

McCarthy, Karen

From: Elizabeth Urbanski Farrell <EFarrell@wnyha.com>
Sent: Monday, December 14, 2015 10:38 AM
To: McCarthy, Karen
Subject: Items to clock in for Thursday's Erie County Legislative Session
Attachments: StaffingratiosErie County LegislatureResolution OppositionMemo_WNYHA1210_2015.pdf;
StaffingratiosErie County LegislatureResolution OppositionMemo_WNYHA1210_2015.docx;
NYONEL Position Ratios 2015.docx

Karen,

As discussed, attached please see our amended memorandum of opposition to the proposed Erie County Resolution in favor of enacting statewide nurse-to-patient staffing ratios ("Safe Staffing") as well as a brief question-and-answer document on the topic.

Also attached is a statement on the staffing ratios from the statewide New York Organization of Nurse Executive Leaders, many of whom either are currently charge nurses and individual patient care nurses or have been charge nurses and individual patient care nurses.

Regarding the suggestion that staffing ratios for nurses would be similar to ratios of day care workers to children, as a working mother of two children who were in day care, my children were welcome to attend when they were well but there are no guidelines for sick children in day care as they are not welcome. The fact is that illness makes us all unpredictable as to our rate and level of illness and rate and level of recovery at any given moment. Once again, we would submit that the level of care needed by a patient at any given time and what type of care they may need is far too complex for a state-legislated ratio.

Thank you once again for your assistance and I hope you are able to get out and enjoy the weather today!

Sincerely,

Liz

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Amended
OPPOSITION
Memorandum

TO: Members, Erie County Legislature and
Health and Human Services Committee

DATE: December 10, 2015

RE: Proposed Legislator Resolution (Nov. 5, 2015)
on Supporting NYS Legislation to Enact the
Safe Staffing for Quality Care Act

Directed toward support of:
A.01548 (Gottfried)—In Assembly Health Committee
Same as S.00782 (Hannon)—In Senate Health Committee
"Safe Staffing for Quality Care Act" Bill

Legislation has been introduced (A.01548 and S.00782) that would impose minimum nurse-to-patient staffing ratios for health care providers across New York State. State-mandated staffing ratios would not only impose a massive unfunded mandate, but are the wrong approach to staffing. ***Supporting the precedent of ratios mandated by our state Legislature in Albany does not account for the unique patient population at each facility and the combination of clinical and non-clinical staff making up specific care teams needed by individual patients at hospitals here in Western New York.***

This statewide bill would amend the New York State Public Health Law to create specific staffing ratios for nurses and other direct-care staff in hospitals and nursing homes. This bill is a combination of two previously separate pieces of legislation that create nurse staffing ratios in hospitals and in nursing homes. **The Western New York Healthcare Association (WNYHA) strongly opposes this legislation and urges the Erie County Legislature *not* to support it.**

In Summary:

- Meeting the goal of quality patient care requires a complex system of checks and balances and cannot be achieved by imposing staffing ratios that do not account for the many, varied and unique factors involved in creating individual institutions' patient care staffing plans.
- Formulas and ratios **do not provide the needed flexibility to adapt to patients and residents with different needs that can change quickly.** All patients and residents are different, even those within the same hospital or nursing home unit. To pick any one ratio is to deny the real needs of an individual patient from moment to moment.
- Implementing a staffing ratio standard **also implies that every unit, shift, and hospital or nursing home is the same, when it is not.** Formulas and ratios do not capture many differences, nor do they provide the flexibility needed to adapt to special situations that arise in a hospital or nursing home. For example:

