Testimony in Regard to AB 313 and the Workforce Shortage

Presented by Bill M. Welch, President/CEO Nevada Hospital Association

Before the Legislative Committee on Health Care Subcommittee to Study Staffing of the System for Delivery of Health Care in Nevada Hospital Association

(Assembly Bill 313, Chapter 410, *Statutes of Nevada* 2003)

April 13, 2004

Good morning, Chairwoman Koivisto and Committee Members. For the record, my name is Bill Welch, President/CEO of the Nevada Hospital Association (NHA), and on behalf of NHA's members, I want to thank you for this opportunity to speak before you today to present information in regard to efforts being made by the Nevada Hospital Association and its member hospitals in addressing the critical shortage of health care workers within the state of Nevada, and the effect this shortage would have if mandated numerical nurse staffing ratios were imposed upon the hospital communities within Nevada.

As I have testified in previous Legislative Health Care hearings, but feel it necessary to restate, the Nevada Hospital Association and its members oppose mandatory numerical nurse staffing ratios. While it should also be remembered that AB 313 as proposed by the Legislature was to look at the staffing of the health care profession, of which nurses represent the largest group of professionals within the health care community, this Interim Study is to address the **staffing of the system** for delivery of health care, it is imperative we recognize that staffing shortages also exist in Pharmacy, Radiology, Medical Billing and Coding, Respiratory Therapy, Physical and Occupational Therapy, and Dietary, to name a few, each shortage contributing to an imbalance in health care staffing. Recognizing this Subcommittee has primarily focused upon nursing as the delivery agents of health care in Nevada, I would like to provide data that will depict the impact, if mandated numerical nurse staffing ratios, as implemented in California, could have on Nevada, as evidenced by California's experience since their enactment of AB 394 on January 1, 2004.

It is clearly time to ask, what is the reality; and who will or will not receive care? Using the implementation of AB 394 in California January 1, 2004 as a comparative model, it might be of interest to visualize the effects of mandatory numerical nurse staffing ratios on access to health care in Nevada.

California vs. Nevada Demographics
(A five year comparison)

	California 1998	California 2003	CA % of Change	Nevada 1998	Nevada 2003	NV % of Change
Population	31,589,000	34,501,130	9% increase	1,530,000	2,106,074	38% increase
Tourist Influence	50,7000,000 (1998-2002)	50,700,000 (1998-2002)	Equates to 10,140,000 per year	47,285,809 (1999)	48,603,237 (2003)	3% increase
Tourists Utilizing Health Care	Unavailable	Unavailable	----	Unavailable	250,270 (2000) (includes ER & inpt)	----
Beds	74,482	74,343	-1% decrease	5,860	6,461	10% increase
Admissions	3,170,435	3,430,241	8% increase	171,158	211,657	24% increase
In-patient Surgeries	989,428	978,223	-0.5% decrease	52,096	75,406	45% increase
Out-patient Surgeries	1,348,773	1,342,641	-0.5% decrease	63,138	87,157	38% increase
Emergency Room Visits	8,717,395	10,111,529	16% increase	463,706	626,330	35% increase

Source: Hospital Statistics 2004, an Affiliate of the American Hospital Association
United States Census Bureau, 2000
Nevada Commission on Tourism 2003
California Tourism 2003

California Post 1-1-2004

	January 2004	February 2004
Beds Taken Out of Service	45% of all beds	39% of all beds
ED on Diversion	43% of time	44% of time
Average ED Wait Time	42% longer (6 hours)	44% longer
Ratios Met At All Times	15% of time	16% of time
Surgeries Postponed	.35%/facility/week	.25%/facility/week
Unable to Transfer Patient Because Couldn't Meet Ratio	31% of time	36% of time
Receiving Hospital Was County Facility	46%	47%
Facility Closure	None	One (LTC Unit Still Open)
Cost to Implement	$5,337,000 per facility (Est. $400M - $800M overall)	$5,337,000 per facility
RN Vacancy Rate	Imports 50% of nurses from registry agencies/foreign	Imports 50% of nurses from registry agencies/foreign

Source: California Healthcare Association 2004
Center for California Health Workforce Studies

According to the California statistics produced to date, 39% of all California hospital beds were taken out of service to meet ratio requirements. The Emergency Departments at California hospitals were on diversion 44% of the time. This means that, collectively, 13 days out of the month, hospital Emergency Departments were effectively closed.

Without ratios, Nevada's acute care Emergency Departments are already experiencing moderate to severe diversion on a daily basis, due in part to an ever-increasing patient load, population growth, and the burgeoning number of psychiatric patients occupying Emergency Department beds. If Nevada's Emergency Departments were to close 13 days out of each month in order to maintain staffing ratios, how many patients will die waiting for a bed?

