composition can even differ between unit types. And care team design extends beyond the direct bedside, for example: rapid response teams, IV teams, case management teams, fall prevention teams and skin care teams. Since hospitals clearly could not afford to hire the requisite number of nurses to meet the 24 x 7 requirements as described, such customized models of care – that have contributed to achieving quality outcomes -- would be decimated in the effort to meet the requirements.

California has had mandatory nurse staffing ratios laws since 2004. Various studies have been done and references are provided in the materials we are leaving with you today. Studies have shown no consistency in that state's having achieved the intended outcomes of the legislation: improved quality of care, lower length of stay, lower cost of care, fewer complications of care and adverse events, better patient and nurse satisfaction, longer nurse tenure among them. Had California achieved said outcomes other states would have adopted mandated ratios based on their results. Further, a hospital unit in California that cannot meet ratios closes beds. Therefore, incoming patients from the Emergency Room must be held there. In this scenario, ER beds fill with non-ER patients. Once filled, the ER must divert patients, resulting in delays in care that could be catastrophic and that do community residents a disservice.

More recent California studies have demonstrated inconsistent results as well. The Cal-NOC data demonstrates improvement in only one Patient Sensitive Indicator (PSI) and reduced length of stay (LOS) for one PSI.

Recent international research by Dr. Linda Aiken studied outcomes related to organizations' adherence with their own established staffing standards, studying the number of shifts at or below the staffing plan. Results indicated that when two consecutive shifts were below the standards, outcomes were negatively affected. While confirming that good nurse staffing effects outcomes, no specific ratio was identified as effective.

All healthcare organizations are responsible to meet or exceed the care needs of all patients, to provide safe patient care and work environments, and to achieve optimal patient outcomes. This is especially important in light of New York State having embarked on transforming the healthcare system's delivery of services and payment structure. The "pay for performance" model requires the team to focus on optimizing patient and population outcomes, delivering high value care, and improving long term financial sustainability. Over the years, New York State hospitals have achieved excellent quality outcomes through the competence of direct care staff and the design of existing staffing structures.

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Consideration must be given to a final, likely-unintended outcome of mandated RN ratios as proposed by the bill: reduction of other direct care positions in order to offset the cost of hiring additional RNs. This will affect local job markets and non-professionals from entering the nursing field. Further, when other members of the care team such as patient care technicians/aides, unit secretaries, transporters, dietary assistants, and LPNs are eliminated, those ancillary functions will be imposed on the RN, and will negate the anticipated additional nursing care hours intended to be gained from the mandated RN ratios.

The literature suggests that nurse staffing levels have an impact on nurse satisfaction and patient mortality. CNOs and their leadership teams are best equipped to determine nursing practice issues including staffing. Direct care nurses have a right and responsibility to participate in those decisions. NYONEL's recommended strategy is to empower agency-based staffing committees that include at least 50% direct care nurses to assess variables such as intensity of patient needs, acuity, organizational staffing competencies, etc. that would dictate requisite safe staffing levels. It is essential to give RN staffing committees the responsibility and authority to establish staffing models that take into account the dynamic needs of patients and the workforce characteristics. The numbers of team members caring for patients will need adjustment in response to changing patient needs, to achieve the desired organization-specific outcomes.

To this end, we urge you to consider approaches that are more flexible, patient-focused, effective and data-driven in order to achieve the goal that all healthcare providers share: safe staffing that results in safe, high quality care.

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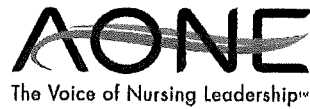
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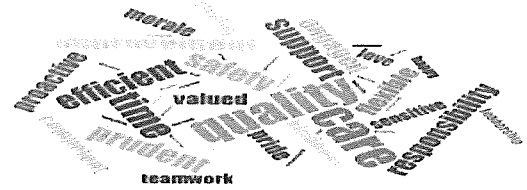
Policy Statement on Nurse Staffing

The American Organization of Nurse Executives (AONE) is committed to safe nurse staffing to ensure quality care and optimal patient experience is delivered throughout our nation. The number of patients for whom a nurse can provide safe, competent and quality care is dependent upon multiple factors. Studies show nurse staffing levels are a determinant of patient safety, outcomes, satisfaction and nurse well-being.

Nurse staffing is a decision based on a complex set of variables under the purview of the registered nurse such as hospital type, patient population, care delivery models, unit layout, patient acuity and the education and experience of the nurse. Mandated nurse staffing ratios imply a “one size fits all” approach to patient care.

AONE believes mandated nurse staffing ratios are a static and ineffective tool that cannot guarantee a safe health care environment or quality level to achieve optimum patient outcomes. Hospitals and health systems across the country are working to advance patient safety, affordability and enhance value by transforming health care delivery. Mandated approaches to nurse staffing limit this innovation and increase stress on a health care system already facing an escalating shortage of educated nurses.

AONE is working with national nursing and health care organizations to systematically address nurse staffing to enhance value, while optimizing quality and patient outcomes.



Toolkit for Safe Nurse Staffing Always

Recommended components for assuring safe staffing always in New York Hospitals and Long Term Care Facilities (LTCF)

- CNOs are professionally accountable for providing the direction for safe nurse staffing processes and should have the **authority** to take action to ensure safe nurse staffing always.
- Clinical nurses, nurse leaders, and hospital leaders, including administrative and financial, should be **responsible** and **accountable** for nurse staffing processes and should have the authority to recommend affordable **nurse staffing guidelines**.
- Hospitals and LTCF's should consider establishing organization-level and/or unit-level **staffing committee(s)** which are comprised of $\geq 50\%$ clinical nurses for developing/reviewing/refreshing **organization-specific** staffing guidelines and endorsing policy and procedures related to implementing the guidelines.
- Hospital/LTCF-level staffing guidelines should be consistent with the American Nurses Association's Principles for Nurse Staffing (ANA, 2008) and should be refreshed annually. Staffing guidelines should contain a minimum-maximum range and consider the relevant national professional organization or benchmark while also considering the following organization-specific factors:
 - Patient complexity/intensity, unit admissions, discharges, and transfers;
 - Care environment architecture and technology;
 - Nursing staff characteristics such as educational preparation, experience, competency and credentialing such as specialty certification, and
 - Team-based clinical and non-clinical support staff availability, experience and competency.

The plan should include **organization-specific actions to be taken** when a unit/department is below the recommended staffing guideline to ensure safe staffing always.

- **Conformance with staffing guidelines** should be evaluated daily and aggregated on a scheduled frequency (monthly, quarterly) and compared to nursing-sensitive clinical and administrative quality indicator benchmarks. These data should be accessible to all clinical nurses, nurse leaders, and hospital leaders, including administrative and financial, who are responsible and accountable for nurse staffing processes.
- Conformance with staffing guideline metrics should be added to the organization's performance indicators and reported to hospital leadership and governing body on a scheduled basis. Consistent non-adherence should be addressed by hospital leadership.
- Leaders of units demonstrating a negative trend in clinical and administrative quality indicators should analyze and present corrective actions through the organization's quality/performance improvement structure.
- **Patients and families** should be informed about the organization's intent to provide safe staffing organizational publications and patient education materials. Patients and families should be provided information about where to direct any concerns.



ENGAGE • EDUCATE • EMPOWER

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NYSHFA
NYS HEALTH FACILITIES ASSOCIATION

NYSCAL
NYS CENTER FOR ASSISTED LIVING

Testimony of:

**NEW YORK STATE
HEALTH FACILITIES ASSOCIATION**

and the

**NEW YORK STATE
CENTER FOR ASSISTED LIVING**

on the

**2019 New York State Department of Health Staffing Study Engagement Session
Friday, September 20, 2019**

Albany, New York

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Introduction

Good afternoon. My name is Nancy Leveille, R.N., M.S. and I have the privilege of serving as the Executive Director of the Foundation for Quality Care (FQC), the research and education arm of NYSHFA/NYSCAL. NYSHFA/NYSCAL members and their 60,000 employees provide essential long-term care services to over 50,000 elderly, frail, and physically challenged women, men, and children at over 400 skilled nursing and assisted living facilities throughout New York State. A discussion of the healthcare workforce crisis that New York and our nation is facing is desperately needed and we greatly appreciate the opportunity to share our ideas and findings from the experiences of our NYSHFA/NYSCAL members.

NYSHFA/NYSCAL recommends the following topics as structural concerns to the overarching issue to be addressed in the discussion of safe staffing and quality patient outcomes in NYS nursing homes:

1. Staffing needs and staff/patient ratios cannot be viewed in isolation of the current national health workforce crisis especially in the nursing home industry.
2. Solutions for the health workforce crisis require short and long-term planning, partner collaboration and financial support.
3. With New York's Medicaid reimbursement rates for nursing homes not meeting the cost of services being provided today, any additional cuts to Skilled Nursing Facilities (SNF) Medicaid reimbursement rates will devastate initiatives to build a stronger workforce. If major cuts occur the unintended consequences will not only be felt in the SNF community but across the healthcare continuum for years to come.

I will now summarize NYSHFA's recommendations on nurse staffing ratios as outlined below. For further information on nursing home workforce quality initiatives, please see the joint association letter submitted December 27, 2018 to the New York State Commissioner of Health outlining a variety of potential solutions to develop a stronger health workforce in New York State. (See Attached).

Current Plan for Minimum Staffing

Unlike other Article 28 providers, skilled nursing facilities already have mechanisms designed and implemented by the Centers for Medicaid and Medicare Services (CMS) to determine the expected RN, LPN and CNA staffing levels in a SNF.

