NYC HEALTH + HOSPITALS

New York City Council Hearing

Safe Staffing Ratios in Hospitals

Committee on Hospitals

Mitchell Katz, M.D.

President and Chief Executive Officer

New York City Health + Hospitals

June 24, 2019

Good afternoon Chairperson Rivera and members of the Committee on Hospitals. I am Mitch Katz, M.D., President and Chief Executive Officer of the New York City Health + Hospitals ("Health + Hospitals"). I am joined by Natalia Cineas, DNP, RN, MS, a respected nurse leader and care provider, who recently joined our management team as Senior Vice President and Chief Nurse Executive. Thank you for the opportunity to testify before you today on safe staffing ratios in hospitals.

At Health + Hosptials nurses are at the heart of our mission to deliver high quality, compassionate care for all New Yorkers. From our emergency departments to our skilled nursing facilities to the neonatal ICU, nurses are essential caregivers for all of our patients. They not only offer top quality clinical care but they help patients navigate a complex health care system and support them during some of most trying times in their lives.

In my first year and a half back in New York I've listened and learned a lot from our nurses. I've learned about the amazing work they do for our patients, often under very difficult circumstances. I've learned it took far too long to recruit and hire nurses at Health + Hospitals. I've learned we do an amazing job training new nurses and that we have incredibly dedicated career nurses, but that we often lose early career nurses to private health systems. I've learned that we are one of the only

systems I've come across that doesn't pay nurses higher salaries for more specialized tasks. And I learned that in some of our units we needed more nurses.

In the past year and a half we have taken some great steps to address these challenges. We have hired 340 net new nurses across our system. Some are still in training and orientation but the new staffing is being felt across the system.

Historically, we have not had standard nurse staffing plans, but now we do in almost all units. The staffing plans allow us to hire nurses in the units where our patients need them the most, and help us react quickly if staffing levels get too low on any one unit. We took steps to hire and train nurses more quickly and effectively. We have made our training and orientation more efficient. We reduced unnecessary paperwork. Now, whenever possible, we start to train a new nurse before a departing nurse officially leaves so there's no gap in staff coverage. And we launched a series of very successful recruiting campaigns like Nurses4NYC.

Our contract renewal negotiations with NYSNA began earlier this month. We have a terrific relationship with NYSNA and I think those negotiations will help us make great progress. I know we both want to focus on retaining the great nurses we have and boosting staffing in areas we have the hardest time hiring.

We love to hire new nurses and we are proud to train the next generation of nurses. We're currently looking at our business model because when we hire nurses directly

out of nursing school and train them - after one to two years they become very marketable and they leave the public hospital system for the private sector. So, we've paid for their training, but do not gain the benefit. If we can retain more nurses through those early years we know they'll fall in love with our system and we'll have more stability in our staff. That is better for our patients and for our care teams.

Another key area we are working on together is improving our ability to hire in specialty nursing care. Nurses all across our system do amazing work but it does take special training and experience to be an ER nurse or to work in an ICU or neonatal ICU. Other health systems in this city, and both public and private systems around the country, pay differentials for nurses who are certified to work in certain specialized settings. That change would help improve our staffing in key areas.

I know as a related issue to nurse staffing, members are concerned about wait times in the emergency department (ED). First, it's important to note that if you have a very serious injury there is no wait time in the ED – the most urgent patients are always triaged and they don't wait. For less urgent visits, a sprained ankle, a bad cold – there can be a wait if the ED is busy. While nurse staffing is one factor in wait times, patient demand and the historical difficulty in getting primary care or express care services at Health + Hospitals are very important. With new hiring, better workflows, and investments in express care and primary care, we've made great

progress in reducing wait times and improving the flow of our EDs. There is much more to do and our nurses will play a critical role.

There are more than 9,600 full and part time nurses in Health + Hospitals and they are essential to our efforts to deliver safe, high quality care to our patients. My elderly parents, my husband and I receive care at Health + Hospitals, and my daughter will, once she arrives in July. I would not have my family receive care if I did not believe it is safe. I believe in safe staffing and I will not operate facilities that are not safe.

