

SAFE STAFFING FACT SHEET



New York patients are at risk. Healthcare administrators are forcing nurses to take on 9, 10, or even more patients at once.

There is a solution: legislated safe nurse-to-patient ratios. Safe nurse ratios save lives – and can help save money for our healthcare system. NYSNA supports legislation that will require all acute care facilities to meet minimum nurse-to-patient staffing ratios. The bill would also require all residential healthcare facilities to comply with minimum care hours for registered nurses, licensed practical nurses and certified nurse aides.

1 Safe Staffing Saves Lives

- The number of patients assigned to a nurse has a direct impact on our ability to appropriately assess, monitor, care for and safely discharge our patients.
- Outcomes are better for patients when staffing levels meet those established in California. Research demonstrates lives are saved, quality of care is improved and hospital stays are shorter in other states, when hospitals meet the CA staffing benchmarks (*Health Services Research*, 2010).
- Hospitals which routinely staff with 1:8 nurse-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse-to-patient ratios (*Journal of the American Medical Association*, 2002).
- The odds of patient death increases by 7% for each additional patient the nurse must take on at one time (*Journal of the American Medical Association*, 2002).

2 Safe Staffing Reduces Adverse Patient Outcomes in Hospitals and Nursing Homes

- When registered nurse staffing is increased by only 5%, the number of adverse events, including pressure ulcers, catheter-associated urinary tract infections, hospital-acquired injuries, air embolism, blood incompatibilities, vascular catheter-associated infections and mediastinitis following coronary bypass graft, are reduced by 15.8% (*Quality Management in Health Care*, 2010).
- Hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrest, urinary tract infections and upper gastrointestinal bleeds; all leading to longer hospital stays, increased post-surgical 30-day mortality rates and increased rates of failure-to-rescue, i.e. death of a surgical patient following a hospital-acquired complication (*Agency for Healthcare Research and Quality Pub. No. 04-0029*, 2004).
- In nursing homes, safe nurse staffing levels have a positive impact on both facility processes and on resident outcomes, for example, fewer facility deficiencies for poor quality and improved functional status of the residents (*Health Services Research*, 2012).
- There is a correlation between unsafe staffing and high nurse turnover and in nursing homes, research has also shown that as nurse turnover increases, the quality of resident care declines which results in more frequent use of restraints, urinary catheterization, and psychoactive drugs; increased risk of contractures, pressure ulcers and other adverse patient outcomes (*Gerontological Nursing*, 2008).

3 Safe Staffing is a Cost-Effective Way to Improve Patient Care and Can Lead to Savings for Hospitals and our Healthcare System

- In California, hospital income rose dramatically after ratios were implemented, from \$12.5 billion from 1994 to 2003, to more than \$20.6 billion from 2004 to 2010. Not one California hospital closed because of ratio implementation.
- When compared to other ‘life-saving’ interventions, nurse staffing is a cost-effective way to improve patient care (*Nursing Administration Quarterly, 2011*).
- Safe nurse staffing reduces turnover in hospitals. Inadequate staffing levels are correlated with nursing turnover and poor patient satisfaction. The average cost to replace an RN ranges up to \$88,000. (*Nursing Administration Quarterly, 2011; The Journal of Nursing Administration, 2008*)
- Safe staffing in hospital intensive care units saves lives. A nurse-to-patient ratio of 1 RN to 1.5 patients (or less) is independently associated with a lower risk of in-hospital death. Higher nursing care hours per ICU patient day significantly contribute to prevention of Central Line-Associated Bloodstream Infections. (*Critical Care Medicine, 2014; Nursing Care, 2013*)
- When regular (non-overtime) RN staffing is higher on a unit, patients report higher quality discharge teaching and are less likely to be readmitted within 30 days—saving patients and their insurers \$608 per patient hospitalized. (*Health Services Research, 2011*)
- Increased RN staffing helped hospitals reduce penalties for avoidable readmissions. For Medicare patients with heart attacks, heart failure or pneumonia, this study found hospitals with high nurse-staff ratios had 25% lower odds of being penalized and 41% lower odds for the maximum penalty for readmissions by CMS (Centers for Medicare & Medicaid Services). (*Health Affairs, 2013*) based on quality of care (*CMS.gov, 2013*).

