

**New York State Nurses Association  
2015-2016 Budget  
Summary of Priorities**

**Funding to Conduct a Study of Registered Nurse Staffing Patterns in New York**

NYSNA and all other unions representing registered nurses support the enactment mandatory nurse to patient ratios in New York.

Numerous studies demonstrate that minimum nurse staffing ratios are critical to protecting patients, maintaining the quality of care in acute care, long-term care and in other settings, reducing patient mortality and complications, reducing length of stay, reducing wait times in emergency rooms and outpatient settings and reducing hospital readmission rates. The benefits of minimum staffing ratios thus not only protect patients, but also offer the opportunity to reduce healthcare costs and improve the financial standing of hospitals and other healthcare providers.

It should also be noted that understaffing and excessive patient loads have negative effects on the health and safety of nurses in the workplace. Nurses have among the highest rates of workplace injury and exposure to communicable disease of any profession. Among the health and safety threats inherent in the nursing workplace are assaults by patients and family members, ergonomic and musculo-skeletal injuries, infection from needle sticks and exposures to bodily fluids and waste, repetitive motion stresses and patient lifting and handling related injuries. The incidence and rate of injuries to nurses is exacerbated by the exhaustion and stress of working short-staffed and trying to provide proper care to too many patients. In short, understaffing directly contributes to injuries and illnesses suffered by nurses.

In California, the application of nurse to patient staffing ratios has been shown to have resulted in better care and patient outcomes, to have had no adverse effect on hospital revenues and profitability, and has led to improved working conditions for nurses.

New York has enacted and recently implemented regulations pursuant to the Nursing Care Quality Protection Act (PHL Section 2805-t) that require all hospitals and nursing homes to provide detailed information about the numbers of registered nurses, patient census, nurse to patient ratios and nursing staffing plans on a unit-by-unit basis. The regulations also require reporting of specific patient care quality indicators.

These regulations now provide an opportunity to conduct a comprehensive comparative study of nurse staffing levels at hospitals and other healthcare institutions throughout New York State. This information also provides the basis for an analysis of the correlation of staffing levels to the incidence rates of adverse patient quality outcomes.

NYSNA supports the inclusion in the budget of funding and necessary legislation directing the State Department of Health to (1) conduct a systematic and comprehensive study of the actual nurse staffing and nurse to patient ratios provided by hospitals and nursing homes throughout the state, (2) analyze whether reported staffing is consistent with actual staffing patterns and (3) analyze the concrete impact of nurse staffing levels on quality of care (using both the quality indicator data reported under PHL Section 2805-t and other data available pursuant to CMS and NY State DOH regulations).

### **Increase DOH Budget to Fund an “Independent DSRIP Public Advocate” Office to Monitor and Supervise the DSRIP Process**

The 1115 Waiver/DSRIP program is providing the state of New York with \$8 billion in funding over five years to restructure the healthcare delivery system in furtherance of the “Triple Aim” of improving community health, improving the quality of healthcare and lowering the per capita costs of providing health care to Medicaid, uninsured and dual-eligible patients. The DSRIP process further refines this general policy direction by adding as an additional goal the reduction of Medicaid costs through the reduction of “preventable admissions” by 25%.

While the 1115 Waiver/DSRIP program has made some strides in creating a more transparent and inclusive process for the implementation of the DSRIP program, NYSNA is concerned that the ongoing implementation of the DSRIP program does not sufficiently protect the interests of local communities, patients and healthcare workers. Though the DSRIP guidelines agreed to by the State and CMS require that each PPS system that is given a DSRIP award must include community and worker representatives on a Project Advisory Committee (PAC) and include them in the in the decision making process, the implementation of these guidelines has been uneven and inconsistent. Many PPS applicants have relegated community and worker representatives to participating in peripheral roles and excluded them from a meaningful role in drafting DSRIP program proposals. In addition, many of the PPS PACs that do include community and worker representatives have not invested these PACs with any meaningful powers or role in the process, and they often serve only to provide a shallow briefing or ongoing progress updates.