Improving quality and safety requires the right staff but also the right tools and processes and teamwork across disciplines. I want to hear from our nurses if we can improve the care we deliver on any of our units. Those open lines of communication and the strong relationship we have built with our nurses will be critical to making our system even better in the years ahead.

Thank you for the opportunity to testify before you today, and I look forward to answering your questions.

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Additional information for written testimony:

To assist in our nurse recruitment and retention efforts, we've launched Nurses4NYC, are participating in the first City-led nurse residency program. We also encourage our nurses to participate in loan forgiveness and scholarship programs sponsored by the system:

- **NURSES4NYC**: During the recent National Nurses Week, we officially unveiled our system's first official nurse recruitment campaign, NURSES4NYC, to recruit the next generation of dedicated and committed men and women who will care for our patients. This recruitment effort will help Health + Hospitals fill nurse positions and expand access to community-based primary care across the five boroughs. The NURSES4NYC campaign focuses on four high need specialty areas where nurses are needed the most: Emergency Room/Trauma; Ambulatory Care; Home Care; and Correctional Health Services/Behavioral Health. Our transformation as a health system demands that we invest in nurses and doctors to meet the future needs of our primary care focus. Nurses4NYC is a vibrant campaign that will attract those drawn to our mission of caring for one and all.

- **Nurse Residency Program**: Last fall, the Mayor announced the launch of the nation's first City-led nurse residency program in 24 participating local hospitals – including all of our 11 acute care facilities at Health + Hospitals. During the first year of the program, called the Citywide Nurse Residency program, 500 newly-hired nurses will be provided with specialized training and mentorship to promote job retention. Estimates show that losing one nurse can cost up to $100,000 and retention of newly-graduated nurses is a challenge. While residencies are a recognized best practice for retaining nurses, New York City's public and safety net hospitals have not had the capacity and resources to launch these programs. We are excited to offer our nurses this opportunity to thrive in our hospitals and help us deliver quality health care to so many New Yorkers.
- **Nurse Corps**: For accepted applicants, Nurse Corps pays for 60 percent of unpaid nursing education debt over two years, with an option to extend to a third year for an additional 25 percent of the original balance. In exchange, applicants commit to two years at an eligible facility experiencing a critical shortage of nurses.
- **National Health Services Corp (for Nurse Practitioners)**: The National Health Service Corps (NHSC) Loan Repayment Program (LRP) offers primary care medical, dental, and mental and behavioral health care providers

(including Nurse Practitioners) the opportunity to have their student loans repaid in exchange for providing health care in eligible facilities with limited access to care.

- **Public Service Loan Forgiveness Program (PSLF):** The federal government provides student loan forgiveness through its Public Service Loan Forgiveness Program (PSLF) to all qualifying public service employees. Your employment at NYC Health + Hospitals may allow you to take advantage of this program if you meet the program's requirements.

Health + Hospitals has implemented the below initiatives to address overcrowding and wait times in our EDs.

- **NYC Care:** We will launch NYC Care throughout New York City by the end of 2020, starting with the Bronx on August 1. One of the primary goals of the program is to increase access to primary and specialty care for 300,000 New Yorkers who are ineligible for insurance or cannot afford it, which will decrease reliance on emergency rooms.
- **Providing appropriate levels of care:** We are providing access to other appropriate levels of care to prevent people from showing up in the EDs in the first place when they don't need to be there through expansion of primary and specialty care, and having them self-select our express care clinics. We

are also implementing targeted interventions for conditions where we see high rates of potentially preventable ED visits by expanding care to the home, as well as participating in a program that would allow 911 ambulances to treat in place and transfer patients to alternate destinations (e.g. urgent care, clinics, behavioral health centers).