Costs associated with implementing staffing ratios in the 100-plus hospitals in California are estimated to average $5,337,000 per facility. In Nevada, there are eleven rural hospitals, six of which are classified as Critical Access Hospitals - small, frontier facilities offering the only hospital care for many miles around. Their annual operating expenses are approximately equal to the average amount of money it has taken each California facility to implement staffing ratios.

As of 2004, there are approximately **7,046 FTE nurses** working in Nevada hospitals to staff **6,729 beds** and meet the average current patient demand of **235,642 annual admissions**. It is estimated that in order to meet the same patient demand currently being served if mandatory numerical nurse staffing ratios were in place, it would necessitate an increase of **33% over** and above the current staffing patterns. This would mean, Nevada would have to find an additional **2,348** nurses at the cost of **$164,360,000** to pay for those nurses (salary and benefits alone) just to meet the existing patient volumes. Since the average cost to recruit a nurse is $3,800, those costs would amount to **$8,922,400**. In addition, the average cost to retain a nurse is $415 annually; those costs would amount to **$974,420**. Keep in mind, all of these increased costs will eventually be borne by the payers of healthcare, namely the patients themselves. Therefore, the **TOTAL COSTS** to the hospital industry, minimally, to meet the requirements of AB 313 would amount to **$174,256,820**. Nevada currently has 34 hospitals. Therefore, just to sustain the staffing requirements of AB 313 at each facility, not including implementation and "gear up" is estimated to be **$5,125,201 annually.**

As previously stated, *The California Post* claims that in February of 2004, 39% of all California hospital beds were taken out of service to meet ratio requirements. In 2004, there will be **6,729** licensed hospital beds available statewide, allowing the hospital community to admit approximately **240,387** admissions per year. A reduction of **39%** would equate to a closure of approximately **2,624** beds. According to the Nevada Hospital Quarterly Reports (NHQR FYE 6/30/02), the average statewide hospital bed occupancy rate was 67%. Assuming this same occupancy rate applies today, this would amount to a decrease of approximately **93,750** admissions per year.

As of today, there is one licensed bed for every 296 citizens in Nevada (excluding the tourist population). A 39% bed closure would mean one bed for every 487 citizens. In a worst case scenario, bed closures would cost Nevada's hospital industry **$47,969,465** in net revenues, which to date have been reinvested to expand Nevada's hospital health care delivery systems to meet the state's rapidly

growing population. This loss of revenue would greatly stifle or possible even halt this expansion.

If bed closures materialized due to the inability to recruit the nurses necessary to meet mandatory numerical nurse staffing ratios similar to California, **6,500** hospital ancillary jobs would have to be cut, amounting to **$325,000,000** in lost salary and benefits to Nevada workers. Nevada hospitals and workers would stand to lose a minimum of **$361,423,806.** Again, the question is: where will the patients go for care?

These statistics beg the question: if California's health care industry is struggling to accommodate the regulations in California's AB 394, what do we think will happen in Nevada, given the fact that our growth is faster and our nurse shortage, as well as other health care disciplines, is far more critical, if mandatory numerical nurse staffing ratios are implemented?

During the 2003 Interim hearing process, numerous speakers have come forward to provide presentations and testimony in regard to the issues brought forth in AB 313. Volumes of testimony have been given to date by proponents and opponents of AB 313, and I have reiterated just a few comments made by those who have spoken to date. To briefly review testimony given by a number of those who have testified:

- January 8, 2004: Noelle D. Brown and Carol Gilhooley of the Joint Commission on Accreditation of Hospital Organizations (JCAHO) indicated their "approach to staffing effectiveness standards includes an evaluation of outcomes to ensure that the right numbers of competent staff, in the right skill mix are available to provide safe, quality service. Staffing standards are complex, dynamic, and unique to each facility, and staffing ratios cannot be applied universally."

- January 8, 2004: Diane S. Allen and Jeannie Anspach of the Bureau of Licensure and Certification testified that "the Bureau's regulations do not utilize ratios of numbers of nurses to patients. Most regulations require sufficient nursing staff to meet the needs of the patients; however, there is a critical shortage of nurses to provide care in hospitals and skilled nursing facilities."

- January 8, 2004: In his presentation concerning staffing requirements in other states, including state initiatives to regulate nurse staffing, Tim M. Henderson, Director of the Primary Care Resource Center for the National Conference of State Legislatures, Washington, D.C., indicated that in order to comply with the new California nursing ratios, an additional 4.5 nurses would be needed in each facility to meet the "at all times" regulations of AB 394. In referring to the implementation of California's mandatory numerical staffing ratios, Mr. Henderson indicated, and I quote:
    1. "California has no idea what impact the staffing ratios will have."