4 Research Establishes Ratios and Hours of Care

- The hospital nurse-to-patient ratios specified in the Safe Staffing for Quality Care Act are based on peer-reviewed academic research, evidence-based recommendations from scholarly entities and lessons learned from California’s experience implementing nurse staffing ratios. The minimum care hours specified for nursing homes are also based on research evidence and the recommendations of the Institute of Medicine’s report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004).

Proposed Ratios

These ratios were specified in last year’s version of the Safe Staffing for Quality Care Act. We expect the same language to be introduced this year.

All intensive care	1:2
Emergency critical care	1:2
Trauma emergency unit	1:1
Operating room	1:1
Post-anesthesia care	1:2
Labor – stage 1	1:2
Labor – stages 2 & 3	1:1
Antepartum	1:3
Non-critical antepartum	1:4
Newborn nursery	1:3
Intermediate care nursery	1:3
Postpartum couplets	1:3
Postpartum mother-only	1:4
Well-baby nursery	1:6
Pediatrics	1:3
Emergency department	1:3
Step-down & telemetry	1:3
Medical/surgical	1:4
Acute care psychiatric	1:4
Rehabilitation units	1:5

MYTHS & FACTS

ABOUT SAFE STAFFING



There is a crisis in New York patient care - a staffing crisis.

As nurses, we see every day how this crisis hurts our patients. But hospital administrators are trying to stop us from solving the crisis, by campaigning against safe staffing ratios.

That's because hospital administrators are used to having all the power over staffing. Putting safe minimum staffing levels into law will take some of that power out of their hands. Most managers will eventually come to see how safe staffing saves lives, but many are spreading myths now to try to stop us – the nurses of New York State – from taking power into our own hands and protecting our patients with safe staffing ratios.

Here are some of the myths they are spreading. We need to be prepared to counter those myths with the truth – our patients depend on it!

MYTH #1: There is no direct link between mandated nurse staffing ratios and improved patient outcomes.

FACT: The number of patients assigned to a nurse has a direct impact on our ability to appropriately assess, monitor, care for, and safely discharge our patients.

- Hospitals which routinely staff with 1:8 nurse-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse-to-patient ratios (*Journal of the American Medical Association, 2002*).
- The odds of patient death increases by 7% for each additional patient the nurse must take on at one time (*Journal of the American Medical Association, 2002*).
- Outcomes are better for patients when staffing levels meet those established in California. Research demonstrates that lives are saved, quality of care is improved and hospital stays are shorter in other states, when hospitals meet the CA staffing benchmarks (*Health Services Research, 2010*).

MYTHS & FACTS ABOUT SAFE STAFFING

MYTH #2: Mandated staffing ratios could force hospitals to close or cut services, which could compromise access to care

FACT: Not one California hospital closed because of ratio implementation.

- In California, hospital income rose dramatically after ratios were implemented, from \$12.5 billion from 1994 to 2003, to more than \$20.6 billion from 2004 to 2010.
- There was no evidence that linked changes in hospital finances to the implementation of Safe Staffing Ratios after the law was enacted in California. In fact, some managers reported that the staffing legislation made it easier to secure funding. (*California Health Care Foundation*)
- When compared to other 'life-saving' interventions, nurse staffing is a cost-effective way to improve patient care (*Nursing Administration Quarterly*, 2011).

MYTH #3: Safe staffing ratios would cost New York's hospitals and nursing homes too much

FACT: Safe Staffing is a cost-effective way to improve patient care and can lead to savings for hospitals and our healthcare system.

- Safe staffing reduces costly RN turnover in hospitals. Inadequate staffing levels correlate with turnover and poor patient satisfaction. The average cost to replace an RN can run \$88,000. (*Nursing Administration Quarterly*, 2011; *The Journal of Nursing Administration*, 2008)
- Increased RN staffing helped hospitals reduce penalties for avoidable Medicare readmissions. Hospitals with high nurse-staff ratios had 25% lower odds of being penalized and 41% lower odds for the maximum penalty for readmissions by Centers for Medicare & Medicaid Services. (*Health Affairs*, 2013)
- When regular (non-OT) RN staffing is higher on a unit, patients report higher quality discharge teaching and are less likely to be readmitted within 30 days—saving patients and their insurers \$608/patient. (*Health Services Research*, 2011)
- Since the ratio law, California had 32% fewer RN occupational illnesses and injuries, relative to states without a ratio law, with potential Workers Compensation savings and reduced turnover. (*International Archives of Occupational & Environmental Health*, 2013)

MYTH #4: Hospitals need flexibility in staffing - fixed ratios won't meet the needs of patients.

