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The New York State Department of Health's Staffing Study Highlights the Importance of *NYSNA's Campaign for Patient Safety*

Summary

Quality care and patient safety are the primary concerns of every frontline healthcare professional. They are also the central focus of NYSNA's *Campaign for Patient Safety*. Over the past five months, COVID-19 has demonstrated that guaranteed minimum staffing standards are a matter of life or death for too many New Yorkers. It's also clear from the past five months that reducing the stark health disparities for people of color and marginalized communities across the state is directly linked to improving staffing. The first wave of the COVID-19 pandemic would have been very different in New York's hardest hit communities if the state had acted on the staffing concerns of frontline caregivers prior to the pandemic. As we prepare for a resurgence of COVID-19 this fall, the need for action in Albany has never been clearer.

That is why we are extremely disappointed with the New York State Department of Health (NYSDOH) staffing study on hospitals and nursing homes. The study was eight months late, supposedly so the NYSDOH could incorporate New York's COVID-19 experience. But they failed to address one of the pandemic's most important features, the glaring disparities in COVID-19 death rates by race and zip code.

Furthermore, the report discounts the experiences of direct care nurses, sidelines stakeholder input, and demonstrates a staggering lack of understanding of how nursing care is provided. It provides a superficial and skewed review of the existing literature on the benefits of improved nurse staffing on patient outcomes, and is built upon a fatally flawed, unstable methodology that produced grossly inaccurate and over-inflated cost estimates. This report seems designed to validate purported costs from the state's hospitals and nursing home operators rather than provide policy-makers with an evidence-based approach to addressing New York's staffing crisis. Below are some of the key shortcomings of the NYSDOH report:

- Despite an eight-month delay, the study ignores key racial and geographic disparities with COVID-19, as well as the obvious connection between these disparities and the low levels of nurse staffing in facilities serving a disproportionate number of at-risk groups.
- The study fails to account for existing staffing regulations, grossly overstating the number of RNs required to meet proposed staffing standards. For example, state law already requires 1 RN in every OR during surgical procedures, but the study estimates New York hospitals will need over 10,000 new OR nurses to meet the identical 1:1 staffing ratio contained in proposed legislation. This oversight increases estimated costs for hospitals by upwards of $700 million.

- The study estimates New York nursing homes would need to increase RN staffing by 130% to meet the proposed staffing ratio of 45 minutes of RN care per patient per day. However, the statewide average is currently 41 minutes, according to the Centers for Medicare and Medicaid Services, only 9% below the proposed standard. This discrepancy increases estimated costs by more than $500 million.
- The study estimates statewide wages for nursing staff could rise by as much as 15%, without any empirical evidence. This arbitrary assumption inflates the potential costs of staffing legislation by upwards of $1 billion.
- Despite existing disclosure requirements, there is no uniform source for staffing data by hospital in New York. The NYSDOH should release the data used in this report publicly, and begin collecting and publishing detailed staffing data so that researchers have the tools necessary to examine this critical policy issue.
- NYSDOH should also publish facility-specific information collected through the Hospital Emergency Response Data System (HERDS). These data are critical to evaluating the disparate impact of COVID-19 on communities across the state.

Analysis of NYSDOH Staffing Study

What follows is a detailed critique of the NYSDOH staffing study, including numerous methodological issues that completely undermine the report's conclusions.

1. **Failure to Address Structural Racism and Health Inequalities**. The Department of Health is committed to reducing disparities among racial, ethnic, disability, and low socioeconomic groups.[1] However, the NYSDOH staffing report makes no such mention of the disparities in health outcomes, particularly the fact that Black and Latinx New Yorkers are dying from COVID-19 at more than twice the rate of whites. ***The report also does not address the obvious connection between existing health disparities and the low levels of nurse staffing in facilities serving a disproportionate number of at-risk groups.*** Instead, the study authors analyze data by region, an approach that masks important differences between public and private hospitals, as well between safety net hospitals and larger, better resourced academic medical centers, making it impossible to draw connections with existing health disparities data.

2. **Failure to Incorporate Existing Staffing Regulations Leads to Grossly Overstated Costs.** New York State does, in fact, have regulatory requirements for staffing in acute care hospitals for certain types of units, as well as for certain types of procedures, including burn units, certain kinds of transplant procedures, and operating rooms. The report failed to account for any of these existing requirements. As a result, the NYSDOH study contains wildly skewed cost estimates for proposed safe staffing legislation. The most obvious example pertains to staffing in operating rooms. Under the Safe Staffing for Quality Care Act, operating rooms would require a 1:1 staffing ratio. However, under a 2013 law operating rooms are already required to have 1 RN in every OR during surgical procedures. Nevertheless, the NYSDOH study estimates that an additional 10,416 OR

[1] See https://health.ny.gov/prevention/prevention_agenda/2013-2017 for more on the state's commitment to addressing health disparities.

nurses would be required to meet this proposed staffing ratio. This discrepancy increases ***the NYSDOH's cost estimate for New York hospitals by as much as 50 percent, or upwards of $700 million.***