The formulation and implementation of the DSRIP program is creating a dynamic in which healthcare providers are given financial incentives to consolidate and concentrate into large and increasingly powerful systems, to reduce services and inpatient infrastructure, to pursue “de-skilling” workforce strategies in which higher skilled care workers are replaced with less skilled (and cheaper) workers, and to relocate, reduce and eliminate vital health services based largely on financial considerations. In this context, the goal of reducing “avoidable admissions” by 25% is increasingly being translated in practice into an improper mandate to reduce beds and infrastructure capacity by 25%.

The forces at work within the DSRIP program thus create conflicting pressures, as the surface goals of improving community health and patient care quality are opposed and undermined by the goal of cutting the costs of care for Medicaid patients, the uninsured and medically underserved populations and communities.

These conflicting purposes find expression in the manipulation of the DSRIP process by some large provider networks to increase their market power and profitability, expand into profitable new markets and population segments, undermine competitors by cutting into their market share and profitable patient care services, close and eliminate unprofitable services and infrastructure, and otherwise further their pre-existing strategic plans and private corporate interests.

This process threatens to accelerate the creation of an increasingly stratified or tiered healthcare system in which wealthier patients with good insurance or the ability to pay out of pocket receive the highest quality of care and services, while those who are uninsured or underinsured will receive inferior services (and thus reduce expenditures for the State and the providers). This tendency is expressed clearly in the health exchange insurance options which are explicitly ranked on the basis of a “precious metals” system – Gold, Silver, Bronze and Basic levels of coverage based on ability to pay. The DSRIP program threatens to reinforce this tendency by creating an even lower level of care for Medicaid and uninsured patients.

NYSNA opposes the structural tendencies built into the DSRIP process that will create pressure to undermine quality of care, limit universal access to care and reinforce the trend toward a stratified healthcare system.

NYSNA supports equal access to the highest quality of care for all communities and patients and the democratization of the decision making process when it comes to the allocation, structure and distribution of healthcare resources and services in our communities.

Accordingly, in order to protect the interests of the public, local communities, patients and direct care health workers in the ongoing implementation of the DSRIP process, NYSNA proposes the creation through budget legislation and funding of an independent “DSRIP Public Advocate” within the DOH that will have the following responsibilities and powers:

- a) To monitor and audit as necessary all DSRIP PPSs to ensure full compliance with all State and CMS programmatic requirements;
- b) To ensure that each PPS fully integrates community, patient and healthcare workers in the decision making process at all levels so as to maximize the democratic operation of the DSRIP process;
- c) To investigate complaints from patients, members of the public and healthcare workers relating to the manner in which DSRIP programs and policies are designed and implemented;
- d) To act to enforce the rights of patients and local communities to quality of care, access to care, maintenance of services and infrastructure necessary or desirable to protect the healthcare interests of local communities, categories of patients and/or on the basis of findings as to community healthcare needs;

- e) To monitor and enforce improper or abusive grant of anti-trust protections through the Certificate of Public Advantage process or through applications for exemption from regulations; and;
- f) To act as the guardian and protector of the public interest generally and of local communities in all matters related to the implementation of DSRIP programs.

### **Against For-Profit Ownership and Private-Equity Investment in New York Hospitals**

NYSNA strongly opposes the introduction through the budget process of any proposals to allow direct or indirect for-profit corporate ownership or private-equity capital investment in hospitals and other Article 28 health care providers.

There is a clear and indisputable link between for-profit health care, rising costs, poorer quality and lack of access to care for underserved communities and population segments.

For-profit corporate ownership and private-equity capital investment in hospitals serve to generate profits for share-holders and/or investors and erode quality of care by providing incentives to private providers to focus healthcare services on those with better insurance coverage or ability to pay at the expense of the uninsured and underinsured. This in turn intensifies the tendency of health care delivery to become stratified in a tiered structure that reinforces class and racial disparities.