Specifically, CMS utilizes a formula for determining the expected staffing hours by comparing the data in the MDS with expected hours and actual staffing hours reported quarterly through the Payroll-Based Journal system (PBJ). This information is provided to each SNF and publicly reported via the CMS 5-Star system on a quarterly basis. SNF use these parameters to guide their nurse staffing plan.

As a condition of opening and operating a SNF, the SNF submits their minimum staffing plan prior to opening for DOH approval and then yearly thereafter for DOH review. In addition, the SNF is required to post their actual daily staffing schedule in their facility for public review. Special SNF ventilator units already have unique staffing requirements to meet the intensity of ventilator care with additional Respiratory Therapists staffing requirements.

Therefore, an existing system for staffing accountability is currently in place at each nursing home which is reviewed at least annually by DOH during the onsite Nursing home standard or complaint surveys.

Numerous significant concerns have been raised, including by the New York State Bar Association, that State-specific statutory staffing ratios would impose standards that are inconsistent with CMS' Conditions of Participation, which establish standards for patient protections and a provider's eligibility to receive federal funds.

Valid Staffing Tools

No valid, industry vetted and reliable tool for setting nursing home staffing ratios is available. There are tools designed for acute care based on the intensity of care utilizing the Diagnosis Resource Groupings (DRG) that are specific to acute care settings, not SNF.

Projected Expenses for Minimum Staffing

Arbitrary staffing ratios have been calculated to cost 1 billion dollars across the health care continuum in New York State if implemented. No financial support has been identified to reimburse organizations for this massive expense, making it an untenable unfunded mandate. Current proposed cuts to Medicaid funding to nursing homes would be catastrophic to nursing home operations including the ability to hire and retain a team of skilled competent staff.

I would also like to take this opportunity to correct a misconception about mandatory staffing ratios as it relates to New York's dwindling health workforce, which is that mandating staff ratios will draw nurses into the field and to New York and that this will solve our workforce shortage problems. There is absolutely no evidence of this happening in California or in any area that does not invest substantially in training, recruitment and retention. Mandatory staffing ratios will exacerbate the struggles of hospitals and nursing homes competing for the same limited pool of healthcare workers, directly increasing costs while doing nothing to improve patient care. It is a fact that New York's aging population is growing. It is a fact that New York's healthcare workforce is currently struggling to meet the demand for care.

Collaboration by NYSHFA and other NYS Nursing Home Associations

On December 27, 2018, NYSHFA was part of an ad-hoc coalition of organizations representing New York's skilled nursing providers that submitted a letter outlining numerous potential solutions for developing a stronger health workforce in New York State. The recommendations set forth in our December letter are based on our collective years of experience and knowledge in developing long term care staff and bolstered by the reporting and research of the Center for Health Workforce Studies at the University of Albany's School of Public Health. The proposal addresses the assistance we need to get to the next level of solving the current and future healthcare workforce crisis.

Experience from California Mandated Minimum Staffing Ratios

California's nursing homes have not met the goals intended by the policy. California has had difficulty maintaining staffing ratios and there is not documentation of the effects and unintended consequences of pulling so many RNs to acute care and the downward effect on other parts of the health continuum.

Advocates for mandatory staffing ratios often claim that California hospitals actually did better financially post-implementation. Despite evidence to the contrary, it is concerning that these advocates are equating hospitals and nursing homes. This is a dangerous misconception. For example, the State of California, which implemented hourly nursing home ratios in 2018, has also provided two types of waivers to exempt nursing homes from the ratio requirements due to workforce shortages. Over half of California's nursing homes have applied for the waivers, and the State is now faced with the significant financial burden of determining how to fund and enact legislation for developing a workforce they are requiring facilities to employ.

No significant positive patient outcomes have been noted in literature that were not already beginning to occur prior to the enactment of staffing ratios. Specific outcomes noted in literature included:

- An increase in per diem and agency nurse utilization,
- Elimination of ancillary support staff, thereby adding non-nursing functions to nurse's jobs,
- Strong decreases in the hospital revenues across the board, and
- Elimination of services deemed no longer affordable

Experience from Massachusetts Minimum Staffing Ratios

In Massachusetts last year, 70% of the voters rejected the staffing proposal after studying the potential outcomes. California implemented mandatory ratios in 1999. No other State has done so since.

Outreach to Academia and other Professional Stakeholders

New York should learn from California and employ initiatives that cannot be ignored in conjunction when discussing health workforce needs, the most basic being can we meet our own requirements. In addition to the December recommendations, we urge the Department to include in its final report:

- The development of a coalition of all the key stakeholders to work together to identify short-term and long-term solutions.

- Providing nursing scholarships and other financial incentives/benefits for individuals seeking jobs in the healthcare workforce, especially in long term care.
- Building a stronger career ladder for non-professionals (CNA).
- Identifying barriers and solutions in current legislation limiting the scope of practice (medical technicians).
- Building campaigns for the promotion of healthcare as a credible and dynamic career for individuals at the start of their careers and/or as a second career choice.

We must ensure that discussions and research with other stakeholders, academia, licensing bodies, labor departments and other groups continue in order to promote collaboration and partnership for developing and implementing multiple options for growth of a competent workforce. Healthcare is ever-evolving and it would be a mistake to enact public health policy that fails to recognize the need for flexibility and innovation.

NYSHFA's Mission for Training LTC Leaders

One of NYSHFA/NYSCAL's core goals have been to ensure a set of standards for care for LTC residents by developing education programs for long term care staff. NYSHFA created the Foundation for Quality Care (FQC) to devote time and resources to lead the workforce training for LTC. The FQC provides educational courses for licensed nursing home administrators, RNs, LPNs, CNAs Directors of Nursing, managers, supervisors, nurse educators, quality specialists, various clinicians and career development courses for entry level staff. The goal has been to not only provide education, but to help retain quality long -term care staff.

Conclusion

New York State unfortunately leads the Nation with the largest shortfall between the amount Medicaid reimburses providers and the actual cost of providing resident care in the nursing home (approximately \$55 per day). Moreover, New York State's providers have continued to endure mounting budget cuts and growing operational expenses to comply with minimum wage, health insurance increases, and ever rising

food and utility costs. However, unlike most all other industries, skilled nursing facilities cannot pass these increased costs on to the consumer.

If the goals are safe quality care for patients, safe and decent working conditions for patient care workers and equal access to care for all New Yorkers, then New York State needs to recognize that statutory nurse staffing ratios will not solve or change the fact that a significant percent of SNF lack the necessary broadband services and financial ability to move to electronic health records. Statutory staffing ratios will not improve the lack of staff at the State Education Department, further delaying the licensing process and hiring at SNFs. Statutory staffing ratios enacted in a vacuum will not help other professions advance in health care careers and will hamper innovation, which is clearly shown by California's most recent funding of \$2.4 million in May for even more training for nursing home staff to meet the State's staffing mandates.

The lack of health care workforce has caused skilled nursing facilities to compete with other parts of the healthcare continuum, but not in ways that benefit health care because rates and funding for Long Term Care have simply not kept up with the costs and demand. The health care workforce continues to lose quality employees to food/retail industries, exacerbating the shortages for all health care providers.

We thank you for your time and attention on these critical issues to ensure the continued delivery of high-quality, cost effective long-term care to our most vulnerable individuals.

It is vitally important that New York State protect and enhance access to the crucial services provided by skilled nursing facilities for our rapidly aging population. Longer lifespans and better chronic disease management will contribute to the need for increased long-term care services as the baby boomer generation is aging. Worldwide those aged 60 and over are expected to double by 2050. New York cannot continue to cut funding to essential long-term care and assisted living programs and expect to be able to adequately serve this aging population.

As always, NYSHFA/NYSCAL will continue to work together with the Governor, the Legislature and all affected constituencies to ensure the continued delivery of high quality, cost effective long-term care services throughout New York State.

Thank you.



X



December 27, 2018

Mr. Keith Servis
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Dear Keith:

Thank you for the opportunity to comment on the Nursing Home Quality Initiatives. This is the Joint Association's top issues and priorities.

Overview of Current Quality Initiatives

There are multiple quality initiatives that have been in progress for years supported by internal nursing home funding, as well as by state sources including the Health Workforce Retraining Initiative (HWRI), Workforce Investment Organizations (WIO), Civil Money Penalty (CMP) funds and the Delivery System Reform Incentive Payment (DSRIP) program.

New York's nursing homes have made excellent progress in the CMS Quality Measures, as evidenced by the progress demonstrated since 2013 in the state's Nursing Home Quality Initiative (NHQI). In addition, the state's nursing homes, via the Dementia Coalition and targeted quality programs, have: (1) reduced antipsychotic medication usage by over 15% in residents with dementia over the last few years (shifting NY's ranking on the measure from 11th best in the US to 5th best); (2) reduced unnecessary hospitalizations by implementing strategies from the INTERACT program; (3) increased the use of customer satisfaction surveys; and (4) focused on Improving residents' functional outcomes and increasing discharges to home or lower levels of care.

Review of Factors Challenging the State's Capacity to Sustain or Improve its Quality Profile

- No trend factor in 10 years, despite growing costs of operation.
- Rapid cycling through Medicaid reimbursement models: rebasing, to pricing, to MLTC-mediated payment.
- Growing instability and turnover within the State's provider infrastructure.
- A perfect storm of negative pressures, which in combination could cause NY's quality ranking among States to fall below current levels.
- A major shortage of health care workers across the health continuum, but especially in the long-term care (LTC) sector.
- Lack of financial support for technology for all nursing homes across all regions of NYS.
- Concerns about the consistency, timeliness and administration of the survey process, amid changing requirements of participation.
- Lack of a dedicated rate, program development, and competency-based education to meet the needs of individuals with behavioral, substance abuse and mental health needs requiring nursing home care.