3. **Inflated Estimate of RN Needs for Long-Term Care.** The NYSDOH's estimate of the number of RNs needed to meet safe staffing requirements in nursing homes is inexplicably high. The proposed legislation calls for .75 RN hours (45 minutes) per nursing home resident per day. The current statewide average is 41 minutes of RN time per nursing home resident per day, according to the Centers for Medicare and Medicaid Services.[2] Despite the fact that the legislation would only increase RN staff time on average by 4 minutes (an increase of less than 10%), the NYSDOH study claims the state would need to more than double the number of RNs in nursing homes (adding an additional 10,181 RNs to the 7,841 currently working in nursing homes). It is unclear why such a large increase would be needed when the statewide average is already very close to the staffing standard required by the proposed legislation. This inconsistency **increases estimated costs for nursing homes by more than *$500 million.***

4. **Arbitrary Estimates for Potential Wage Increases from Safe Staffing Legislation.** The NYSDOH report tries to account for the ways safe staffing legislation could impact wages for nursing staff, however their estimates are based on arbitrary assumptions rather than empirical evidence. In their calculations, the NYSDOH estimates wages for nursing staff will increase between 5% (the "low bound") and 15% (the "high bound") should the nurse staffing bill pass. However, the study notes that estimated wage effects from the implementation of minimum staffing levels in California have ranged from 0% to 9% statewide. The "low bound" of 5% for New York is still higher than the average wage increase in California, while the "high bound" exceeds the largest estimated statewide wage increase in California by 6 percentage points. The authors note that "the California setting was different from this one in ways that likely led the wage effects to be lower than might be seen in New York" and cite five sources to support this point. However, upon review none of these sources lend support for a higher wage increase in New York. While some of these sources found evidence of increased wages in California after the passage of that state's nurse staffing bill, none attempted to quantify setting-specific factors in California that could then be used to estimate wage increases in other states. ***By using this arbitrary "high bound" estimate, the NYSDOH study exaggerates its already overstated costs of proposed staffing legislation by more than $1 billion.***

5. **Flawed FTE/Patient Calculations** – There are two problems with the way the NYSDOH analyzes staffing ratios. First, the study estimates one RN FTE is equal to 1,575 productive hours, assuming a 31.5-hour work-week, 50 weeks per year. From decades of collective bargaining we know that this is an underestimate of actual hours worked, and overstates the number of nurses actually required to meet the minimum staffing standards under consideration. This estimate is also substantially lower than

[2] Data for New York State are available on the CMS Nursing Home Compare website, https://www.medicare.gov/nursinghomecompare/search.html .

comparable calculations in the literature.[3] The second problem is that the NYSDOH does not report the more commonly used measure of nursing hours per patient day, and instead created the confusing category of RN FTEs per patient FTEs. To arrive at the denominator for this calculation, the NYSDOH took the "patient days" reported by the employers, multiplied them by 24 and then *divided the total hours by the same hourly measurement used for RN FTEs,* 1,575 hours*.* While this produces the same measure, barring rounding differences, as the more convention standard of nursing hours per patient day, it's a confusing metric and unnecessarily complicates the report's analysis.[4]

6. **Overstated Risk of Hospital Closure.** Throughout the report the NYSDOH suggests that implementation of nurse staffing ratios may threaten provider viability and lead to closures. However, this potential for hospital closures in New York is not operationalized or modelled. Moreover, the source cited is an article discussing hospital closures in California subsequent to that state's nurse staffing bill that explicitly disclaims a causal relationship between the two, noting that "it is beyond the scope of this paper to infer that California's staffing regulation led to hospital closures…previous research points to a number of factors that have influenced the state's high rate of hospital closures."[5]

7. **No Dynamic Modeling of Cost Offsets.** The study does not model potential offsets to higher wage costs, though it concedes they exist, noting that "costs [of implementation] may be offset by improvements in employee satisfaction and decreases in employee turnover". Unfortunately, the NYSDOH makes no attempt at calculating these figures. A more accurate accounting of the cost of implementing nurse staffing ratios should include estimates of these offsets, which prior research has demonstrated to be substantial.[6]

8. **Stakeholder Input Sidelined.** In addition to the numerous methodological critiques, we are extremely disappointed that almost all of the stakeholder input from healthcare professionals and patient advocates was relegated to a one-page summary within the study itself. By contrast, input from employer stakeholders shaped many aspects of the final study, including the report's cost estimation methods. There were days of testimony that touched on many factors of care provision in hospitals and nursing homes, factors that could have provided useful insights and meaningfully shaped the report's conclusions if they had been incorporated into the final study.

9. **Transparency and the Need for Publicly Available Data.** A cornerstone of scientific research is the replication and verification of published findings. To that end the NYSDOH must make the data used in their staffing study available to other researchers

[3] See, for example, the discussion in Spetz, J. et al. (2008). How many nurses per patient? Measurements of nurse staffing in health services research. Health services research, 43(5 Pt 1), 1674–1692. https://doi.org/10.1111/j.1475-6773.2008.00850.x

[4] For a more detailed discussion of the various ways to measure nurse to patient ratios, and the related methodological issues, see Spetz, et al. op. cit.