The opening of New York to for-profit hospitals will also exacerbate the existing problems we have raised in the ongoing implementation of the \$8 billion 1115 Waiver and the DSRIP programs. We can expect that any for-profit corporate or private equity operators will vigorously seek to siphon off as much of that money as they can and that investment decisions will be made with DSRIP in mind as a financial target.

Accordingly, we oppose any effort to introduce for-profit hospital models to New York and stand against experimentation with this flawed and discredited approach to providing care. The opening of our hospital system to manipulation and control by private equity capital and publicly traded corporate interests is not a viable solution to the problem of hospital access to capital. This approach will result in the deterioration of the existing quality and availability of care in areas with high need, will exacerbate the financial problems of vital access and safety-net providers, and will ultimately undermine current efforts to reform and restructure our health care system.

### **Move from the “Basic Health Plan” toward Universal Single Payer Coverage**

The enactment of the Basic Health Plan created a vehicle for the State to bridge gaps in health care coverage between the expanded Medicaid program and coverage provided by the private insurance exchange.

NYSNA believes that universal, high quality and cost effective health care will not be achieved by the current hybrid patchwork of government and private insurance coverage. Current efforts to reduce the costs of healthcare, improve quality and expand access to care require more comprehensive structural changes. We must move beyond a healthcare delivery system that treats patients as cost

centers and sources of profit, creates increasingly stratified and disparate levels of care based on income and insurance coverage, and is increasingly controlled by large corporate insurers, provider networks and capital investors who operate beyond the control of local communities and democratic structures.

The ultimate solution to the ongoing health care crisis in New York is to move toward a universal single payer system of health insurance.

Accordingly, NYSNA supports budgetary allocations and related budget legislation to modify and expand the existing Basic Health Plan structure and begin the transition to a universal, single payer health care system in New York.

### **Strengthen Certificate of Need (CON) Regulations**

NYSNA strongly supports the maintenance and expansion of Certificate of Need (CON) regulations as a necessary check on the power of increasingly concentrated and powerful healthcare delivery systems and as a necessary element for real public oversight and control over the decisions that affect access to and availability of healthcare services in local communities.

In a healthcare system that is dominated by privately controlled and operated healthcare providers, a robust CON system is often the only opportunity for the public to have any say or influence over decisions related to the location, scope, quality and types of healthcare services that are available in local communities. CON regulations allow local communities, patients and direct care providers to monitor and intervene when changes in services are being proposed.

The CON regulations also provide the State the ability to direct and control the operations of the healthcare system and to link healthcare services to a concrete analysis of local community health needs.

Industry efforts to erode or eliminate CON review will accelerate the concentration of power and control in the hands of an ever shrinking number of hospital systems and private providers and increasingly freeze the public out of the decision-making process.

In the context of the current structure of the healthcare delivery system, the CON process plays a critical role in regulating the allocation of healthcare resources and offers an opportunity for the government and affected local populations to assert control of and have a say in the workings of the healthcare system. In fact, for most decisions, the only point at which the public has any opportunity to assert its interests is in the context of public hearings of CON applications.

The CON process also offers the state DOH an opportunity to actively regulate unnecessary and wasteful healthcare expenses and, more importantly, to impose a more equitable and fair distribution of healthcare resources and improve access to care by restricting the actions of self-interested providers motivated primarily by their own financial concerns. The CON process thus provides the state and local communities with a vital tool to affect and improve the effectiveness and fairness of the healthcare delivery system.

Industry efforts to dilute and dismantle the CON system, which started to accelerate in 2011, are especially dangerous in the context of the increasingly concentrated and consolidated healthcare environment created by the MRT and DSRIP reform process. These increasingly large and powerful provider networks and the private investors who seek to profit from the restructuring process have targeted CON regulations as an “obstacle” to be removed so that they can freely pursue their private agendas with limited government oversight and no public input or control.