FACT: The ratios set a minimum standard based on research evidence, best practices and the experience in California.

- Ratios will provide a safe minimum level of staffing. Hospitals and nursing homes will still have flexibility in staffing – but they cannot go below the levels that the research demonstrates are safe.
- The bill requires facilities to use an acuity system to determine the care needs of particular patients. They must also take into consideration other activities on the unit such as admissions and discharges, and equipment and administrative needs.
- Based on all of these considerations, the facilities have the flexibility to assign nurses fewer patients than the set ratios if they determine that is appropriate.

MYTH #5: Hospitals will have to lay off other caregivers if safe staffing ratios are implemented.

FACT: Non-nurse staffing levels at hospitals increased after safe staffing ratios were implemented in California.

- The number of total nursing assistive personnel increased by 64% in California hospitals since 2005, after the ratios were implemented. That is a rate 59% higher than the rate of increase of hospital nursing assistive personnel nationally. (*Institute for Health & Socio-Economic Policy*)
- Ancillary staff continue to be vital to the healthcare team after safe RN staffing ratios are implemented. In fact, the bill requires hospitals to maintain appropriate level of all caregiver staff.

RESPONDING TO TOUGH QUESTIONS ABOUT SAFE STAFFING

The Hospital Association of NYS (HANYS) and the Greater NY Hospital Association (GNYHA) have been spreading myths and lies to legislators about the cost of Safe Staffing. You may get questions from your legislator based on their misinformation.

Here's a proven method to handle tough questions:

1. **Acknowledge** the question as valid;
2. **Answer** the question;
3. **Get back to the core issue of Safe Staffing** – the key to safe patient care.

QUESTION 1: “The Hospitals and nursing homes say that it will cost \$3 Billion to implement these staffing ratios. How can they afford to pay that much money?”

ANSWER:

We share your concerns about healthcare funding – and we have fought alongside you to get New York State the \$8 Billion in Medicaid waiver funds.

The \$3 billion cost being claimed by the hospital industry is exaggerated. They have given no data to support this claim. But even if the number were true, it is only 1.8% of the revenue of hospitals and nursing homes – that's a very small cost for quality patient care. They can come up with that cost by cutting excessive management salaries and other non-patient care overhead expenses. (See: http://www.ahd.com/states/hospital_NY.html; http://www.ahcancal.org/research_data/trends_statistics/Documents/ST_rpt_STStats2011_20110906_FINAL_web.pdf) Actually, safe staffing will help hospitals save money – savings that can offset the cost of increased staffing.

Safe Staffing will help hospitals save money from re-admission penalties. About 86% of NYS hospitals evaluated will be penalized in 2014 by Medicare for high re-admission rates. In California, where Safe Staffing ratios are set by law, only 33% of hospitals had a re-admissions penalty, and the average penalty amount is **half** what the NYS average penalty will be. (See: <http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/>)

Hospitals will also save money with reduced turnover of staff RNs and lower costs for lawsuits. When all these savings are factored in, it will cost hospitals less than one percent of their budget to implement staffing ratios.

Get back to the core issue: Hospitals' top priority should always be quality patient care – especially when budgets are tight. Hospital executives might have to take a hard look at their spending on luxury buildings, exorbitant technology and their own executive salaries, in order to ensure safe care for patients. That would be a good thing for New York's health – and the long-term health of our healthcare institutions.

QUESTION 2: “Maybe the big hospitals can afford Safe Staffing. But won’t this bill shut down the struggling community hospital in my district?”

ANSWER:

We share your commitment to stop hospital closings. NYSNA nurses have stood with you and many others to keep hospitals open for care. If we thought Safe Staffing would harm hospitals, we would not support it.

More than two dozen hospitals have closed in New York since 2000, and many more that are in bad shape. Not one of those hospitals closed because of Safe Staffing.