- ***ExpressCare***: This new care setting will provide an alternative for patients seeking fast, reliable and non-emergent care. We do community outreach to encourage patients with non-life threatening conditions to avoid the ED and directly walk in to the clinic. In addition, patients who go directly to ExpressCare and who are experiencing health emergencies requiring more acute care will be quickly transported from ExpressCare to the emergency department. We currently have ExpressCare clinics at Elmhurst, and Lincoln, and expect to have a clinic at Jacobi by the beginning of 2020.
- ***Potentially Preventable ED Visits***: Under OneCity Health and DSRIP, we have seen a 12.5% decrease in our preventable ED visits in the OneCity Health PPS population over the first three measurement years of the program. We are also doing targeted interventions for conditions where we see high rates of potentially preventable ED visits by expanding care to the home. For example, we are connecting patients with asthma to

community based organizations' community health workers who work with the care team to engage patients in an asthma action plan and go into the home to address environmental triggers. We've seen a 20% reduction in potentially preventable admissions for pediatric patients with asthma in the performing provider system's population since the program started and are expanding to adults this year.

- ***Emergency Triage, Treat, and Transport (ET3) Model***: In the fall the federal Center for Medicare & Medicaid Services (CMS) will issue a request for proposal, which would allow providers to apply to participate in the ET3 payment model. Under the model, CMS will pay ambulance suppliers and providers to transport an individual to an ED, an urgent care clinic or primary care doctors office, or treat in place with a qualified health care practitioner. The ET3 model will allow individuals to access the most appropriate emergency services at the right time and place, and reduce costs by reducing avoidable transports to the ED, and unnecessary hospitalizations. Health + Hospitals is in discussions with the Fire Department of the City of New York (FDNY) on participating in this program.

- **Improving ED Throughput**: When patient do show up in our EDs, we have developed processes to quickly move them through our EDs and get them to

right to type of care that they need, whether it's putting them in observation status, utilizing providers in triage to get the definitive evaluation and treatment initiated right away. We are also working on improving efficiency by reducing our lab and radiology turnaround time, and moving our discharge times to earlier in the day.

COMMUNITY BOARD ELEVEN

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Nilsa Orama
Chair

Angel D. Mescain
District Manager

RESOLUTION

Date: **February 19, 2019**
Re: **Safe nurse-patient staffing ratios at Mount Sinai Hospital**
Board Vote: **44 in favor; 1 Opposed; 2 Abstained**

Whereas, Community Board 11 is aware that there is a danger of an impending strike of the nurses at Mount Sinai hospitals which we understand would have a devastating impact on our community;

Whereas, in the current contract negotiations between Mount Sinai and the New York State Nurses Association (NYSNA), the two sides have not agreed on staff levels per unit, particularly the number of Registered Nurses (RNs) per patient;

Whereas, it has been reported by representatives of the nurses that the hospital has not complied with previous contract guidelines;

Whereas, moreover, academic and specialty nurse associations recommend nurse/patient safe staffing ratios. For example, 1 RN per 3 patients in the emergency room is considered a safe ratio; and

Whereas, however, RNs at Mount Sinai hospitals report ratios of 1 RN to 7 patients in the emergency room; a differential that if confirmed is alarming; now therefore be it

Resolved, that Community Board 11

1. urges the New York State Nurses Association and Mount Sinai to negotiate in good faith in order to agree in their collective bargaining agreements upon safe RN to patient ratios in each unit of the Mount Sinai hospitals that will result in better patient outcomes; and
2. implores the leadership of Mount Sinai and the union to make every effort to prevent a strike.

Nilsa Orama
Chair

archcare
The Continuing Care Community
of the Archdiocese of New York

ArchCare Testimony opposing mandatory staffing ratios for nursing homes
New York City Council
Committee on Hospitals
Monday, June 24, 2019

Chairwoman Carlina Rivera and members of the Committee on Hospitals, Good Afternoon. I'm Migna Taveras the Director of Business and Strategic Planning for ArchCare. Thank you for the opportunity to testify today regarding our concerns about mandatory staffing ratios.