Recommendations:

BUILDING A MORE EFFECTIVE, SKILLED AND FLEXIBLE LONG -TERM CARE WORKFORCE

NYS should develop an integrated LTC workforce development strategy that focuses on the central importance of human interaction in nursing homes.

- Develop a LTC workforce development committee, inclusive of key stakeholders in the LTC field, DOH, the Department of Education and the State University System, to advise on approaches – including scope of practice issues and training and education initiatives – to improve the quality and quantity of the LTC workforce.
- Enhance the ability to create career ladders for health care workers by creating a core curriculum for entry level workers; unbundling a few Certified Nurse Aide (CNA) functions to expand levels and create a career ladder within the role; and create an advanced role of medication technicians by adding additional competencies.
- Leverage the State's training resources to drive improvement in organizational performance and workforce competence to meet the changing needs of long-term and subacute residents.
- Direct monies from current funding streams including HWRP, WIOs, the Advanced Training Initiative (ATI) and CMPs to assist with supporting initiatives for a larger number of nursing homes across NYS.
- Create a Statewide Campaign for Health Care Workers showcasing health care as a desirable profession.
- Provide dedicated funding from the proceeds of the sale of Fidelis to Centene to nursing homes throughout the state to underwrite evidence-based recruitment, onboarding, training and retention projects/initiatives.
- Provide incentives for scholarships/recruitment for regions of the state suffering from the most severe workforce shortages.

- Utilize maximum state flexibility (e.g., amount and timing of fines, etc.) in decisions about whether to institute bans on offering CNA training programs. Seeking DOH assistance for providers to retain their CNA training programs notwithstanding a minor deficiency. CNA bans also affect a facility's ability to offer administrator-in-training programs, another training initiative that should be supported.
- Work with law enforcement agencies to expedite completion of criminal background checks for CNAs and avoid delays that are costly and disruptive to nursing homes.

ADVANCE HEALTH INFORMATION TECHNOLOGY AND INTEROPERABILITY IN LTC SETTINGS

NYS should more proactively work to ensure that technology and HIT interoperability are leveraged to support better care quality and care transitions in all nursing homes.

- Include LTC providers in the opportunities that arose from HIT incentive payments for hospitals and physicians, including support for technology implementation.
- Learn from the experience in the hospital and physician community to build a better LTC technology strategy that meets the providers' needs - including an intuitive and streamlined process; improves quality for patients/residents, which could result from Health Information Exchange (HIE) opportunities with hospitals, pharmacies, etc.; and creates operational efficiencies that are possible, especially in the remote care and transfer process.
- Streamline any new investment in HIT with automatic connection to State-driven HIE to gain the benefit of appropriately sharing information among providers.
- Facilitate development and expansion of LTC providers' telehealth and telecommunication capabilities to fully allow for the technology to assist patients and providers that are challenged by transportation, access to specialists and translation, coordination with transfer partner clinicians, and communication with families.

SUSTAIN AND EXPAND FINANCIAL SUPPORT FOR LONG TERM CARE

Years of losses from serving Medicaid beneficiaries have prevented many nursing homes from accumulating the capital needed to make transformational investments in their facilities and care delivery.

- Provide added support to the LTC community through programs such as the Vital Access Provider program, the ATI, CINERGY, the Statewide Health Care Transformation Program (SHCFTP) and any other programs offering grant funding support for capital initiatives and operating support. These programs are essential in the face of Medicaid reimbursement levels that have not been adjusted for inflation in 10 years, and that are demonstrated to fall short of actual care delivery costs by \$1.6 billion annually in New York State.
- Provide support through accelerated Medicaid depreciation reimbursement and/or the SHCFTP for life safety code-related upgrades facilities need to make.
- Expand the current \$50 million NHQI with funds derived from outside of the existing nursing home Medicaid funding base.
- Analyze the possibility of replacing the RUG-III classification system used for Medicaid rates with the Patient Driven Payment System Medicare is adopting for October 1, 2019 implementation.

- Provide adequate funding to address the effects of the minimum wage increase, including recognizing the effect of wage compression on other salary bands.

PROGRAMMING AND FUNDING

Nursing home residents are increasingly multi-morbid, frail, functionally limited and likely to be suffering from behavioral issues. Many have post-acute medical needs, and there is a need for expanded programmatic and funding support to meet these changing needs.

- Develop program regulations and enhanced Medicaid reimbursement for residents who have behavioral health, mental health and/or substance abuse issues. Existing programs and funding do not provide adequate support for addressing the needs of these populations.
- Develop program regulations and enhanced Medicaid reimbursement to support increased development of specialty units with the clinical capacity to prevent avoidable hospital and emergency room use.

ENSURE SURVEY PROFESSIONALISM, QUALITY AND CONSISTENCY

Assuring adequate levels of staff in the survey bureau, and adequate resources for training and oversight, is vital to assuring that the process accomplishes its goals – and that these goals are achieved professionally, timely, and with consistency in the assigned members of the survey team.

- Support DOH's efforts to seek and provide the resources to support the bureau in this regard.
- Continue efforts to address regional differences in the numbers of survey citations, and the resulting effects on facilities' Five-Star ratings.
- Reduce the frequency of annual surveys for facilities with favorable survey outcomes and increase the frequency of surveys for facilities with poor surveys.
- Revise the Informal Dispute Resolution (IDR) process to incorporate best practices such as incorporating third-party administration of the program, providing facilities with adequate time for filing requests, and providing IDR program statistics and specific feedback to facilities on the disposition of their requests.
- Adhere to federal timeframes on state surveys and to defined timeframes for completion of state investigations and "closing out" surveys to ensure timely follow up on issues and reduce operational uncertainty.

STATE-DRIVEN PUBLIC EDUCATION

More education and positive public relations on nursing home care would enhance worker recruitment and retention efforts; increase public support for adequate funding through Medicaid and other programs; and better align consumer expectations with provider capabilities.

- Create a Quality Campaign and showcase positive stories of quality care successes in NYS nursing homes.
- Create a Public Service Campaign to promote health care (and LTC in particular) as a valuable career choice and profession offering life-long learning and service to those most in need of care and compassion.
- Promote education to assist individuals to proactively plan for LTC before they need it or are in crisis.
- Set and manage expectations for consumers and their families about the natural decline in health that can be helped to some extent with high quality LTC services.
- Reward high performing facilities through public recognition.

If you have any questions or comments, feel free to contact Nancy Leveille, Scott Amrhein or Dan Heim.

Respectively submitted,

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ACUTE CARE
STAFFING

1199SEIU
United Healthcare Workers East
QUALITY CARE AND
GOOD JOBS FOR ALL



WHO WE ARE

St. Barnabas

Montefiore –
Wakefield Brookdale

Mount Sinai Beth Israel

Mount Sinai Queens

Mount Sinai Brooklyn

New York Community

Jamaica Hospital

Northwell Forest Hills

New York

Presbyterian Queens

St. John's Episcopal

Southampton

Eastern Long Island

St. Vincent's Westchester

Orange Regional
Medical Center

Good Samaritan Hospital

Mercy Port Jervis

Mid-Hudson Hospital

Kaleida Health

Crouse Hospital

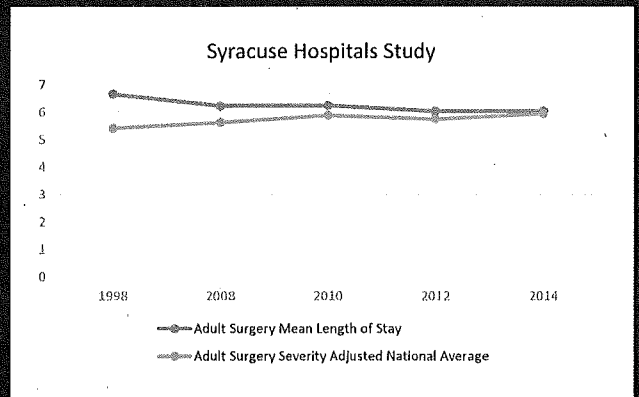
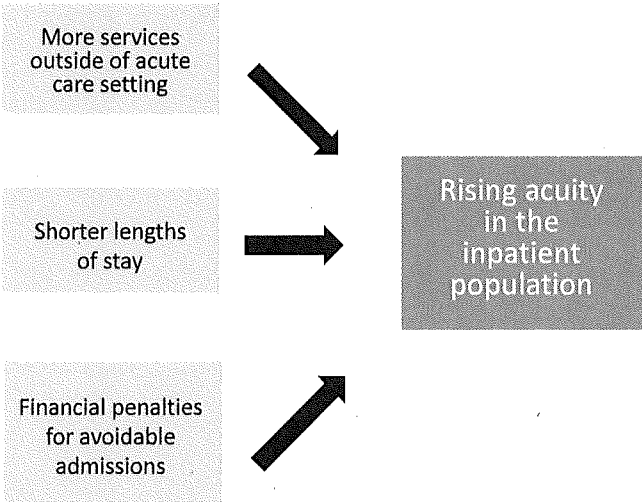
150,000 hospital
workers from all over
New York State,
including over 9,000
Registered Nurses.