- Most medical/surgical units in a hospital have a wide variety of patients at different places along the clinical spectrum—some just out of surgery, others recently transferred from intensive care, and some ready for discharge.
- The type of patients in similar units, but at different hospitals, will vary considerably from hospital to hospital (for example, teaching v. rural hospitals).
- The Joint Commission on the Accreditation of Healthcare Organizations (the Joint Commission) has stated that legislative initiatives to mandate specific staff-to-patient ratios are “...most undesirable...” . The Joint Commission has further stated, that “staffing adequacy is not simply measured by applying numbers and ratios, but rather by evaluating a constellation of factors.” In its recent publication “Health Care at the Crossroads”, they issued the following statement: **“(C)urrent mandated ratios, related legislative proposals, and other nurse staffing initiatives are aimed primarily at adding to the supply of nurses. However, these efforts do not address other critical issues, such as nurse competency, skill mix in relation to patient acuity, and ancillary staff support.”**
- **Excellent patient care involves a variety of factors and an entire patient care team**, consisting of nurses, aides, medical technicians, physicians and physical plant maintenance. Every hospital and health system in the state continues to aggressively invest in and implement a variety of patient care improvement strategies, including those comprising the **New York State Partnership for Patients** initiative.
- New York hospitals’ nurse-to-patient ratio is mandated by the New York State Department of Health. The State Health Department mandates compliance in this and a number of additional regulations for Article 28 facilities to maintain operating certificates in our state. Additionally,
 - The Centers for Medicaid and Medicare Services (CMS) monitors and reports on hospitals’ performance in more than 100 quality measures, with a variety of hospital performance statistics regularly published online. Although these measures rely on old data currently, efforts are underway to update data calculation so that publicly available data more accurately reflects more recent conditions in a healthcare facility.
 - These measures apply to Article 28 facilities, hospitals and nursing homes providing care to patients who receive Medicaid and Medicare, currently.

What can policymakers do to help?

Providing quality patient care is the top priority of WNYHA’s members. New York is a center of quality improvement efforts that help health care providers identify priorities and implement, manage, and sustain quality improvement initiatives. New York hospitals and health care providers participate in numerous quality initiatives and targeted clinical education programs to help leverage evidence-based knowledge and provide high-quality patient care. These quality collaboration efforts and initiatives include efforts to reduce readmissions, infections, and hospital-acquired conditions, as well as improve patient safety and care for patients with diabetes.

We ask the Erie County Legislature to resist the temptation of state-imposed legislation to impose staffing ratios. Additionally, WNYHA strongly believes that staffing ratios are an additional unfunded mandate that hospitals and nursing homes will not be able to withstand.

For all of the reasons cited above, and more, WNYHA strongly opposes this proposed resolution.

QUESTIONS AND ANSWERS RELATED TO STATE-MANDATED STAFFING RATIOS:

How does a hospital or nursing home decide how many patients or residents each nurse should care for?

- Staffing is determined by a host of complex, interrelated factors that appropriately vary across facilities. It starts with the condition of the patient and their 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 facility; and the number and competencies of clinical and non-clinical staff that collaborate with nurses.
- Managing a widely diverse range of patients and residents is complex and must consider the judgment and experience of health care professionals who deliver care, while accounting for variation in a patient or resident's status hourly, daily, and over the course of a stay. ***This cannot be achieved by imposing rigid, state-mandated staffing ratios***—greater flexibility is needed.

What would be the cost of implementing new nurse staffing ratios in New York State and how would it be paid for?

- The cost of implementing mandated nurse-to-patient ratios as stated in the currently proposed legislation is estimated at a total of at least **\$3 billion**, at *current* average wage, salary and benefit packages (Healthcare Association of New York State estimate) and not entirely including the cost of recruitment and training of new nurses for New York's hospitals. This legislation proposes an unfunded, mandated ratio.
- Supporters naively suggest the costs would be recouped by lower turnover rates and lower rates of hospital-acquired illnesses, without citing any hard facts, figures or fiscal methodology. At a time when our state's non-profit Article 28 facilities (all hospitals in New York are non-profit) have profit margins falling below 1 percent, it is hard to see how they could withstand the huge fiscal burden of mandated nurse staffing ratios.

Doesn't California have mandated ratios?

- Yes, beginning in 2004, and they remain the only state with minimum nurse-to-patient ratios. **Implementation caused disruptions in services, increased diversion of patients arriving at the emergency department (ED) and increased ED wait time, and postponement of surgeries.** Hospitals in California have examined options for closing units, curtailing services, limiting admissions, and possibly closing. Licensed continue to voice concern over the lack of autonomy and control.
- **Research on the effects of legislatively imposed nurse-to-patient staffing ratios has been inconclusive:**
 - o Several articles indicate **multiple structural and process factors are important** in improving patient outcomes (Spetz et al., 2013; Aiken et al., 2011; Needleman et al., 2009; Needleman et al., 2011).
 - o Another study notes, "in order to assess the future viability of minimum nurse staffing policies, it is critical to understand all of the trade-offs hospitals face when increasing staff, and how these trade-offs affect the care that patients receive in hospitals." For example, in California, **staffing ratios resulted in a decline in the number of additional care staff employed that support nurses in their duties or that enhance care** by offering services in other specialized categories.