Hospitals don’t close because they have good staffing and good quality patient care. Hospitals close because they don’t get reimbursed enough for the cost of providing care to Medicaid and uninsured populations in their districts.

Unsafe staffing only makes it more likely that hospitals will close. The hospitals with the best staffing are actually the ones doing the best financially.

Struggling hospitals often give millions of dollars to “consultants” who promise to save the facility, then leave it deeper in debt. Investing those same funds in Safe Staffing would improve the hospital’s quality of care and community reputation – and might help avoid deaths and the malpractice lawsuits that really can kill a community hospital.

We want to join with you to reform Medicaid reimbursement and fairly allocate the Medicaid Waiver funds to keep those hospitals open in the short-term. And we hope you will support the NY Health bill to fairly fund hospitals in the long-run.

Get back to the core issue: There is one state where these safe ratios are law: California. Not one hospital close because of the ratio law. In fact, hospital income rose dramatically after ratios were implemented. Before ratios (1997 to 2003) hospital income was \$12.5 billion. After ratios (2004-2010), it jumped to \$20.6 billion. Safe staffing is good for patients and good for healthcare institutions. (See: <http://www.chcf.org/publications/2009/02/assessing-the-impact-of-californias-nurse-staffing-ratios-on-hospitals-and-patient-care>)

“NY HEALTH” BILL FOR UNIVERSAL HEALTHCARE

Frontline RNs, Patients & Single Payer Healthcare

Our fragmented and for-profit insurance system denies care to millions of patients. There is a realistic alternative.

US for-profit insurance actually blocks access to quality healthcare for all. We need healthcare and insurance systems that puts patient needs first, ahead of private profit.

Can we afford it? “The US spends \$8,508 per capita on healthcare. That is much more per person than in other industrialized countries—all of which have universal access to healthcare.

Despite all that spending, the US has worse health outcomes than these countries when it comes to infant mortality, immunization and overall life expectancy rates. ([Wall St. Journal, 2013](#); [Organization for Economic Cooperation & Development, 2011](#))

Most of these other countries, that spend less but get better results, have some form of Single-Payer Healthcare. One way to think about this in America is extending Medicare to everyone.

Our current health insurance system wastes 18% of every healthcare dollar on insurance profits and marketing costs and the billing staff for every hospital, doctor and clinic. But Medicare has a very low overhead of 3%. Extending Medicare to all US patients could save \$350 billion. ([BMC Health Services Research, 2014](#))



Is the fragmented and for-profit insurance system harming your patients and your nursing practice?

When patients come into the Emergency Department in distress, is one of the first questions they are asked:

- “Do you have insurance?” “What kind?”

Have you seen patients and families worry::

- “Am I covered for this? Are the hospital and doctors in my Network?”
- “How much is all this going to cost us?!?!”

Sometimes, as RNs providing care we can tell when our patient lacks insurance:

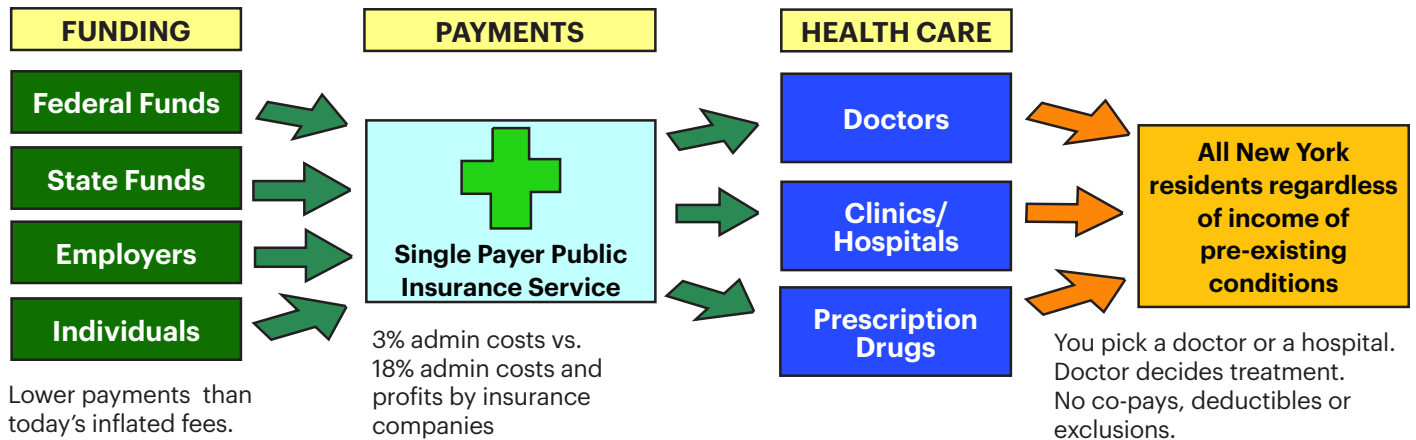
- Have you discovered that a woman about to deliver a baby has had no pre-natal care?
- When you tell a patient at discharge to see a doctor or rehab facility for follow-up, have they ever told you, “I don’t know if I can afford it”?