1199SEIU
United Healthcare Workers East

RISING ACUITY



THE ACUTE CARE LANDSCAPE IS CHANGING



“ The study data demonstrated that the reductions in adult medicine lengths of stay were paralleled by an increase in the severity of illness of the adult medicine population of the hospitals.”¹

THE ACUTE CARE LANDSCAPE IS CHANGING

- Fraying of the social safety net and underinvestment in behavioral health services, leading to an increase in patients with complex social and behavioral challenges ^{2,3}
- New models of patient care focus on population-based management rather than simply responding to patient conditions



INCREASING PRESSURE



INCREASING PRESSURE ON RNS AND THE CARE TEAM

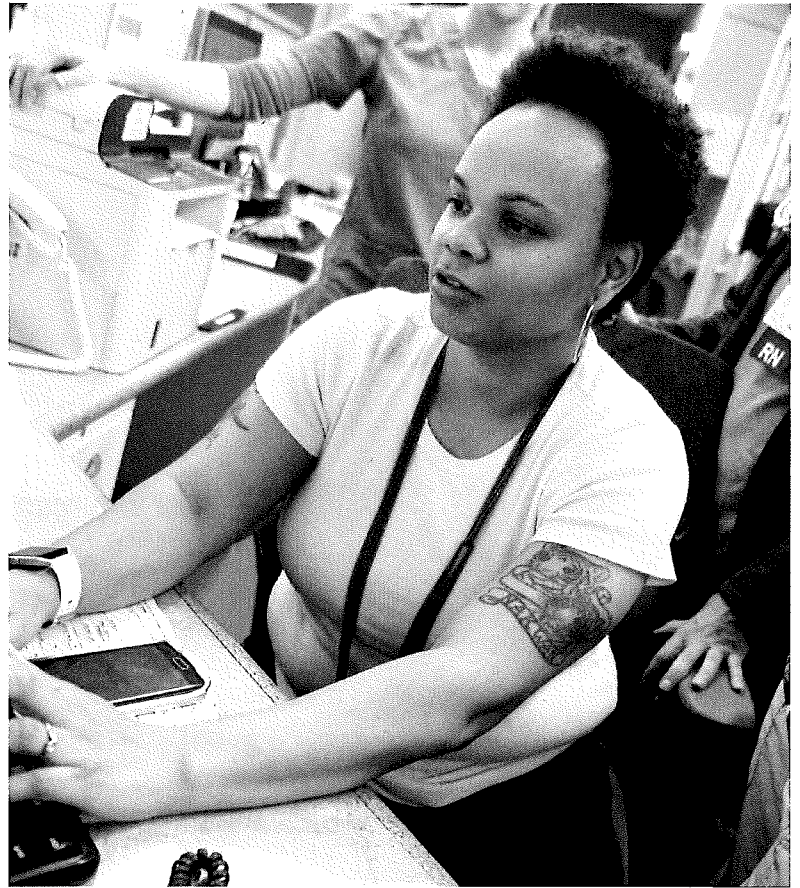
- Advances in technology and the proliferation of new medications require constant learning of new technical skills and clinical information ⁴
- Electronic medical records can add new administrative burdens and come between nurses and patients ^{5,6}



INCREASING PRESSURE ON RNS AND THE CARE TEAM

Nurses are being asked to take on more and more roles in addition to direct patient care:

- Coordination and care management, including patient education and counseling, even post-discharge ⁷
- Systemic data-based quality improvement, especially improving the patient experience ⁸



INCREASING PRESSURE ON RNS AND THE CARE TEAM

- Newly-licensed RNs and newly-graduated BSNs may not be fully prepared for clinical work, requiring incumbent nurses to act as preceptors, often without adequate preparation or protected time.

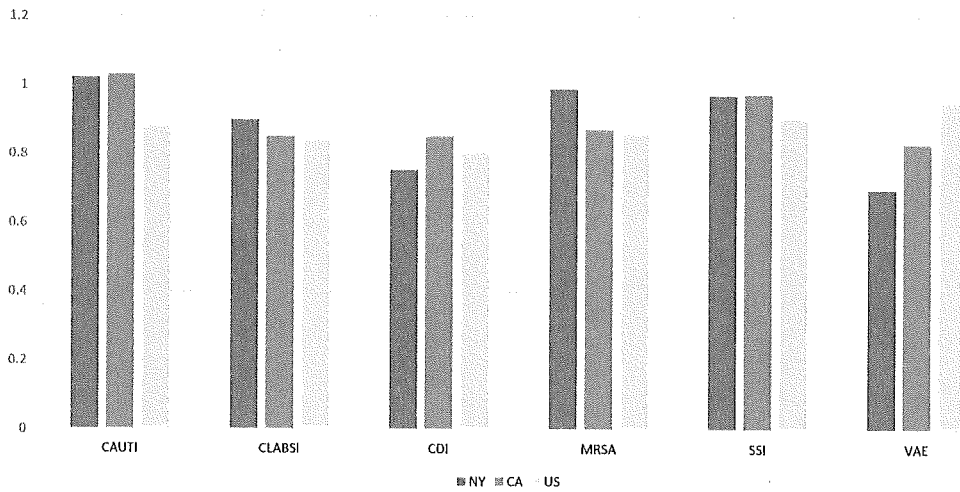


IMPACT ON QUALITY CARE



NY MUST IMPROVE ON STAFFING-ASSOCIATED QUALITY MEASURES

CENTERS FOR DISEASE CONTROL
HEALTHCARE-ASSOCIATED STANDARDIZED INFECTION RATIOS



CAUTI: Catheter-Associated Urinary Tract Infections

CLABSI: Central-Line Associated Bloodstream Infections

CDI: *C. difficile* events

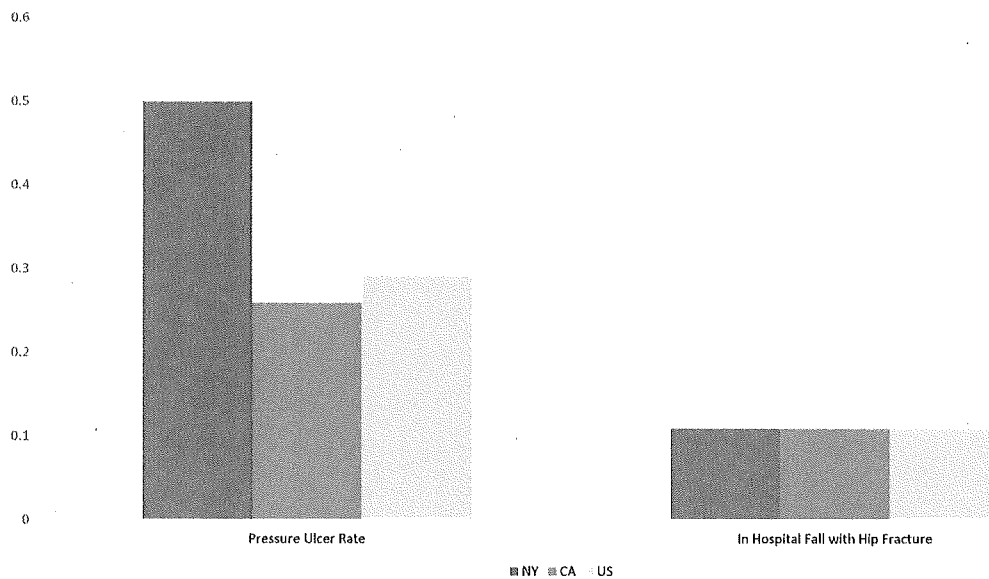
MRSA: MRSA Bacteremia

SSI: Surgical Site Infections following Colon Surgery

VAE: Ventilator-Associated Events

NY MUST IMPROVE ON STAFFING-ASSOCIATED QUALITY MEASURES

MEDICARE QUALITY MEASURES – MEDIAN RATES FOR HOSPITALS



TEAM APPROACH



THE TEAM MODEL

- “The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system”
- Registered nurses, LPNs, nursing assistants/patient care technicians and unit clerks, as well as social workers or nurses doing discharge planning.
- A full team allows RNs to focus on bedside care and practice to the full extent of their licenses.



THE TEAM MODEL

- Nurse-only ratios fail to capture the value of the full team and can lead to nurses working at the bottom, rather than the top, of their licenses.
- The California experience shows an increase in RN staffing and staffing overall, but a reduction in Licensed Vocational Nurses and clerical workers.¹⁰