[5] E. Munnich, Labor Market Effects of California's Minimum Nurse Staffing Law, Health Econ. 23: 935–950 (2014).

[6] As just one example, Dall et al. estimated that for every dollar invested in additional nurse staffing there was a minimum additional return of 75 cents, Dall et al. The economic value of professional nursing. Med Care. 2009;47(1):97-104. doi:10.1097/MLR.0b013e3181844da8

interested in verifying their methods and results. Despite existing disclosure requirements, there is no uniform source for staffing data by hospital in New York. In addition to releasing the data used in this report, NYSDOH should begin collecting and publishing detailed staffing data so that independent researchers have the tools necessary to examine this critical policy issue.

10. **Urgent Need for COVID-19 data from New York Hospitals.** The NYSDOH should also publish facility-specific information collected through the Hospital Emergency Response Data System (HERDS) during this pandemic. These data are critical to evaluating the disparate impact of COVID-19 on communities across the state. They are also critical to evaluating staffing issues under COVID conditions, since there is currently no publicly available information on the number of front-line caregivers that were infected with COVID-19 and fell ill or missed work, became disabled, or passed away. This is a critical component to any COVID-19 staffing analysis and was completely absent from their accounting.

Recommendations for Analytical Improvement and Transparency

1. **Address Racial and Socioeconomic Disparities** – Hospitals and long-term care facilities vary widely in terms of the patient populations they serve, patients' access to health insurance coverage, and the ownership status of the provider (private for-profit, private non-profit, public sector). These factors contribute to existing racial and socioeconomic health disparities. That's why examining the impact that guaranteed staffing standards would have on hospitals serving New York's Black, Latinx, and Asian communities is of critical importance, particularly given COVID-19's stark racial disparities. That element was nowhere to be found in the NYSDOH study, and we believe that racial and socioeconomic disparities must be introduced into the analysis and tied to the data elements incorporated from the American Community Survey, as well as other sources.

2. **Better Data Collection and Transparency** – New York currently has a disclosure requirement for hospitals that requires them to provide RN staffing levels upon request. The state does not currently collect this information, and the NYSDOH study suffered because of it. We believe that the NYSDOH should immediately begin collecting and publishing these data so that independent researchers can examine these critical policy issues. Other state Departments of Health[7] have required this level of transparency from their acute care facilities, and we believe New York can build on these successes in other states.

3. **A Complete Review of Current Regulatory Staffing Requirements** - New York State does in fact have regulatory requirements for staffing in certain types of units/procedures in acute care facilities, like burn units, certain kinds of transplant procedures, and operating rooms. These regulations must be included in any assessment of the financial or operational impact of safe staffing legislation.

[7] See, for example the reporting requirements in New Jersey, https://healthapps.state.nj.us/nursestaffing/quarterly.aspx

4. **Dynamic Modeling** – The NYSDOH report was based on a number of faulty methodological assumptions. However, another shortcoming is that it did not build a dynamic model of the impact of minimum nurse to patient ratios. Any analysis of costs should also examine potential savings stemming from improved patient outcomes, lower turnover, and fewer workplace injuries for front-line caregivers. In a recent paper from a University of Pennsylvania team lead by Linda Aiken, over two-thirds of surveyed RNs in New York State reported interruptions to their work due to insufficient staffing, and over half reported burnout on the job.[8] Improved staffing would reduce these costs, and it is important to account for these factors.

5. **Better RN/Patient Calculations –** We believe the productive hour calculation used to estimate RN FTEs is too low and should be recalculated based on actual hours worked by RNs statewide. We also believe that calculating "Patient FTEs" is a flawed and unnecessary step and the NYSDOH should use more transparent measures such as nursing hours per patient day.

6. **Projected RN Wage Increases that are Transparent and Realistic** – The NYSDOH study projected a "high bound" wage increase that is unsupported by any empirical estimate in the existing literature. The NYSDOH must to be more explicit and spell out their methodology for estimating such wage increases, especially when those estimates exceed all empirical estimates from California, the only state to implement mandatory nurse-patient ratios. Otherwise the NYSDOH must re-calibrate their cost calculations, using more empirically grounded parameters.

Conclusion

Despite the fatal flaws in the NYSDOH staffing study, it has reignited debate over how to address the severe staffing shortage in New York's health care facilities. For too long, healthcare providers have relied on just-in-time decision-making on resource allocation. We witnessed the deadly consequences during the first wave of the COVID-19 pandemic. It's past time to put patients at the center of our decision-making, focusing on quality care, safety, and improved outcomes. A more objective assessment of guaranteed staffing standards, not driven by the industry's primary focus on costs, will conclude they are a proven strategy for protecting our most vulnerable patients as we move through this uncertain period.

[8] Lasater KB, Aiken LH, Sloane DM, et al. Chronic hospital nurse understaffing meets OVID-19: an observational study BMJ Quality & Safety, Published Online First: 18 August 2020. https://qualitysafety.bmj.com/content/early/2020/08/13/bmjqs-2020-011512