2. "They don't know if enough aggregate nurses will be available to fill the vacancies, or the type of nurses that will be required to meet the needs on the floors."
3. "California does not know what issues already financially strapped hospitals will face," and
4. "They have no idea what services hospitals staff will need to cut in order to meet the cost of ratios."

- February 19, 2004: Joanne Spetz, Associate Director for the Center for California Health Workforce Studies, discussed the relationship between patient safety and nurse staffing as established by scientific research, however, indicated this "research has limits," which include:

    1. California hospital data does not use different staffing on different units;
    2. Studies at the nursing unit level involve primary data collection and are costly;
    3. Single-year studies cannot prove a causal relationship; and
    4. No study identifies the "ideal" staffing ratio, nor that more nurses are better.

Ms. Spetz suggested to strongly consider the impact on access and quality of care in addition to the cost versus benefits gained before implementing legislation that mandates nurse staffing ratios. In her presentation, she indicated "How much money are we willing to spend to improve the quality of care? Do you take money from the school budget, decrease the salary for state employees, scale back Medicaid whereby indigent care increases, or request funding from private employers?" Improvements in staffing are not free, and they cost more money every minute. With any policy decision, there is always a cost/benefit trade-off."

In a policy statement on mandated staffing ratios dated December 2003, and approved by the American Organization of Nurse Executives (AONE) Board of Directors, the AONE, states: "Because staffing is a complex issue composed of multiple variables, mandated staffing ratios, which imply a 'one size fits all' approach, cannot guarantee that the quality level will be sufficient to prevent adverse outcomes. It is for this reason that AONE does not support mandated nurse staffing ratios." They further indicate that "mandatory nurse staffing ratios will only serve to increase stress on a health care system that is overburdened by an escalating national and international shortage of registered nurses and has the potential to create a greater risk to public safety." The AONE believes that "because of the unpredictability of the patient care environment, mandatory staffing ratios are viewed by AONE, as a static and ineffective tool with which to address the demands and constant fluctuations of patient care and nursing care needs." The AONE "strongly supports research to identify the components of appropriate levels of nurse staffing," "evidence-based and outcomes-driven research," and consideration of "the entire ethical spectrum of the ratio debate and the potential consequences of the growing nursing shortage and the inability to meet or maintain mandated staffing levels."

In a September 24, 2003 message to the Select Committee on Homeland Security Subcommittee on Emergency Preparedness and Response Hearing on Disease Surveillance Systems, Congresswoman Shelley Berkley indicating that, "Even before September 11th, we were concerned about the state of our nation's health infrastructure. Of particular concern were shortages of nurses."

Although Maine ranks third in the country in the quality of care provided to Medicare patients, the Health and Human Services Committee of that state are currently considering bill LD 616, "An Act to Provide Safe Staffing Levels for Patients and To Retain Registered Nurses." On January 9, 2004 the Maine Hospital Association (MHA) is quoted as stating, in reference to a bill (LD 616) currently being considered by their legislature, that "LD 616's fixed nursing ratios are not only unnecessary but will jeopardize vital access to health care services and will needlessly increase health care costs. . . " The MHA further indicates that "Fixed RN ratios circumvent the judgment and decision-making of health care professionals in assessing and meeting patients' needs, RN ratios disregard and threaten the valuable role played by other hospital staff such as Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs), and ignore the day-to-day realities of an ever-changing patient population in the hospital. The Legislation fails to recognize the difference between hospitals, in-patient needs over a 24-hour period, and that illness and injury know no clock. Hospitals and their professional staff must be able to use their judgment to manage staffing based on patient needs and the skills and competencies of their staff. Staffing effectiveness must be evaluated on results not arbitrary numbers that ignore the day-to-day realities of providing and managing patient care."

In a February 4, 2004 letter to the editor of the Reno Gazette Journal by Delores Dellarwelle, Ms. Dellarwelle states that "data from the state nursing board suggests that there isn't really a nurse shortage as such, but rather a shortage of nurses who are willing to work at the bedside in acute-care hospital settings." She further states that in 2002, Nevada had 16,000 registered nurses, but only 14,000 who were employed as RNs." In a February 9, 2004 response letter from Debra Scott, Executive Director of the Nevada State Board of Nursing, Ms. Scott indicated "these numbers did not come from the Nevada State Board of Nursing," citing the Nevada State Board of Nursing - on June 30, 2002 - reported there were 17,087 registered licensed nurses in Nevada. "Ms. Scott's letter further indicates the Nevada State Board of Nursing "does "not compile, nor report, data on nurse employment." She further cautioned "drawing any conclusions from comparing licensure and employment data."