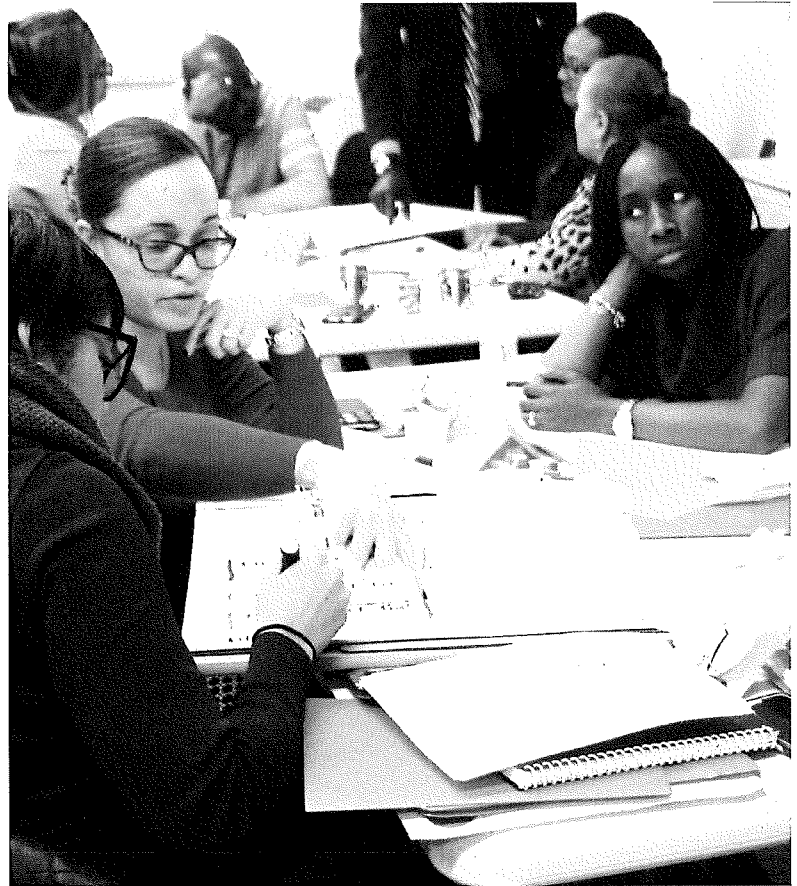
Labor Productivity by Employee Classification	2013		2012		2011		2010		2009		2008		2007		2006	
	FTEs Per		FTEs Per		FTEs Per		FTEs Per		FTEs Per		FTEs Per		FTEs Per		FTEs Per	
	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed	Adj. Occupied Bed
Mgt & Supervision	0.49	0.43	0.44	0.40	0.39	0.39	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38
Technical & Specialist	1.20	1.22	1.17	1.17	1.12	1.10	1.07	1.06								
Registered Nurses	1.46	1.48	1.44	1.45	1.43	1.40	1.36	1.32								
Licensed Voc. Nurses	0.09	0.10	0.10	0.10	0.11	0.12	0.12	0.13								
Aides & Orderlies	0.38	0.38	0.37	0.38	0.38	0.38	0.38	0.38								
Clerical & Other Admin.	0.77	0.82	0.82	0.83	0.82	0.83	0.83	0.84								
Environ. & Food Services	0.32	0.33	0.33	0.34	0.33	0.33	0.32	0.32								
All Other Employees	0.35	0.34	0.35	0.31	0.32	0.31	0.31	0.31								
Total Productive Hours	5.07	5.10	5.02	4.98	4.90	4.85	4.78	4.74								
Total Paid Hours	6.01	5.98	5.91	5.82	5.78	5.75	5.66	5.59								

1199 PROCESS



1199SEIU BARGAINING APPROACH TO STAFFING STANDARDS

- Under the collective bargaining agreement with the League of Voluntary Hospitals and Homes and 1199SEIU, a labor-management Quality/Performance Improvement Program team is convened at each institution where 1199 represents RNs.
- A similar process is undertaken at other 1199—represented hospitals like Crouse.



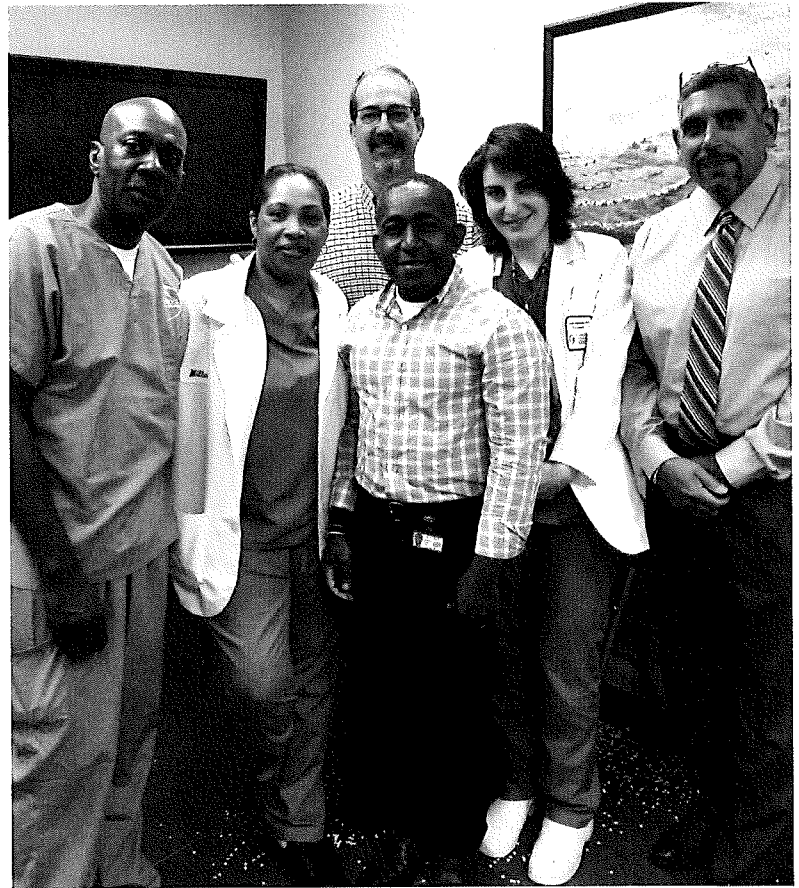
1199SEIU BARGAINING APPROACH TO STAFFING STANDARDS

- The team is tasked with examining relevant data, including patient acuity, daily census and skills of the existing workforce, and agreeing to unit-specific nurse to patient ratios.
- The agreements also include the hiring or scheduling of non-RN staff to ensure a full team.



1199SEIU BARGAINING APPROACH TO STAFFING STANDARDS

- These standards are then enforceable under the contract.
- There is a continuing emphasis on compliance and a League-wide committee that is responsible for performing a root cause analysis of factors that can impede proper staffing.



RECOMMENDATIONS: STAFFING

New York State should require every acute care hospital to undertake a process to set specific staffing requirements every 3 years

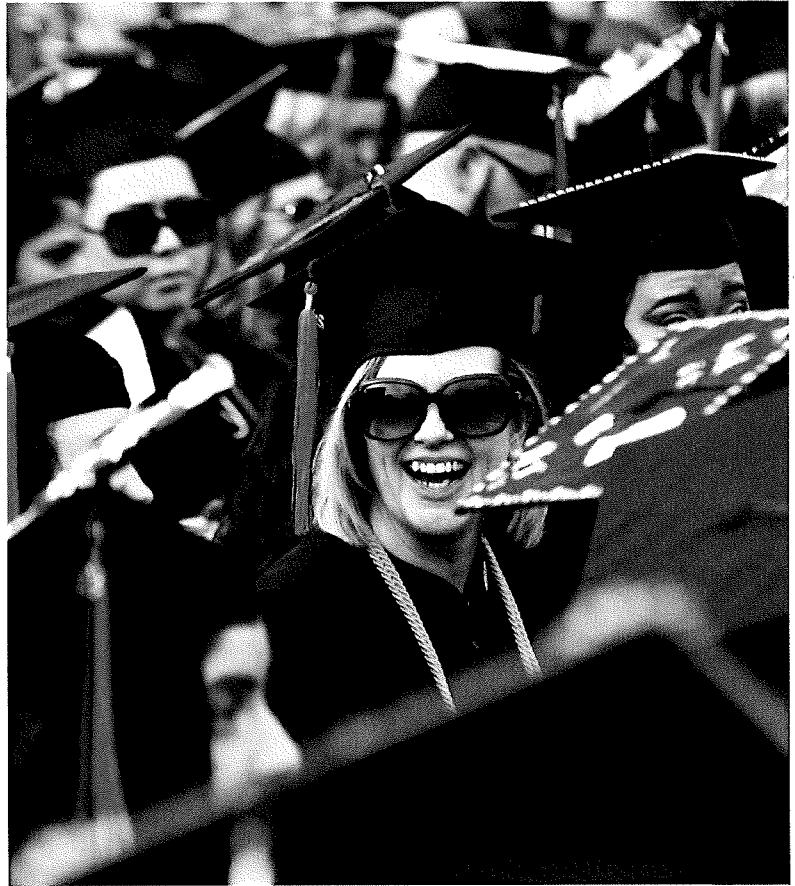
- Set up a labor-management council with representation from frontline RNs and other caregivers and labor representatives as well as management, with labor and management having equal votes
- Have access to and examine relevant data
- Agree upon appropriate RN and support staff ratios
- Agree upon the number of workers that must be hired and scheduled to adhere to these ratios in a 24/7 environment, with provisions for worker absences and required breaks.

RECOMMENDATIONS: STAFFING

- The agreed-upon ratios and hiring as well as documentation of the process would be submitted to the state and publicly available
- DOH would set up a process for nurses and caregivers or other affected parties to complain if the ratios were not being followed
- DOH would be given authority to investigate and fine institutions who substantially violate the process or the agreed-upon ratios

RECOMMENDATIONS: WORKFORCE DEVELOPMENT STRATEGIES

- Our union has bargained employer contributions to the 1199SEIU Training and Employment Funds, which provide initial education, tuition support and wrap-around services for healthcare workers seeking to advance in the field.
- 40,000 members take advantage of programs across the Funds annually, including 1,200 members in nursing programs.