ArchCare cares for people of **all** ages and faiths where they are most comfortable and best able to receive it – *at home, in the community and in nursing homes*. As the Continuing Care Community of the Archdiocese of New York, we see enhancing the lives of our elders and others who need extra help to stay healthy and live life to its fullest as more than just a job. **To us, it's a privilege and our calling.**

We strive to provide the highest quality of service to our patients; it is integral to everything we do including, how we staff our nursing homes. We have been able to provide 5 star quality across many of our nursing homes and receive national recognition for our achievements.

It's important to understand that within our nursing homes there is a wide range of acuity levels. Acuity in this context means some are sicker than others (clinically complex) whereas some are completely stable. We have young people living in our facilities who have no place else to go but have minimal care needs. Housing is the real problem here not medical care. You can't discharge someone onto the street. Mandatory patient staffing ratios limits the flexibility needed to achieve high quality and distracts from patients having higher medical needs. It would be a failed policy enactment to not consider these complexities. This required change called for within this resolution will negatively impact the provision of specialized care and therapies.

The ecosystem of the type of facility needs to be properly assessed and considered, coupled with patient care needs and balanced with the realities of financial resources to support the various needs and functions of the institution providing care. Housekeeping, food services, various therapists, doctors, social workers, security guards, among other professional service providers, are all roles that contribute to overall patient health and are key team members to promoting successful patient healing. Prescribing a mandatory staffing ratio fails to consider the clinical care team needed to support a patient towards healing. Other service professionals that are part of the patient service delivery model must be considered as an integral part of the care equation.

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archcare
The Continuing Care Community
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It will cost ArchCare upwards of $23 million to implement the proposed nurse staffing ratios which will not be covered by the reimbursement rates that we currently receive. This proposal would virtually ensure the complete privatization of the nursing home industry despite the fact that studies have demonstrated that nonprofit nursing homes provide higher levels of quality.

According to a Harvard Medical School study, when compared to private commercially owned nursing homes, non-profit nursing homes;

- Decrease hospitalizations by 9.5%;
- Increase mobility improvement by 12.8%;
- Increase pain improvement by 19.9%;
- Increase ADL functioning improvement by 8.3%.

Similar legislation in California's law excluded nursing homes. If enacted, this change would be a multimillion dollar unfunded mandate to nursing homes. Nursing homes are already operating on very small margins.

Nursing homes are currently monitored by both NYS DOH and CMS. CMS recently modified their surveillance and rating system for nursing homes. The updated policy holds operators accountable for staffing ratios. CMS requests that Personnel and Benefits (PBJ) data be provided to them directly. The staffing information allows them to know how nursing homes staff their units. If the staffing levels are not reached, CMS automatically reduces the facilities' rating to one star. It would be prudent to allow CMS's recent rating changes to affect the outcomes that are attempting to be reached through this legislation.

The proposed nurse-staffing ratio legislation is a one-size-fits-all prescription for nursing homes that will not best advance patient care and quality. The approach does not recognize the wide range and complexity of patient needs. Nursing homes are providing skilled nursing care, physical and occupational therapy, medication, nutrition, mobility, and spiritual care. ArchCare is committed to providing all of this care and caring for the whole person. A funded mandate is one thing, but an unfunded mandate will potentially fail our most vulnerable New Yorkers.

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Testimony of Judith Cutchin, RN
President, NYC H&H and Mayorals Executive Council
Oversight – Intro 396 - Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019

Good Afternoon, I am Judith Cutchin, President of NYC H&H Executive Council and Mayorals representing nearly 9,000 public sector nurses in NYC H&H acute care facilities, and Mayoral agencies throughout the five boroughs. I'm a registered nurse for over twenty seven years most of those years I've spent working at Woodhull Hospital.

I would like to thank Hospitals committee chair Carlina Rivera and Councilmembers Cabrera and Salamanca for their work on this critical issue. I am here today to testify in support of Resolution 396 with amendments. You will hear from my colleagues from throughout the city, why this resolution is important to the patients of New York City. I would like to start by discussing the proposed amendments to this bill.