NYSNA thus opposes any proposals that will further dilute the effectiveness of CON regulations and urges the inclusion in the budget of measures to strengthen and expand the CON regulatory framework. Such measures should include the following elements:

- a) Greater input and control by local communities and direct care workers in the CON process
- b) Rigorous analysis of the healthcare needs of communities in the context of CON applications involving closures, reductions or relocation of health services;
- c) Requirement that all providers care for all, regardless of ability to pay, including specifically the uninsured and Medicaid patients, as a condition to granting of a CON application;
- d) Requirement that CON applications correspond to and address objective community health needs as to geographic siting and types of services being proposed;
- e) Imposition of rigorous quality of care standards, including an analysis of direct care personnel staffing levels as a condition for granting a CON application.

NYSNA further supports increases in the Department of Health budget through inclusion of funding to support a more rigorous oversight and analysis of CON applications and to allow prompt processing of applications.

### **Protect the Quality of Care and the Practice of Nursing**

NYSNA strongly opposes any initiatives to change nurse practice regulations and standards through the budget process. Proposed changes to the Nurse Practice Act (Higher Education Law Sections 6901-6912) can have significant repercussions on the practice of nursing, the quality of patient care and on patient outcomes and safety.

The rushed and improvised implementation of the 1115 Waiver/DSRIP program has raised significant concerns around patient safety, the quality of care and erosion of professional standards for nurses and other care givers. The DSRIP program goals of improved community health, better quality and lower per capita Medicaid expenditures are being manipulated by some provider systems to further long term goals of cutting labor costs through de-skilling and the shifting of care to less skilled categories of workers. The DSRIP process should not serve as cover to allow private healthcare providers to endanger patient safety and undermine quality care by diluting patient care and professional practice standards.

Any changes in existing standards of care and professional practice should be based on thoroughly researched, evidence-based studies that provide a clear objective basis for any proposed changes, maintain the quality of care and protect patients.

Accordingly, NYSNA opposes any efforts to dilute the Nurse Practice Act that are not thoroughly analyzed and discussed as part of the full legislative process in stand-alone bills. Changes in standards of nursing practice should not be introduced in the budget process.

### **Increase funding for the Capital Restructuring Financing Program**

The existing program provided for \$1.2 billion in capital funding over seven years. The current level of funding is inadequate to provide necessary support of the capital needs of safety-net and public hospitals and should be increased substantially.

Core safety net hospitals (public and private) continue to shoulder a disproportionate share of health care for under-insured and uninsured patients, putting them at a distinct disadvantage in comparison to hospital systems that consciously shirk their duties to these populations and focus their operations to more profitable types of patients and procedures.

Given the critical role of safety-net hospitals in providing access to care in medically underserved communities throughout the state, NYSNA urges the State to substantially increase the level of funding available for capital restructuring and to specifically limit and target such funding to institutions that meet strict safety-net criteria.

NYSNA also urges that the programmatic scope of the funding be expanded to focus on systematic support for vital services that are threatened with closure or reductions due to low or negative operating margins. The program should be reoriented to provide support to maintain and expand vital services in underserved communities, rather than as an incentive to close or reduce the scope of “unprofitable” services and infrastructure.

### **Increase Funding to Establish Regional Health Improvement Collaboratives**

NYSNA strongly supports the concept of regional planning bodies that will provide democratic input into the determination of local healthcare needs and a planning process for the allocation of healthcare resources.

NYSNA thus supports substantial increases in the funding for Regional Health Improvement Collaboratives (RHICs) and a focus on forming and implementing a robust RHIC structure throughout the state.

NYSNA also supports changes to the proposed RHIC structure to make these bodies more democratic in structure. The RHICs should provide meaningful opportunities for local communities, patients and health care workers to have a direct say in assessing local and regional community needs, determining the structure and types of services provided by local health care delivery systems and playing a role in the decision-making process for the allocation of resources necessary to meet local and regional health care needs.