RECOMMENDATIONS: WORKFORCE DEVELOPMENT STRATEGIES

New York State should invest in all levels of the nursing pipeline

- Support for training for nurse assistants, patient care technicians and telemetry technicians to recruit new workers
- Funding for paid release time for nursing programs (LPN-RN-BSN or RN-BSN)
- Ensuring that RN programs articulate to BSN programs, especially in public colleges and universities



RECOMMENDATIONS: WORKFORCE DEVELOPMENT STRATEGIES

New York State should invest in all levels of the nursing pipeline

- Ensuring nursing programs are aligned with real-world practice, including expanding pre-graduation clinical placements
- Increasing transition to practice programs for RNs and BSNs by funding preceptor time and wider adoption of nurse residencies
- Using the cohort model to support worker-learners

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STAFFING IN NEW YORK
NURSING HOMES

1199SEIU
United Healthcare Workers East
QUALITY CARE AND
GOOD JOBS FOR ALL



Who we are: over 63,000 nursing home workers across New York State

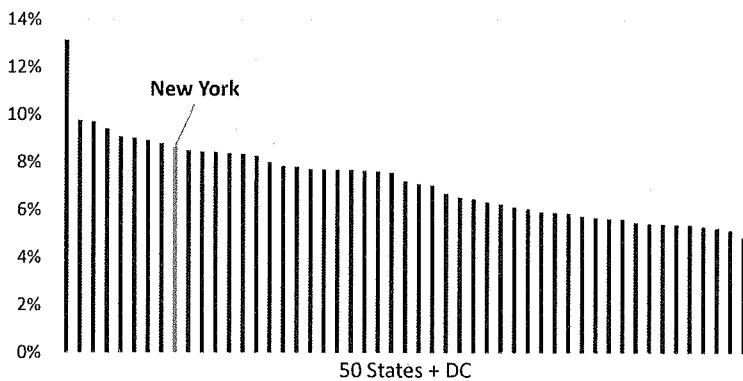
1199SEIU
United Healthcare Workers East

SHORT STAFFING
AND RESIDENT CARE



STAFFING IMPACTS RESIDENT OUTCOMES

PERCENTAGE OF HIGH-RISK LONG STAY RESIDENTS WITH PRESSURE ULCERS¹



““ Pressure sores, falls, and malnutrition are endemic in many nursing homes, and strongly linked to inadequate staffing.”²

NEW YORK TIMES, 2014

““ Total nurse staffing and RN staffing levels were negatively related to total deficiencies, quality of care deficiencies, and serious deficiencies that may cause harm or jeopardy to nursing home residents ... with every 6 minute increase (tenth of an hour) in [CNA hours per resident day] there is a 3% reduction in the quality of care deficiency scores.”³

HYER, et al, *THE GERONTOLOGIST*, 2009

SHORT STAFFING:
THE WORKER EXPERIENCE



STAFFING IN NEW YORK: 38TH OF THE 50 STATES

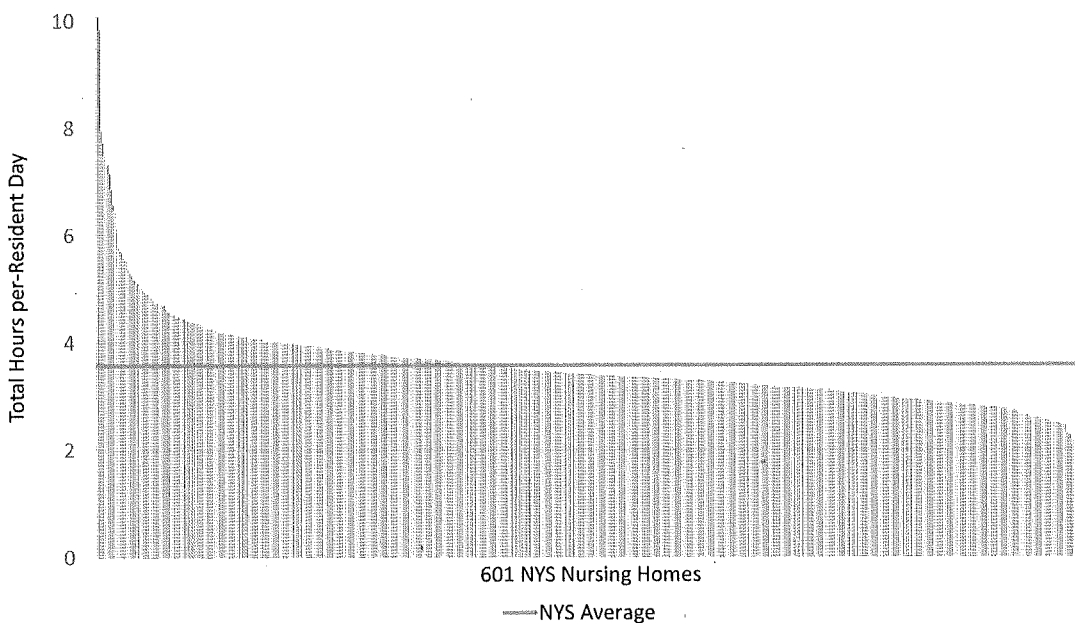
CRITERIA	RANK VS NATION	DATA	CRITERIA
State Average, Direct Care Staffing Hours per-Resident	38th	2.36 HPRD	D
State Average, Professional Nurse Staffing Hours per-Resident	33rd	1.63 HPRD	D
% of Facilities With Direct Care Staffing Level Above Average	45th	21.84%	F
% of Facilities With Professional Nurse Staffing Level Above Average	44th	23.14%	F

“New York’s nursing home staffing hours remained woefully stagnant for the third consecutive reporting period, clocking just 2 hours and 20 minutes of direct care per resident daily.”⁴

FAMILIES FOR BETTER CARE 2019 REPORT CARD

STAFFING IN NY: MOST NURSING HOMES BELOW AVERAGE

NEW YORK STATE NURSING HOMES & AVERAGE HPRD⁵



THE CHANGING
NURSING HOME



NURSING HOME POPULATIONS IN FLUX

Nursing homes are undergoing significant changes in resident population that make the jobs of direct-care workers more challenging:

- Nursing home residents are growing older, sicker, and requiring more care^{6,7}

	Residents 65+	Residents 85+
2016	83.3%	33.8%
2040	90.4%	40.9%

- They have more frequent diagnoses of dementia or other psychiatric conditions⁸
 - 45.3% of nursing home residents were reported as having a dementia diagnosis
 - 32% of nursing home residents were reported as having other psychiatric conditions
- There are more patients with post-acute-care-intensive conditions, but with shorter lengths of stay⁹
 - 27 days for Medicare fee-for-service patients
 - 20 days for ACO patients
 - 14 days for managed care patients
- More facilities are treating particularly complex populations: young residents, residents undergoing dialysis, residents with a TBI or HIV diagnosis

STAFFING
AGENCIES



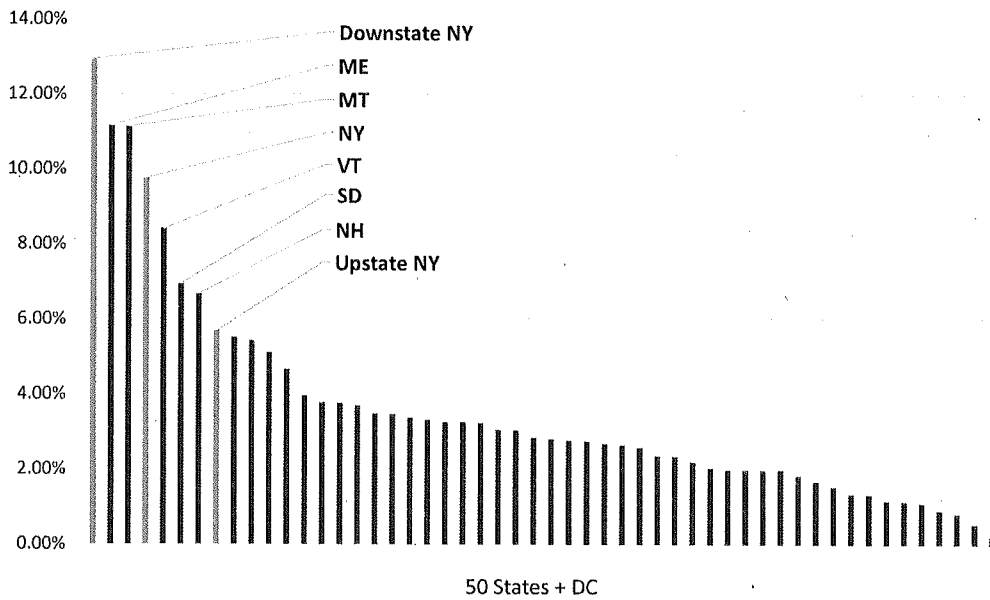
AGENCY STAFFING: THE QUALITY IMPACT

QUALITY MEASURE	HIGH CNA AGENCY USE DIFFERENCE
Need for help with daily activities increased	5.1% worse
High-risk residents with pressure ulcers	3.0% worse
Physical restraint used	1.1% worse
Spend most time in bed or chair	4.4% worse
Catheter inserted and left in bladder	1.5% worse
Developed urinary tract infection	2.3% worse

Academic research shows a strong association between lower CNA, LPN and RN staffing agency use and higher quality of care. Among others, a 2009 study by Dr. Nick Castle at the University of Pittsburgh looked at this relationship and found significant negative impacts from high agency staffing across numerous quality measures.¹⁰