We believe that Safe Staffing Saves lives and we are committed to providing high quality healthcare regardless of one's ability to pay for it. That's why we are committed to NYC H&H

The following are the amendments we would like to see in the bill: I will not read them all. I will just read a few of the changes we support, and the rest are listed in my testimony which you have a copy of:

AMENDED INTRO. 396:

Resolution calling upon the New York City Council to endorse state enactment of the "Safe Staffing for Quality Care Act" to ensure that all acute care facilities and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff, and further calling upon the City of New York to consider pursuing similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

By Council Members Cabrera and Salamanca

WHEREAS, according to the United States Department of Health and Human Services (HHS), the inadequacy of nurse and other direct care staffing levels leads to poor patient outcomes; and

WHEREAS, research funded by the federal Agency for Healthcare Research & Quality (AHRQ) has found that hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrests, urinary tract infections and upper gastrointestinal bleeds leading to higher costs and mortality from hospital acquired complications; and

WHEREAS, the Journal of the American Medical Association (JAMA) published research that estimated five additional deaths per one thousand patients occurred in hospitals that routinely staff with a 1:8 nurse to patient ratio compared to those staffing with a 1:4 nurse to patient ratio and that the odds of patient death increased by 7% for each additional patient the nurse must care for at one time; and

WHEREAS, The National Institute of Health and other research shows that better staffing policies not only result in better patient outcomes, but also lower the operating costs of health care providers by (a) reducing the recruitment and training expenses resulting from staff burnout and turnover, (b) lowering the penalties and reduced reimbursements imposed to penalize poor patient outcomes and unnecessary readmissions, (c) lowering patient length of stay, (d) reducing legal and malpractice costs, (e) increasing staff productivity due to lower workplace injuries and fatigue, and (f) and increasing patient satisfaction scores and hospital quality ratings; and

WHEREAS, according to a report published by Health Services Research in 2012, nursing homes which have safe staffing ratios have better quality of care in their facilities and improved functional status of the residents; and

WHEREAS, in 2004 California passed AB394 which required hospitals to institute minimum nurse to patient ratios where studies have shown that nurses in California have reported improved patient care outcomes and lower workplace injury rates; and

WHEREAS, the Safe Staffing for Quality Care Act would require all acute care hospitals and nursing homes in New York State to comply with specific minimum nurse-to-patient ratios and staffing requirements, submit a facility staffing plan to the State Department of Health, and require public disclosure of actual hospitals and nursing home staffing levels; and

WHEREAS, ensuring adequate nursing coverage for all patients is an important public health goal that will improve the quality of care in acute care hospitals and nursing homes; now, therefore, ***be it***

RESOLVED, that the New York City Council calls upon the legislature to pass and the governor to enact the "Safe Staffing for Quality Care Act," to ensure that acute care facilities and nursing homes meet appropriate minimum staffing ratios for nurses and direct care staff, and be it further

RESOLVED that the New York City Council commits to pursuing the implementation of minimum safe staffing ratios and standards in the NYC Health & Hospitals system and in all other acute care hospitals and nursing homes that receive funding from or contract to provide patient care services for the City of New York.

I support resolution 396 as we propose to amend it and look forward to its passage! Safe Staffing Saves Lives. Thank you for your time and attention.

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
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June 6, 1989

M E M O R A N D U M

TO: Director of Nursing
Acute Care Facilities

FROM: Margaret F. Budnik
Senior Management Consultant
Patient Care Systems

SUBJECT: NIS Status report

In lieu of a verbal presentation at the monthly Directors of Nursing meeting, I am submitting this written summary of the NIS activities from the kickoff meeting in October '88 through June 1, 1989.

PROJECT DESCRIPTION:

The Nursing Information System (NIS) is a micro-computer based system being installed in the nursing departments at the eleven acute care facilities. The primary contract vendor is Ernst & Whinney with a subcontract with the Atwork Corporation. The NIS consists of three separate and distinct components:

ATWORK	ANSOS (Staffing & scheduling system)
ERNST & WHINNEY	STAFF MANAGER: ACUITY SCAN MODULE PATIENT TRACKING MODULE (Patient acuity/classification system)
	QUALITY MONITORING

PROJECT STATUS:

I. ACCOMPLISHMENTS

* The general kickoff meeting was held on October 25, 1988 at Lincoln Hospital. All eleven facilities were represented. E&W and Atwork presented an overview of their systems and proposed project timeframes.

