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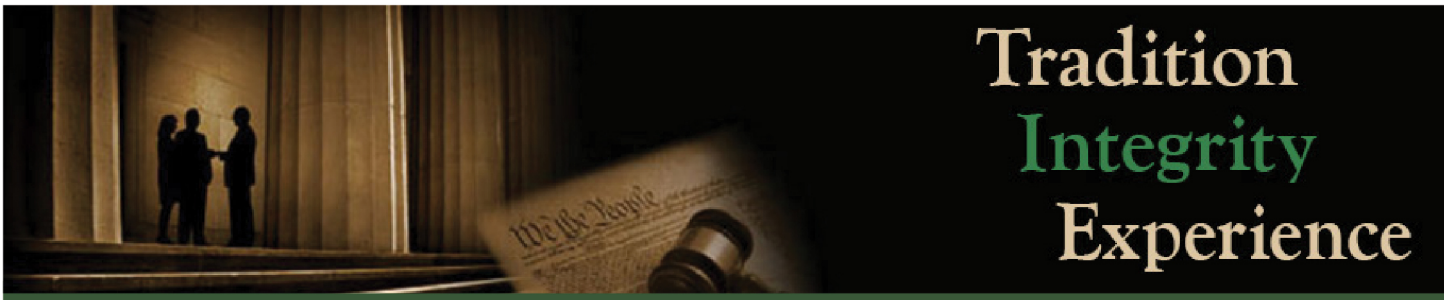

CLIENT UPDATE

August 18, 2020

New York Department of Health Issues Study on Minimum Nurse Staffing Levels

On August 14, 2020, the New York State Department of Health ("DOH") issued its *Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives* ("Study"), which examines how staffing enhancements and other initiatives could be used to improve patient safety and the quality of healthcare service delivery in hospitals and nursing homes subject to Article 28 of the Public Health Law. Specifically, the Study addresses minimum staffing levels for nurses, other nurse staffing enhancement strategies, and patient quality improvement initiatives. It also analyzes the potential fiscal and economic impact of these strategies. The positions addressed by the Study are registered nurses ("RNs"), licensed practical nurses ("LPNs") and certified nurse aides ("CNAs") (collectively "nurses").

Background

Federal and New York State law currently do not impose any minimum staffing levels or ratios for nurses in hospitals and nursing homes; rather, individual facilities have authority to determine adequate coverage. Federal law requires only that hospitals have "adequate numbers" of RN, LPN and other personnel to provide nursing care to all patients as needed but permits individual facilities to determine this requisite. 42 CFR § 482.23. Under State law, hospitals are required to have "an organized nursing service that provides 24-hour services and that meets the care needs of all patients in accordance with standards of nursing practice" and a "written nursing service plan of administrative authority and delineation of responsibilities." 10 NYCRR § 405.5 State law also requires that the director of the nursing service is responsible for "developing a plan for determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital." Similarly, federal law requires

nursing homes to have "sufficient staff" to meet the needs of residents, specifically requiring facilities to provide 24-hour care by licensed nurses and other nursing personnel. 42 CFR § 483.35. New York State law has an identical obligation. 10 NYCRR § 415.13 Additionally, hospitals and nursing homes are subject to various reporting requirements regarding nursing staff under federal and state law.

The Safe Staffing for Quality Care Act, A2954/S1032 ("Safe Staffing Act"), which is pending, would require specific minimum nurse-to-patient ratios by unit in New York hospitals and set minimum RN, LPN and CNA daily care hours for residents of nursing homes. Under the proposed law, these ratios would serve as the maximum number of patients assigned to any licensed nurse at any time during a shift (not an average); however, hospitals are allowed to assign fewer patients to each nurse. Hospitals and nursing homes would also be required to submit a staffing plan each year to the DOH.

The Study

The Study is based on the DOH's extensive review of public reports, academic literature and news publications regarding minimum nurse staffing levels, nurse staffing enhancement strategies and patient quality improvement initiatives, including other state models. The DOH also solicited stakeholder input through one-on-one meetings and two public forums. Additionally, the DOH engaged the Cornell University Schools of Human Ecology and Industrial and Labor Relations for a projection of workforce needs and fiscal and economic analyses.

The DOH noted that published research was mixed regarding the correlation between specific nurse staffing ratios and various outcomes with some studies finding a correlation between staffing levels and outcome while other studies found little or no relationship. Stakeholder input was also mixed.

Stakeholders in Support of Minimum Staffing Ratios

Stakeholders in support of minimum staffing ratios provided reasons consistent with the literature reviewed but provided additional insight based on their personal experiences. In particular, labor unions, individual nurses, and patient advocates provided comments regarding the challenges nurses face when hospital units are understaffed, and the negative impact understaffing can have on quality of care and patient outcomes. For instance, these stakeholders communicated that understaffing in hospitals and nursing homes has resulted in nurses working unplanned or pre-scheduled overtime resulting in nurses working long shifts without breaks. Stakeholders also noted that health care transformation efforts have moved many lower acuity patients out of hospital inpatient settings and into community-based outpatient settings, leaving hospitals with higher acuity patients that require a higher intensity of nursing care, but hospitals have not made the necessary staff changes to accommodate this shift, such as fixing understaffing.