New York Organization of Nurse Executives and Leaders Position Statement Opposition Staffing Ratios

The Chief Nursing Officers, Nursing Administrators, Managers and leaders of nursing in New York State have long opposed the mandating of specific ratios of staff in hospitals and healthcare agencies in general. We believe that these well intentioned, but inappropriate requirements, will have unintended negative consequences on safe and appropriate care.

As the individuals with ultimate responsibility for patient care, it is the nurse and manager who should have the ability to apply clinical judgment in day to day patient management and staff utilization. The members of NYONEL would urge the legislators to think critically in making such a simplistic approach to a requirement.

Our rationale includes:

- To reduce the decision to simple ratios to require a specific number of staff per patient would indicate the belief that every patient is the same. Those of us engaged in clinical care know that nothing could be further from the truth. Patients vary greatly in their care needs and these change rapidly, sometimes with little advance warning. A ratio approach, while intended to set a floor for safe practice, ignores the highly variable nature of patients.
- All staff members are not the same even in a single level of licensure. Preparation (Baccalaureate vs. Associate Degree), tenure, specialization, competency and experience vary greatly.
- Supplemental resources, agency geography and support systems vary greatly and have a major impact on the time requirements to provide care, as well as the types of staff needed in the individual departments.
- The homogeneity of the patient grouping varies from one type of facility to another. Increased variety of patients in a department places a greater burden on the clinicians caring for them. Variation is also seen from one agency to another and within the same agency. Two departments within the same agency may have different staffing standards.
- Patient units have varying staffing standards based on the **average** combined need of the patients. In order to achieve the long term average, however, a department will operate at varying degrees of activity that has little to do with the number of patients. Specific ratios would work only if we could operate on average at all times, ignoring the fact that needs vary based on a combination of multiple factors.
- Lessons learned from the California experience:
 1. Ratio legislation in California has not improved patient outcomes as it was purported to do.

2. California's workforce numbers are at the low end of national statistics. The number of nurses to 10,000 population has not improved as expected.
3. Access to care has been a problem in California and resulted in diversion of patients and closure of departments/services: diversions increased from 24.6-31% in the initial quarter of implementation; 963 surgeries were postponed in first 6 months; and 12 hospitals closed.
4. The Medical Society and nurses have voiced complaints related to a lack of autonomy.
5. 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 another 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 then doing non-professional duties. Since studies have demonstrated that outcomes did not improve in a statistically significant way, the change has been one of increasing the non-nursing duties of RNs at a higher expense (Donaldson, et. al.: 2005)
6. As of 2006 only one MSA of California had a report rating care for the number of RN positions per 100,000 population at 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)
 - The reporting requirements in the proposed legislation are duplicative of other requirements already mandated.
 - Release of the data to the public will generate information that is not valid for comparison between units or agencies. The complexity of variables related to patient need and care giver competencies are too complex. Just obtaining agreement as to which staff should be incorporated as direct care providers would be required in order to have comparisons be appropriate. Much collaboration would need to be done before such a mandate could be promulgated.

With the hardship and the unprecedented economic challenges NYS hospitals are facing, we are taken aback that the Legislature would even entertain this Bill in the current economic climate. We anticipate that the cost increases and lack of corresponding improvements in patient outcomes experienced in California could be duplicated in our state. **NYONEL urges rejection of a mandated staff ratio requirement and mandated reporting requirements.**

Donaldson, N., Burnes Bolton, L., Aydin, C., Brown, D., Elashoff, J. D., & Sandu, M. (2005). Impact of California/s licensed nurse-patient ratios on unit level nurse staffing and patient outcomes. *Policy, Politics & Nursing Practice*, 6(3), 198-210.

Lin, V., Lee, A., Juraschek, S & Jones, D. (2006) California regional registered nurse workforce report card. *Nursing Economics*, 24(6), 290-297.