* During November and December 1988, a project task group consisting of nurses from the eleven facilities worked

To: Executive Board
Pat Lewis
Marion Specker ✓

with the E&W consultants developing the patient classifcation indicators. The criteria was audited at the eleven facilities during December. E&W presented the audit results to the NIS coordinators, the Directors of Nursing, and to Corporate MIS and Nursing in February 1989.

* The installation schedule for ANSOS at the first three sites (Harlem, Elmhurst, and Kings County) was :
  - o Kickoff meeting — December 9, 1988
  - o 1st install visit — January 18, 1989
  - o 2nd install visit — March 13, 1989
  - o 3rd install visit — April 5, 1989

* The first automated schedule was posted March 24, 1989 and went into effect April 9, 1989. Five schedules were generated at Harlem and Kings County, seven at Elmhurst. Since then each facility has increased the number of units creating automated schedules. For the June 4th schedule, each facility will have the computer generate a minimum of twenty schedules. The schedule data from many of the remaining units is manually entered so the system has a record of who is scheduled to work throughout the facility.

* The installation schedule for STAFF MANAGER at the first three facilities is:
  - o Install/Implement Acuity Scan
    - Elmhurst — May 15, 1989
    - Harlem — June 1, 1989
    - Kings County — June 20, 1989
  - o Install/Implement Patient Tracking (Pilot on one unit @ each facility)
    - Elmhurst — June 12, 1989
    - Harlem — June 15, 1989
    - Kings County — June 20, 1989

* Preparation activities underway for second group of facilities (Bronx Municipal, Woodhull, Queens):
  - o Pre-kickoff meeting (discuss workplan) — May 18, 1989
  - o ANSOS kickoff meeting — June 19, 1989
  - o Schedule to go into effect — Sept 24, 1989
  - o E&W implement SCAN MANAGER — Oct-Nov, 1989

* Quality Monitoring - E&W developing system
  - o Coordinated medical record audit at Elmhurst for E&W consultants to test criteria and train their auditors (1/89)
  - o On-going meetings and discussion with E&W to plan development of QM methodology

II. OUTSTANDING ISSUES

A. Networking NIS

All three facilities from the first install group have expressed a desire to network their system. (The second group has also verbalized a need already.) The primary reason for the network request is to establish multiple workstations. According to the staff at the facilities, the daily workload expected to operate the various components of the NIS is not practicial on a single PC. A brief example of workload is:

- Enter CONTROLLER data on all new employees.
- Print POSITION REPORTS each month; (reports edited by ADN or supervisor) enter edits into the CONTROLLER - based on changes reported on position report (transfers, resignations, promotions, leaves, etc.)
- Print plan sheet for each unit once a month (original draft of schedule)
- Enter schedule request into system (from plan sheets); print first copy of schedule
- Enter final schedule edits from Head Nurses; print final schedule for posting for all units
- Enter all staffing changes on a DAILY basis. Staffing changes include: sick, absent, DIF, emergency AL, float, all NRI assignments, etc. (According to feedback from the first three sites, this component has been the most overwhelming)
- Print daily staffing reports; done once a week for all units. (These sheets are used by nursing administration to record staffing changes that will be entered into STAFFER.)
- Once patient classification system begins, the NIS operator will print staffing sheets for each unit for the following three shifts based on the current acuity data entered.
- Create and generate the numerous reports available from the system (Frequency can be monthly, weekly, on demand)
- Scan acuity forms (Athough there is an automatic scan feeder, the NIS operator must be available to monitor the scanning operations carefully since the scanner "rejects" forms for many reasons.)
- Print daily acuity reports for each unit and/or service.
- Patient Tracking (with a projected automated download of ADT information) will involve printing a DAILY UNIT PATIENT LISTING for each unit, downloading ADT information, "matching" patients from previous day's acuity information based on ADT, entering page & column numbers for patients not listed on DUPL, and finally creating and printing reports generated from the patient tracking module

- o Quality Monitoring system has not been defined yet. E&W suggests that operating this system will involve scanning additional forms, somehow matching data with patient tracking module, and of course generating reports.