Stakeholders in support of minimum staffing ratios further argued that implementing such ratios would result in savings due to reductions in re-admissions, errors, and nurse turnover. Further, these stakeholders suggested that waivers should not be granted or only granted on a limited basis in order to make the ratios impactful.

Additionally, some stakeholders argued that minimum staffing ratios should be used over nurse staffing committees and nurse staffing plans, or grids since hospitals develop nurse staffing plans based on their budget, rather than developing nurse staffing plans based on expected patient census, acuity, and best practices and then using the nurse staffing plan to determine budget.

Stakeholders Opposed to Minimum Staffing Ratios

Stakeholders in opposition to minimum staffing ratios, such as hospital and nursing home associations, voiced concerns related to flexibility, quality of care, unintended consequences of mandated ratios, and costs. Specifically, these stakeholders were concerned that mandated ratios create a one-size-fits-all approach that may not meet the needs of patients and residents, noting the dynamic nature of hospitals and the unique needs of nursing homes that necessitate staffing flexibility.

These stakeholders also discussed the unintentional consequences of mandated nurse-to-patient ratios such as reductions in non-licensed staff, such as aides/techs, administrative staff/unit secretaries, and therapists, that may inadvertently increase nurse workloads with tasks that formerly were delegated to non-licensed staff. Likewise, these stakeholders argue that the implementation of such ratios may increase the use of agency nurses, which could potentially have consequences for quality of care since relationships may not be built between agency nurses and permanent staff and patients.

Stakeholders also argued there are not enough nurses in the State to meet the demand created by minimum staffing ratios. Stakeholders further argued that hospitals and nursing homes could not afford the increased costs associated with the mandatory staffing minimums and that such costs could result in facilities closing.

Additionally, stakeholders argued that alternative methods could address staffing levels without needing a legislative mandate. For instance, some stakeholders noted that recent collective bargaining negotiations with New York City hospitals addressed nurse-to-patient staffing ratios. Stakeholders also promoted the use of labor management councils and nurse-led staffing committees to set specific staffing requirements and make such information available publicly.

Fiscal and Economic Impact Analysis

The Study also includes projections on the costs for hospitals and nursing homes if proposed minimum staffing ratios are mandated by using the staffing ratios for RNs in hospitals, and minimum hours of care per resident per day for RNs, LPNs and CNAs in nursing homes in the proposed Safe Staffing Act.

According to the Study's results the proposed minimum staffing standards would require an additional 34,239 full-time RNs, 15,727 full-time LPNs, and 19,970 full-time NAOAs. The Study cites that the estimated total wage costs for hospitals is between $1.8 and $2.4 billion dollars and for nursing homes between $1.9 and $2.3 billion. Most of the wage costs stem from hiring additional staff. The Study also notes the potential costs to providers and the State in implementing the minimum nurse staffing require-

ments, as well as of overseeing compliance with the mandate. Likewise, there will be increased costs due to the recruitment, onboarding, and training of new workers, as well as due to any changes in work design and working conditions. The Study notes that to save costs facilities may resort to cutting non-nursing staff, reclassify staff or alter staff responsibilities.

The Study references studies in California, which implemented comprehensive minimum nurse staffing ratios in 2004, and Massachusetts, which implemented a mandate for maximum patient-nurse ratios in intensive care units in 2014. The Study provides that evidence regarding the Massachusetts mandate does not support actual improvements to patient care outcomes and evidence on the California mandate has been mixed, with mostly limited support for improved patient care outcomes.

Lastly, the Study addresses proposed minimum staffing ratios in the context of the COVID-19 pandemic. According to the Study, the pandemic highlighted the need for flexibility since an increase in nurses were needed in certain units. The Study also highlighted the need for crisis staffing plans to mitigate nurse workforce shortages, testing of employees, the use and ability to receive personal protective equipment, and easing the ability of skilled nurses practicing in New York State to enter the workforce. The DOH noted that New York State has taken proactive steps by issuing several Executive Orders to achieve these goals, and the DOH will take steps to make such changes permanent in statute and regulation where appropriate.

In conclusion, the Study provides that "maintaining a nursing workforce that effectively meets the needs of patients requires a comprehensive approach to address today's multifaceted and complex healthcare delivery challenges" and that while the DOH "supports measures to improve quality of care and patient outcomes, the COVID-19 pandemic has only highlighted the need to maintain workforce flexibility." The DOH further provides that it will continue to work with stakeholders to ensure staffing is adequate to serve patients.

Takeaway

The DOH provides a comprehensive outline of the arguments in support of and against the proposed minimum staffing ratios by various stakeholders. The DOH also provides a fiscal analysis of implementing the minimum nursing staff ratios proposed in the pending Safe Staffing Act, which reveals increased costs to hospitals and nursing homes and the potential effects of those costs on facility operations. Although the DOH does not outright reject the implementation of minimum staffing levels, its conclusion highlights the need for flexibility, especially during the COVID-19 pandemic. The Study cites the minimum staffing level legislation in California and Massachusetts as evidence that such minimum standards do not necessarily result in an improvement in patient care. Lastly, the DOH calls for hospitals and nursing homes to provide nurse protection, particularly during a crisis like COVID-19, by having personnel protective equipment and crisis staffing plans implemented.

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If you have any questions regarding this alert, please do not hesitate to contact us.

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