Every day there is the rush to discharge, once a patient reaches their quota of insured hospital days for a specific procedure (DRG):

- Have you ever had to send someone home that, in your clinical judgment, needed more hospital care to be safe upon discharge?

Is your private safety net or public hospital financially stressed because you treat patients regardless of their insurance, income and immigration status? Do executives tell you that’s why they can’t afford safe RN staffing?

NY HEALTH BILL FOR UNIVERSAL HEALTHCARE



A Single-Payer Solution

Medicare for All, or a single-payer insurance system, would afford to cover everyone for comprehensive care. It could be comprehensive—with access to all hospitals, doctors and other providers. Our patients' diagnosis would determine the course of care, not their insurance card (or lack thereof).

We can afford it! Single-Payer systems in other countries negotiate for bulk discounts on drugs, medical supplies, and equipment. They also negotiate annual budgets for hospitals and doctors. The US could do the same.

Medicare for All would be funded through a progressive tax that would replace all premium costs and co-pays and out-of-pocket costs. (Single Payer Bill H.R. 676)

95% of Americans and most businesses could get comprehensive coverage for less money than they spend now, due to the enormous savings from eliminating the for-profit insurance bureaucracy. ([University of Massachusetts study, 2013](#))

New Yorkers can start with the "NY Health" bill (A5389-A/S2078-A)

Universal healthcare through a New York State "Medicare for All" law would cut insurance red tape, saving New York consumers over \$47 billion a year. That means patients could access the hospitals and medicine they need. Local governments would also benefit. They wouldn't have to pay for Medicaid or as much for their own employees' healthcare. ([Economic Analysis of the NY Health Act, 2015](#))

What progress did the Affordable Care Act (ACA) make towards universal healthcare?

The ACA or Obamacare was created in response to a national movement for universal healthcare. The ACA has expanded insurance coverage and curbed the worst abuses of for-profit insurance.

- The insurance exchanges, coverage of adult children and

expanded Medicaid for low-wage workers did cover more Americans

- It outlawed exclusions of pre-existing conditions and cancellations for serious illnesses and mandated preventive care coverage with no-co-pays.

But millions remain uninsured or under insured

New York's healthcare system still leaves more than 1.5 million people uninsured. Nationwide in 2022, there will still be 30 million uninsured Americans—many of them in states which have refused to expand Medicaid. ([NY State of Health website, 2013](#); [Congressional Budget Office, 2012](#))

Without single-payer, insurance corporations continue to increase premiums to guarantee profits instead of prioritizing quality patient care. New Yorkers insured with Exchange plans face rate hikes that average 6%. And that is on top of a 76% rise in family healthcare premiums from 2003 to 2011.

Medical bills are still the number one cause of personal bankruptcies, even among middle-class families. High medical bills can be compounded by high-deductible health plans and the loss of job-related-insurance when people become too sick to work. ([NYS Dept. of Financial Services, 2014](#); [Commonwealth Fund, 2012](#); [NerdWallet, 2014](#); [American Journal of Medicine, 2009](#))

Postponed Care Is Killing Our Patients

123 Americans die each day due to their lack of health insurance.

Research has found that 1/3 of Americans, without insurance or with high deductible plans, postponed necessary care and in 2013 25 million Americans delayed the purchase of medicine. The lowest-cost exchange plans and many employer plans have such high deductibles and narrow provider networks that some people are still postponing necessary care, almost as much as they did when they were uninsured. ([Wall Street Journal, 2014](#); [Gallup Poll, 2014](#); [NerdWallet, 2014](#); [American Journal of Public Health, 2009](#))

HOW A BILL BECOMES A LAW IN NEW YORK STATE

(From NYS Legislative Bill Drafting Commission)

Since NYSNA actively champions legislation, like the Safe Staffing for Quality Care Act (A06571 S03691-A) we need to understand the lengthy and torturous path a bill must take before it becomes a law. The process by which a bill becomes a law occurs in a parallel manner in both houses of the New York State Legislature - the Senate and Assembly.