We received information from ATWORK regarding recommended networking configurations and we had a private consultant visit Kings County Hospital to evaluate the specific needs of that facility. We have also discussed our interest in networking with Eugene Devine, Prinicpal, E&W and received permission from the vendor to network the system prior to the initial acceptance. (According to the contract any proposed change in the system prior to the initial acceptance had to be "approved" by the vendor.) We are continuing to explore this option.

B. Interface (ADT Download)

During the pre-installation process, HHC identified a problem with the implementation of the patient tracking module. Specifically, patient specific data (ADT information) had to be "entered" into the system to operate patient tracking. Since Corporate MIS, Corporate Nursing, and the facilities involved all agreed that manual data entry was not an option, we have been exploring other alternatives. After meeting with E&W representatives, including their "technical" person, HHC has decided to explore the option of downloading data from the SMS sytem.

In addition to the SMS PC download option, there is the "universal interface" being considered. Incorporated into the pharmacy contract, this "black box" will permit multiple systems to interface to one central source. The time frame for the actual installation of this interface is a consideration.

C. Quality Monitoring

Development of the quality monitoring system hit a "snag" in February 1989 when the consultants planned to conduct the second part of their development process. Their plan was to revisit Elmhurst hospital, interview 100 patients who were discharged and then conduct a telephone follow-up one month later. HHC had several problems with this:

- o The patient interview questions were unacceptable.
- o The patient consent form needed to be revised.
- o The issue of auditor confidentiality was addressed.
- o The question of patient confidentiality was raised.

E&W agreed to revise their questionnaire and they have submitted a revised consent form. Corporate Nursing

"cleared" the paperwork through the appropriate Corporate departments, e.g. legal, patient relations, etc. However, the administrative staff at Elmhurst was still concerned about the audit process and the patient interview questions were never rewritten. HHC also learned that E&W has undergone some adminstrative changes at the executive level which had impact on the QM project.
In May 1989, HHC and E&W both expressed interest in resuming QM development activities.

NEXT STEPS:

1. Work on resolution of three issues discussed above: networking, ADT download, and quality monitoring

2. Continue with installation and implementation activities at the first three sites following the current workplan.

   - o Certification date projected 6/21/89
   - o Original acceptance (schedule D1) 7/21/89

3. Continue data collection at the first three sites for 4 - 8 weeks using new acuity scan forms. (Time varies due to different implementation dates.) HHC will submit the patient acuity data collected from the first three sites to E&W on 7/24/89 for evaluation. HHC will then review E&W's report and recommendations around July 31, 1989. (NOTE: we will not be ordering any additional scan forms before we "accept" the validity and appropriateness of the E&W system based on this re-evaluation process.)

4. Initiate activities to start installation/implementation activities at the second group of hospitals.

   - o These facilites are working on data collection (ANSOS) now to alleviate the projected workload expected during the summer and to facilitate the implementation process.

GROUP 1	GROUP 2	GROUP 3	GROUP 4
Harlem	Queens	?????	??????
Elmhurst	Woodhull	Coney, Met, Lincoln, NCB,	
Kings County	Bronx Municipal	& Bellevue to be decided	

TIMETABLE/TIMEFRAME:

ANSOS:	1st Group	Schedule	4/9/89
	2nd Group	Schedule	9/24/89
	3rd group	Schedule	11/19/89
	4th group	Schedule	1/14/90

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STAFF MANAGER	1st Group	Scan Date Tracking Date	6/19/89 6/21/89
	2nd Group	Scan Tracking	10/10/89 10/23/89
	3rd Group	Scan Tracking	12/11/89 1/8/90
	4th Group	Scan Tracking	2/19/90 3/16/90

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	CERTIFICATION DATE	ACCEPTANCE DATE (D1)
1st Group	6/21/89	7/21/89
2nd Group	10/31/89	12/1/89
3rd Group	1/16/90	2/16/90
4th Group	3/16/89	4/16/89

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Quality Monitoring Dates will need to be re-scheduled based on information we will be collecting during the summer ('89). I will submit a revised workplan in conjunction with E&W after we establish new timeframes.