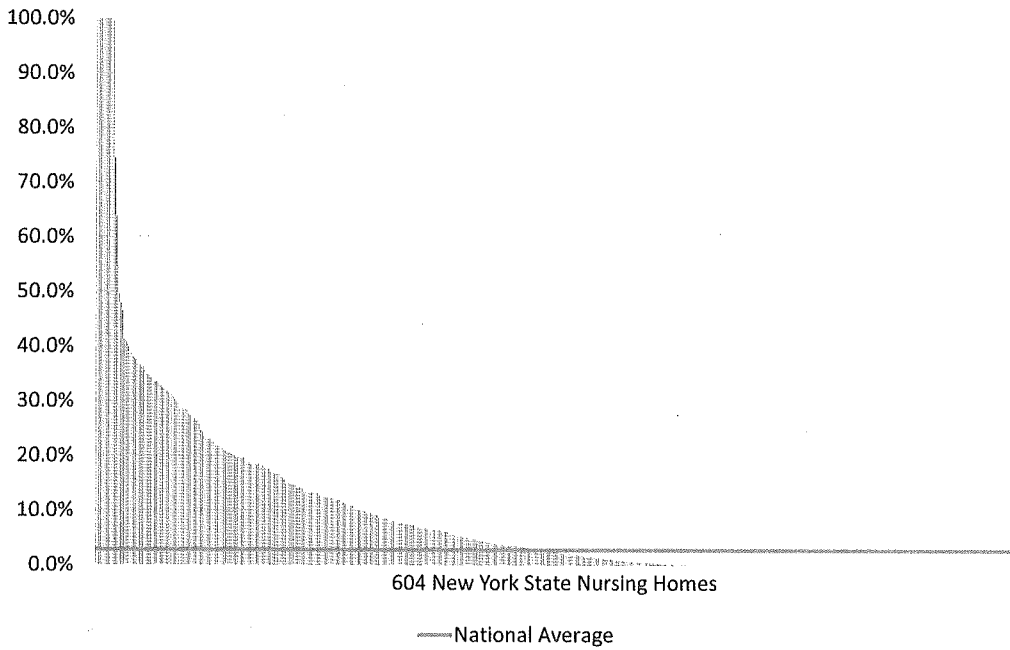
AGENCY USE: NEW YORK IS AMONG THE HIGHEST

% OF CONTRACTOR DIRECT CARE HOURS, BY STATE¹¹



AGENCY USE: NEW YORK NURSING HOMES

OF 604 NY NURSING HOMES, 399 REPORTED AGENCY USE¹²



AGENCY STAFFING: THE FINANCIAL IMPACT

Nursing Home A: 34% agency nursing staff

- Paid over \$1.5M to staffing agencies for nursing staff in 2016¹³

Nursing Home B: 39% agency nursing staff

- Paid over \$1.9M to staffing agencies for nursing staff in 2016¹⁴

Nursing Home C: 27% agency nursing staff

- Paid over \$1M to a related staffing agency for nursing staff in 2016, with an estimated 25% retained by the related agency as profits and overhead¹⁵



WORKER
INJURIES



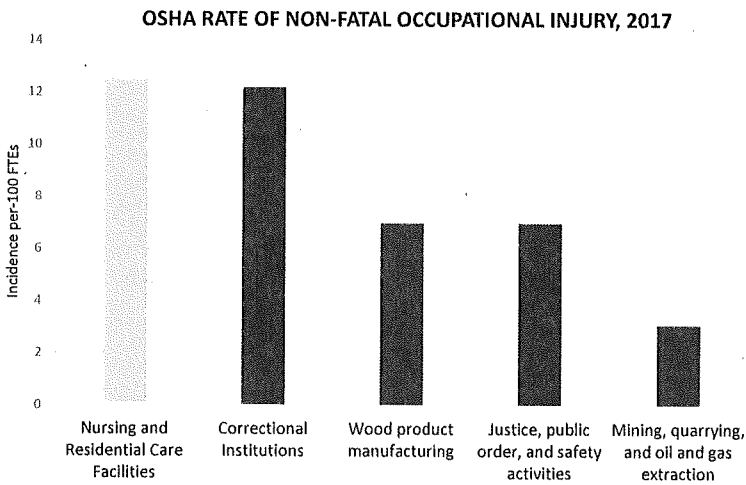
HIGHER STAFFING LEVELS DECREASE WORKER INJURIES

“ Findings suggest that nursing home staffing levels have an important impact on worker health ... each additional hour of nursing care decreased the injury rate by nearly 16%.”¹⁶
TRINKOFF, et al, AMERICAN JOURNAL OF PUBLIC HEALTH (2005)

“ Dangerous profession: nursing home assistants report three times the injuries of other workers”¹⁷
MCKNIGHTS

“ Injury rates are particularly high for nursing assistants, who have an increased risk for injury because they assist multiple residents at once ... a nursing assistant working in a nursing home might lift and reposition as many as 20 or more residents every morning.”¹⁸
PARAPROFESSIONAL HEALTH INSTITUTE

HIGHEST RATE OF WORKER INJURY IN NEW YORK



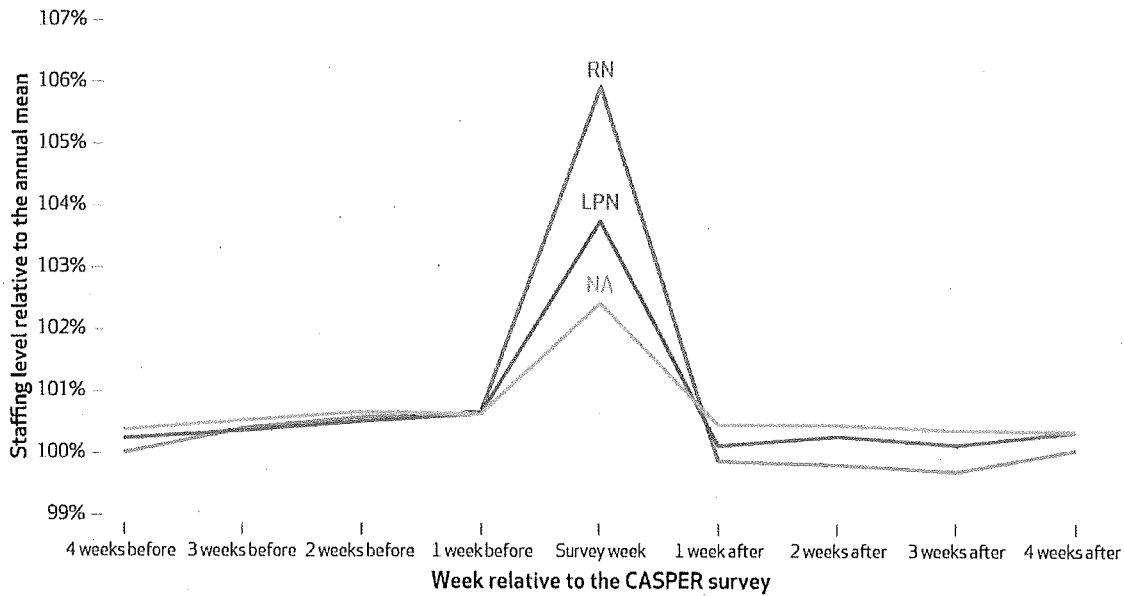
According to OSHA data, New York nursing home workers have a higher rate of nonfatal occupational injury or illness than any other industry in the state: 12.5 per-100 FTEs.¹⁹

ENFORCEMENT

Regulations

NEED FOR STRONG ENFORCEMENT

Staffing levels of nursing homes as percent of the annual mean level around the time of the inspection survey, by time and staff category, April 2017-March 2018²⁰





STAFFING IN NEW YORK NURSING HOMES

RECOMMENDATIONS

RECOMMENDATIONS

- NY must have enforceable evidence-based minimum overall staffing standards for nursing homes, as well as specific CNA staffing standards
- NY must hold homes accountable for spending a fixed percentage of their revenue on resident care. This can also give DOH tools to restrict agency use and related transactions by limiting the amount of those expenses that can be counted towards resident care spending requirements.

RECOMMENDATIONS

- NY should invest additional resources to ensure staffing standards can be met while rationalizing reimbursement for homes, including by rebasing rates.
- NY should set clear goals for improving nursing home quality within 5 years and undertake a public process through a Nursing Home Quality Commission to drive progress towards those goals. The NHQC should also be empowered to examine the existing nursing home capacity throughout the state and make recommendations regarding increasing or decreasing capacity to meet future needs. The NHQC should have sufficient resources to hold hearings, undertake original analysis and publish reports and recommendations.

RECOMMENDATIONS: WORKFORCE DEVELOPMENT STRATEGIES

- Our union has bargained employer contributions to the 1199SEIU Training and Employment Funds, which provide initial education, tuition support and wrap-around services for healthcare workers seeking to advance in the field.
- 40,000 members take advantage of programs across the Funds annually, including 1,200 members in nursing programs.



RECOMMENDATIONS: WORKFORCE DEVELOPMENT

INCREASE THE NUMBER OF LPN SCHOOLS

- State Education Department approval of lower cost certificate programs, particularly in underserved areas like the Bronx
- Articulation from certificate LPN programs to RN programs
- Reopen NYC's Board of Education LPN Program
- SED approval of more part-time programs
- SED approval of existing programs to create satellite programs – approval is complex for qualified schools to a new location

RECOMMENDATIONS: WORKFORCE DEVELOPMENT

LPN APPRENTICESHIP

- Remove barriers to implementation. SED has strict requirements on class-based learning and presently will not allow on-the-job learning to count toward didactic hours and competencies. Creating a process that allows CNAs, CHAs, HHAs and other entry level healthcare workers to test out of specific modules by demonstrating competencies for skills and knowledge already acquired
- Most LPN programs are full time, creating a challenge to apprenticeship programs that seek to combine on-the-job learning with didactic learning. Full time programs often require students to attend 4-5 days a week leaving little or no time for on-the-job training
- SED and the DOH could spearhead an initiative to make this a more viable options for nursing homes



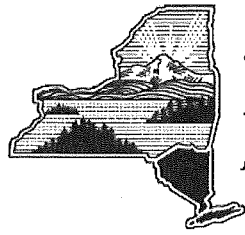
STAFFING IN NEW YORK
NURSING HOMES

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IROQUOIS
Healthcare Alliance

Testimony of the

Iroquois Healthcare Alliance

Presented to the

New York State Department of Health

regarding

**Staffing Enhancements & Quality Improvement
Initiatives**

by Gary J. Fitzgerald
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Good morning, and thank you to the New York State Department of Health for the opportunity to discuss the issues of staffing enhancements and quality improvement initiatives, and the impact of these initiatives on Upstate New York's hospitals and health systems. I am Gary Fitzgerald, President and CEO of the Iroquois Healthcare Alliance (IHA), a membership organization representing 54 hospitals and health systems in 32 counties of Upstate New York, spanning nearly 28,000 square miles. Our membership is diverse, comprising 32 rural hospitals including 13 Critical Access Hospitals and 14 Sole Community Hospitals. We represent the smallest hospital in the state, as well as some of the largest teaching hospitals in Upstate New York.