## **Implement the Stock Transfer Tax (Article 12 of the Tax Law)**

The currently existing stock transfer tax provisions of Article 12 of the Tax Law are effectively suspended and assessed taxes are automatically rebated.

NYSNA strongly opposes repeal of the stock transfer tax and supports its reintroduction as a means of providing funds for hospital capital needs, improving access to and quality of healthcare and removing disruptive volatility in the stock markets.

NYSNA supports the introduction of legislation in the budget to fully re-implement collection of the tax.

In the alternative, the tax could be partially re-implemented to apply to “high speed trading.” The “high speed traders” have played a destabilizing role in the operation of the stock markets, and essentially rely on advantages in computer technology to skim profits from the market at the expense of small and long-term institutional investors by making large volumes of trades in extremely short trading cycles (often measured in micro-seconds). These high-speed traders serve no useful social function within the market. Their activity should be curtailed in the interest of providing more stability to the markets and funding for necessary health care, social services and infrastructure spending.

## **Increase Nursing Education Funding**

NYSNA supports adequate levels of funding for nursing education programs, given the ongoing expectation that the nursing shortage will be a continuing problem in New York, especially in the context of the aging of the “baby boom” generation. Last year’s budget continue funding at prior levels, but NYSNA believes that this is insufficient to meet the needs of nursing students and of the overall healthcare system for new nurses.

Accordingly NYSNA urges an increase in funding for the following:

- SUNY Nursing Education Programs
- CUNY Nursing Education Programs
- High needs nursing programs at private colleges
- The Patricia K. McGee Nursing Faculty Scholarship Program
- NYS Nursing Faculty Loan Forgiveness Incentive Programs

## **Expand the Nurse Family Partnership**

The Nurse Family Partnership program pairs nurses with high-risk pregnant women in order to provide in-home training, education and assistance to expectant mothers in an effort to promote the health of the woman and the infant during the pregnancy and continuing up to age two.

The NFP program has been shown to be highly effective in improving the health of the mother and fetus during the pregnancy and the health of the mother and child after birth. It has led to reductions in health complications during and after the pregnancy, lowered infant mortality rates, ongoing and sustained improvements in health outcomes for mothers and children, higher educational achievements and lower rates of incarceration.



Currently the program is limited in scope and is providing intensive nursing services to a small number of women in a narrow geographic range.

NYSNA supports the expansion of funding to allow universal coverage to be offered to all pregnant women throughout New York State. We believe that the benefits of such expansion, both fiscal and social, will far outweigh the immediate costs of expanding the availability of this intensive public health service.

NYSNA further urges the use of DSRIP funding to expand the NFP program and that the state consider including the NFP and other similar programs with a proven track record of improving health, quality of care and reducing long-term healthcare and indirect social costs as a mandatory element of all DSRIP provider programs.

### **Funding for City and County Public Health Programs**

NYSNA supports increased financial assistance to local health departments to expand the scope of coordinated public health nursing programs at the municipal and county level.

Local public health departments can direct and coordinate services more effectively than private providers, who are often influenced by financial self-interest and narrow corporate goals. Local public health programs are more responsive to the needs of local communities and better able to coordinate the provision of community healthcare education and training programs, provide basic preventive/primary care services, and implement local health planning that is responsive to community needs and democratically accountable to the community.

The expansion of the role of local health departments in providing public health services and coordination is consistent with reforms aimed at restructuring healthcare delivery and the Triple Aim.

Many local health departments, however, have been reducing staff, diminishing the role of the local health department in implementing policies and practices to address local health issues and disparities in access to care, privatizing or sub-contracting vital services, and are not sufficiently involved in planning and providing needed healthcare services in their communities.

NYSNA supports increased funding to local health departments to expand public health programs at the local level.

### **Ebola/Infectious Disease Training and Preparedness**

The recent Ebola outbreak has demonstrated the need for robust public health services at the local level, both in the treatment of infectious disease and the implementation of proper public health protocols for educating the public and implementing measures to stop or prevent the spread of diseases in local communities.