Dedicated to providing safe, quality patient care, the hospital community has had to utilize the services of registry nurses, as well as foreign nurse recruitment. In an attempt to obtain factual and accurate data on the number of registry nurses providing patient care in Nevada, it quickly became apparent that data, let alone accurate data, would err on the high side. More than 500 nurse registry agencies nationwide supply nurses to Nevada. Registry nurses often work for more than one agency, and many agency nurses are employed full-time at a hospital working three 12-hour days, utilizing their days off to pick up agency hours. Because of multiple agency employers, one nurse could be counted numerous times in the data, creating skewed figures.

It should also be noted that the use of registry nurses raises the cost of health care. Nurses who work for registry agencies have testified they make no more, and often times less, money than hospital-employed nurses. Certainly registry nurses understand there is a price to pay for the facility and location flexibility afforded to them in this capacity, as well as the cost of hiring an agency to market their services for them.

Foreign nurse recruitment raises numerous concerns. The AONE clearly acknowledges the complex and ethical culture considerations that exist. In a policy statement approved by the AONE Board of Directors in December, 2003 the AONE indicated, "Qualified professional nurses from all countries should be able to exercise freedom of choice in their ability to emigrate and practice their profession; however, many recruitment agencies have seized upon the U. S. nursing shortage as an opportunity to increase profitability. In doing so, agencies have attempted to lower international regulations governing the profession of nursing, made false promises to recruits, and taken large numbers of nurses from struggling countries, causing the wholesale closure of needed hospitals in desperately poor areas. Although foreign recruitment allows nurses to dramatically increase their income . . . it is a short-term solution that robs poor countries to subsidize the nursing needs of richer economies."

In a March 18, 2004 statement made by California Nurses Association Executive Director, Rose Ann DeMoro, to the *San Francisco Chronicle*, Ms. DeMoro states that "Today, California has 30,000 more RNs than was anticipated - six times more than the number of additional RNs the state health department said were needed to accommodate the safe staffing law."

In a *San Francisco Chronicle* article dated March 23, 2004, the California Board of Registered Nurses (BRN) "debunks the myth that California has added 30,000 new nurses in the past three years." They further state, "It can be misleading to look only at the current number of licensed California RNs as compared to the number of RNs five or 10 years ago. And I quote: "For example, during the past three years, California had a large influx of 30,288 RNs from other states due to recruitment by employers for permanent jobs, temporary help and/or work actions. Although these out-of-state RNs obtained California licenses, it is not known if they remained in California or if they stayed here temporarily." The Board goes on to state that "during these same three years, California lost 27,000 other RNs who moved to other states. At best, these statistics prove, California had a net gain of 3,000 new nurses," not the 30,000 the nurses' labor union would have you believe. It should be noted that California imports 50% of their nurses from registry agencies in order to staff their hospitals.

There are those who believe that nurses are "flocking out of the state of Nevada" to seek employment in California, as well as other states. However, according to the Nevada State Board of Nursing, Nevada has experienced an 8.4 percent increase in licensed Registered Nurses from 2002-2003. This does not represent an exodus, this represents growth. During this same time period inpatient utilization in Nevada's hospitals increased by 9.8 percent.

There are a substantial number of Registered Nurses licensed by the state of Nevada who do not work in the hospital setting. Unlike hospital care delivered twenty years ago, when nursing utilized the team-nursing model, and when a three-day inpatient confinement for a diagnostic workup, or a three-day confinement for educating a new-onset diabetic was considered standard medical practice, today more than 50% of care, not dollars spent on care, is delivered outside the hospital setting. Twenty years ago, a nurse was either employed by a hospital or by a doctor's office. Today, the employment opportunities for a Registered Nurse outside the 24/7/365 work world of the hospital setting are nearly limitless. To indicate that nurses would "flock back to the hospital bedside," because of the implementation of mandatory numerical nurse staffing ratios, and give up their diversity and progress made to date as a profession, sets nursing back twenty years in time.

As an industry, the Nevada Hospital Association unanimously opposes mandatory numerical nurse staffing ratios. Our concerns are for the patient, the driving force behind mandatory numerical staffing ratios, the cost impact, and if mandatory numerical nurse staffing ratios generate a positive outcome that will balance the cost invested.

It should be noted that Nevada hospitals have staffing ratios required by state and federal law. These ratios have been implemented to facilitate optimal safe patient outcomes. It is imperative that hospitals have the flexibility to respond to the patient's needs on a moment to moment situation, balanced against the available workforce. To say that today, regardless of what those circumstances are, we can set a "one size fits all" nurse staffing ratio is an absolute disservice to society, and in the end, will not improve the quality of care. If anything, it will have the opposite effect on the health care needs of the citizens of Nevada.

Thank you, Madame Chair, for this opportunity to speak before you and the Committee today.