Hospitals throughout Upstate New York are the largest employers in every county. They are the lifelines of our communities. All hospitals in New York State are required to operate as not for profit entities. The majority of Upstate hospitals have negative operating margins. In fact, in 2017, IHA member hospitals had an average operating margin of -1.0%. We are the masters at doing more with less. But, it cannot continue at this pace. Upstate hospitals face multiple instabilities due to the unique circumstances of providing care to, for and in rural areas, including: remote geographic location, low-patient volumes, workforce shortages, and a population that is often older, sicker, and more dependent upon government programs. The two government payers in Upstate New York are Medicaid and Medicare, and while widely utilized by patients, unfortunately, both programs reimburse providers far below the cost of providing care.

While the looming threat of federal cuts faces all hospitals, in less than two weeks, there are federal cuts scheduled to take place that would disproportionately affect New York's safety-net hospitals. Many - though not all - Upstate hospitals are now defined in statute as safety-net

entities. These vulnerable institutions will face a financial shortfall of \$4 billion in fiscal year 2020, and \$8 billion in fiscal year 2021, should the cuts take place on October 1.

At the State level, hospitals, nursing homes, and other healthcare providers face additional negative fiscal impacts. According to the New York State Division of the Budget's Fiscal Year 2020 First Quarterly Report, New York State's Medicaid spending is exceeding projections, and as a result, "DOB and DOH are working to develop options to reduce spending within the Global Cap and/or continue to manage the timing of payments. Options to reduce spending include the execution of the statutory powers granted to the Commissioner of Health to limit spending, which include across the board rate reductions to health care providers and plans." The combination of federal cuts and state cuts will undoubtedly devastate Upstate New York's already fragile hospitals and health systems.

Upstate New York is also experiencing a severe healthcare workforce shortage. We do not have an adequate supply of local registered nurses to meet our current staffing needs. As a result, many hospitals and nursing homes are forced to use staffing agency services to fill the requirements of both short-term and long-term staffing needs. According to a recent IHA survey of its member hospitals and health systems, 89% of respondents utilize staffing agencies to fill RN positions. The average hourly rate for a full-time, employed RN is \$34.50, while the average hourly rate for a temporary agency nurse is \$80.00, more than double the cost. Given the financial health of Upstate's hospitals, as previously presented, this is an unsustainable solution. While agency nurse job roles are considered a vital resource for rural and safety-net hospitals that experience difficulty in recruiting and retaining RNs in Upstate New York, agency nurses tend to have less investment in the community which ultimately impacts quality and patient outcomes.

To be clear, IHA opposes any staffing enhancement or quality improvement measure that imposes government mandated nurse staffing ratios for Upstate New York's hospitals and nursing homes. Arbitrary staffing ratios would jeopardize access to care without improving quality or patient outcomes and would prevent experienced, local clinicians from making appropriate staffing decisions to meet patient needs. To implement such a proposal would not only be fiscally impossible, it would be completely irresponsible to our patients and our communities.

There are 217 hospitals and health systems in New York State, yet no two of them are alike, nor are their patients. Each patient has individual needs that can change rapidly while every nurse and care team member has unique experience and expertise. Delivering quality, patient-centered care requires a collaborative approach among doctors, nurses, care managers, social workers, lab technicians, clinical pharmacists and others. Mandated ratios would not allow for flexibility in addressing the important fluctuations in patient/resident need or census and would supersede the professional judgment of clinicians and caregivers making real-time decisions about patient care.

Staffing decisions should remain with local hospitals, nursing homes, and healthcare clinicians. Hospitals and nursing homes are already required to have staffing plans tailored to individual patient care needs. These plans include considerations for factors such as patient acuity, the level of education and experience of staff, technological considerations, and more. State and federal regulations from the New York State Department of Health (DOH), Centers for Medicare and Medicaid Services (CMS), and other accrediting entities provide safeguards to ensure staffing adequacy, education, credentialing, quality measures, care delivery, and patient satisfaction. Additionally, information on safety and outcomes is available to the public.

There is no evidence to support government-mandated nurse staffing ratios. Research

has not demonstrated a direct link between rigid ratios and quality of care in California, the only state to require hospital-wide nurse staffing ratios. On the contrary, research has found that the combination of higher levels of nurse education, the use of evidence-based criteria, and an effective mix of clinical and non-clinical staff are vital to improved patient safety and outcomes. New York has taken an important step in the right direction by enacting legislation that requires new nurses to obtain a Bachelor of Science degree in nursing within ten years of licensure.

Mandated staffing ratios would cost New York's hospitals and nursing homes close to **\$3 billion annually**—the largest-ever unfunded healthcare mandate in New York State. As previously stated, New York State is the only state in the nation requiring hospitals to operate as not-for-profits. The fiscal health of New York's hospitals and nursing homes is among the worst in the country. Since 2000, over 40 hospitals and 90 nursing homes have been forced to close. Upstate New York hospitals and health care systems would be unable to comply with government-mandated staffing ratios, placing them at great risk for penalty. Staffing mandates would force additional hospitals and nursing homes to close their doors when they can no longer remain financially viable and would ultimately drive up costs for patients and consumers.

Access to services and quality care would also be jeopardized. Critical care programs would decrease and various departments within a hospital or nursing home would be forced to downsize. Hospitals would be forced to send patients farther away and emergency rooms may have to divert patients more frequently. If ratios cannot be met, scheduled surgeries may be delayed or canceled and nursing homes may be unable to accept new residents resulting in overcrowding in acute care settings or dangerous living situations in the community.

Over the last five years, New York State has made great efforts to shift care away from hospitals and nursing homes into outpatient and community care settings under the Delivery

System Reform Incentive Payment Program (DSRIP). Hospitals and nursing homes are undergoing constant transformation in order to reduce costs and deliver value-based care. Implementing mandated ratios would reverse the significant progress these institutions have made to the healthcare delivery system in New York State by driving care back to the hospital and removing nurses from these community care settings.

Furthermore, recruitment and retention of new and/or experienced nurses and other members of the care team, presents serious obstacles throughout the state, especially in our rural and underserved communities. Currently, Upstate New York has over **2,000 inpatient nursing vacancies** which would cost an estimated \$200M to fill annually. There is a current workforce crisis throughout much of the State, and that crisis is projected to worsen over the next twenty years as our population ages.

RECOMMENDATIONS

Collectively, we need to contribute to the production of a better prepared healthcare workforce and recruitment and retention efforts that support the healthcare delivery system. Needs are particularly acute in rural areas and will require innovative approaches. Specifically, we would ask for your consideration of the following solutions:

- **Oppose Mandatory Nurse Staffing Ratios**
 - IHA urges New York State lawmakers to oppose any proposed legislation or measure that imposes government mandated nurse staffing ratios on Upstate New York's hospitals and nursing homes.

- **Utilize the Regional Economic Development Councils for Recruitment of Healthcare Workforce in Rural Areas**

- The economic importance of hospitals extends beyond their purchasing power and employment-generating impact. Strong healthcare institutions are a necessity for attracting new workers and companies to their communities, and thereby jobs to a region. Across Upstate New York, the health care infrastructure is often a mainstay of the region's economy. The economic growth and stability of communities requires the presence of a strong health care system to attract and keep residents, and to attract businesses to employ local residents. IHA applauds the state's focus on economic development, specifically the economic development of Upstate New York. The essential role that hospitals play in regional economies should urge New York's Regional Economic Development Councils to view hospitals as a focal point for attention. Healthcare, however, has not been viewed generally by the Councils as an economic development issue. We would suggest utilizing the Councils to address the healthcare workforce shortages in rural areas.

- **Investment in Tuition Assistance/Scholarship Programs**

- Now mandated within 10 years of licensure, Bachelor of Science Nursing (BSN) tuition assistance and/or scholarship programs have the ability to increase patient satisfaction and quality outcomes as being tied to an engaged and better prepared workforce.

- **Support for Nurse Residency & Preceptorship Programs**
 - Nurse residency programs have been shown to increase recruitment and retention of RNs and have direct influence on professional development and commitment to the profession. Additionally, mentor and preceptorship programs promote RN retention.

- **Utilization of NYS Department of Health Workforce Workgroup**
 - The NYS Department of Health (DOH) Workforce Workgroup is a valuable vehicle to address workforce issues across the state. This workgroup is designed to promote New York State's health workforce to support its transition to integrated health care delivery to assure comprehensive, coordinated and timely access to care.

- **Staffing Committees**
 - Hospital-based committees with involvement from all patient care stakeholders, including RNs, case managers, and others promoting population health efforts, can proactively and consistently address policies, processes, procedures, and staffing assignments to ensure patient needs are satisfied.

These are simply a few of the solutions within reach. There are many more to consider and discuss. Thank you again for your time and the opportunity to comment. The people of New York State who reside in Upstate's rural communities deserve access to safe, quality healthcare. The members of the Iroquois Healthcare Alliance look forward to working with you to ensure that quality, affordable health care is accessible to all New Yorkers, particularly our state's most vulnerable populations.