Proper infection control efforts require robust public health infrastructures that can be centrally coordinated and methodically monitor and supervise care. This infrastructure would not only be for

infected patients, but also for tracking potentially infected persons and creating contact lists and monitoring people who are not symptomatic but who may have had contact with infected persons.

These vital public health systems are, as was shown during the Ebola outbreak in New York City, costly and labor intensive. Proper implementation of infection control procedures requires large numbers of trained personnel, including nurses and other direct care staff, and requires ongoing training and maintenance of staffed infrastructure that is in place and available prior to an outbreak. The existence of a robust public health structure in New York City played a key role in protecting the public and preventing the spread of the disease, in marked contrast to the manner in which the situation unfolded in Texas.

Given the critical importance of this public health infrastructure in preventing the spread of infectious diseases, NYSNA strongly supports inclusion in the budget of sufficient state funding support to allow local county, city and municipal health departments to properly maintain a centrally controlled public health system that is equipped to handle future outbreaks in a timely and effective manner.

### **Funding to Support Healthcare Workers Providing Ebola Care in Western Africa**

The recent outbreak of Ebola in western Africa has resulted in thousands of deaths and tremendous suffering by the people of the affected nations, particularly in Guinea, Ivory Coast and Liberia, the hardest hit countries. In addition to the suffering and personal loss experienced by those who were infected and their families, the Ebola outbreak has constituted a threat to other nations and has caused ongoing disruptions in the movement of people and in international commerce. In Texas the botched handling of the outbreak caused widespread panic and fear. In New York, the outbreak has been effectively controlled and at risk persons have been fully tracked and monitored. The costs of treatment of one patient and the continuing public health efforts to prevent the spread of the disease in New York have been estimated to have cost almost \$100 million. This does not include indirect economic costs (lost productivity, disruptions in travel and trade, etc.).

The human and financial costs of the Ebola outbreak and the continuing possibility of a renewed outbreak in New York and elsewhere can only be effectively addressed if the epidemic is effectively eradicated in Africa. So long as the disease continues to be transmitted there, it will continue to present a threat in our communities. Given the poor healthcare infrastructure and lack of resources in the affected African nations the ongoing human tragedy will require the assistance of governments and medical personnel from richer nations, including the U.S. President Obama has already allocated more than \$6 billion to fight the disease, but the efforts of volunteer healthcare workers will continue to be vital in this effort.

In order to support and encourage nurses and other healthcare workers from New York to volunteer to assist in the treatment of Ebola patients and to eradicate the outbreak, the State of New York should provide funding in the budget to compensate volunteers and their employers for the lost work time and other costs associated with medical relief efforts.

Accordingly, NYSNA supports budget funding and necessary legislation to provide the following incentives to nurses and other direct care workers who volunteer to assist in the fight against Ebola:

1. Encourage hospitals and other employers to release employees from work to participate on a voluntary basis in Ebola work, on a paid or unpaid basis, as allowed by policy or collective bargaining agreements;
2. Nurses and other volunteer workers will suffer no negative repercussions to their employment status or benefits;
3. State subsidies (directly or through the employer) for any lost wages and the costs of healthcare, pension and other benefits for the time served and while quarantined or isolated upon return;
4. State educational grants applicable to student loan repayment or to be used as credits to pay future tuition or other educational costs as an incentive to volunteer;
5. State indemnification of volunteers or their employers for any out of pocket health costs not covered by insurance resulting from service or exposure to Ebola;
6. State provision of life insurance benefit to volunteers who die due to causes attributable to their service;
7. State subsidies for elder care or child care costs while volunteers are in service or under quarantine or isolation upon return;
8. Legal protections and enforcement action by State and local human rights bodies/agencies to prevent discrimination in employment, housing, access to services or other areas based on volunteers or other healthcare workers treatment of Ebola patients or participation in efforts to fight Ebola.