STEP 1 - The Idea

The idea for a bill can come from:

- Legislators and their staff members
- Governor and his staff
- Departments such as DOH (these are known as program bills)
- Individuals and lobbyists
- Unions and advocacy organizations
- A bill from a previous session that failed to become a law

STEP 2 - Sponsorship

- A bill must have a sponsor in order to be introduced.
- If a bill is not initiated by a legislator- sponsor (aka the prime sponsor), a sponsor must be found
- The prime sponsor may circulate the bill draft among colleagues in order to find additional sponsors.

STEP 4 - Introduction

- The bill draft is then introduced, assigned a bill number and printed.

STEP 5 - Committee Actions

- Once a bill is introduced, Senate and Assembly leadership refer it to the appropriate committees for review, discussion, revision and ultimately, approval or disapproval. This is where the committees may hold public hearings.

STEP 6 - Revision

- As a bill makes its way through committees, committees or sponsors may want changes, aka amendments.
- A bill can be amended an unlimited number of times by each committee through which it must pass. Thus the process can be very time-consuming.
- Amendments are indicated by a letter after the bill number.
- If a bill makes it through all appropriate committees, it's "reported out" to the floor of the house.
- If a committee does not report out a bill to the floor, then it is said to have "died" in committee and the bill will not become a law that session.

STEP 7 - Assembly Ways & Means and Senate Finance

- Any bill that requires an expenditure of state funds must go to the Assembly Ways & Means Committee or the Senate Finance Committee.

STEP 8 - Rules Committee

- The Majority Leader of the Senate is the chair of the Senate Rules Committee and the Assembly Speaker chairs the Assembly Rules Committee.
- These committees play a significant role in the flow of legislation. They are especially influential near the end of a legislative session when all bills get referred to Rules.

STEP 9 - Floor Vote

- A bill that is reported out of each committee to which it was assigned may be put to a floor vote before the entire house (after it has "aged" three days).
- If a bill passes the floor vote in both houses then it will be sent to the Governor.
- Failure to pass a floor vote in either house means the bill will not go to the Governor.
- Prior to a floor vote a bill is publicly debated before the entire house.

STEP 10 - The Governor

- When a bill has passed both houses, it is delivered to the Governor. The Governor may approve a bill and sign it, or he may disapprove and veto the bill.

STEP 11 - Veto

- A Governor's veto can be overridden by a two-thirds majority vote in each house.
- Often, a bill that was vetoed or otherwise failed to become law is reintroduced in subsequent sessions.

STEP 12 - A Bill Becomes a Law

- A bill becomes a law when the governor signs it.
- As bills become laws, they are assigned chapter numbers.

HOW A BILL BECOMES A LAW IN NEW YORK STATE

The Journey from January to June: Pushing for the Safe Staffing Bill to Become a Law



SAMPLE MINI AGENDA

FOR LEGISLATIVE MEETING

(A 20 MINUTE MEETING)

- 1 Everyone introduces themselves** – name, where you work in the district and your job, and that you are members of NYSNA – 30 seconds each
- 2 Explain why you are there** – what is the topic and provide background (If the legislator is already a supporter, go straight to the ask. Highlight with a few examples.). – 3 minutes
- 3 Have one or two nurses tell a story** to highlight the need for change. – 4 minutes
- 4 Provide an ask to the legislator** (most of this should be the legislator responding to our ask) – 5 minutes
- 5 Conclude the meeting** by clarifying what you heard and what everyone's roles are: “you agreed to support the bill...” or “we have agreed to look up that piece of information you asked about and to provide that to you by next week...” – 3 minutes
- 6 Get the contact information of someone to follow up with.** Thank the legislator and depart. – 1 minute