Submitted by: Margaret F. Budnik, Senior Management Consultant
June 5, 1989

NURSING ADMINISTRATION: ACUTE CARE FACILITIES

BELLEVUE HOSPITAL CENTER	Carol Clark Assoc. Ex. Dir. Nursing
BRONX MUNICIPAL HOSPITAL CENTER	Mary Dougherty Assoc. Ex.Dir. Pt. Care Svcs
CITY HOSPITAL CENTER AT ELMHURST	Juliana C. Tierney Dep. Ex.Dir. Nursing Svcs
CONEY ISLAND HOSPITAL	Joseph Kelly Director of Nursing
HARLEM HOSPITAL CENTER	Martha Grate Assoc. Ex. Dir. Nursing
KINGS COUNTY HOSPITAL CENTER	Elizabeth A. Samuel Assoc. Ex. Dir. Nursing
LINCOLN MEDICAL CENTER	Zaida Dozier Nursing Administrator
METROPOLITAN HOSPITAL CENTER	Dorethea Ripp Assoc. Ex. Dir. Nursing
NORTH CENTRAL BRONX HOSPITAL	Fay E. Malcolm Director of Nursing
QUEENS HOSPITAL CENTER	Sally Dikowitz Director of Nursing
WOODHULL HOSPITAL	Dolores E. Jackson Director of Nursing

Copies also sent to Corporate Nursing and to MIS/PCS.

6/5/89

The New York City Health & Hospitals Corporation (HHC)

Patient Classification System

Nursing Care Time Standard Components

You are utilizing Ernst & Young's Patient Classification System which has been tailored to HHC's environment with input from both staff nurses and nursing management from the eleven (11) acute care facilities. Ernst & Young utilizes a weighted checklist system of approximately 60 indicators (attributes) of nursing care time requirements. These indicators have been statistically proven to differentiate the care requirements of individual patients. As nurses classify patients, they choose the attributes that apply to their patients. Each attribute is assigned a relative value weight. The sum of the weight of the attributes chosen is the patient's acuity score. This acuity score falls into one seven (7) class weight ranges.

The class weight ranges (score ranges) are based on statistical cluster analysis which grouped patients based on similar characteristics. Seven (7) different classes of patients were identified where patients within groups are similar, and between groups are different. The score ranges of patients classified within each group are as follows:

Class	Score	
Class I	0-22	
Class II	23-45	
Class III	45-90	
Class IV	91-124	
Class V	125-149	
Class VI	150-189	> CRITICAL CARE
Class VII	190 and higher	> CRITICAL CARE

Each acuity class is assigned a nursing care time standard which reflects both direct and indirect patient care requirements. The number of patients that fall into each acuity class (acuity profile) on an individual unit determines the average nursing hours per patient day for that unit. If more patients fall into the higher acuity classes (critical care), the average nursing care hours per patient day for the unit will be higher. Conversely, if more patients fall into the lower acuity classes (newborn nursery), the average nursing hours per patient day will be lower. The nursing care time standards are comprised of several components specific to HHC's environment. These components are described below.

A. Personnel Skill Mix:

Based on HANYS budgeted skill mix by specialty area:

Specialty	Skill Level RN	LPN	NA
Med/Surg/Peds/Rehab/OB/NN/ Psych/Substance Abuse	40%	25%	35%
Critical Care (including NICU)	80%	10%	10%

B. Workload Distribution:

Based on HANYS workload distribution for the percent of work performed on each shift:

Specialty	Workload Distribution Day	Evening	Night
Med/Surg/Peds/Rehab/OB/NN/ Psych/Substance Abuse	40%	35%	25%
Critical Care (including NICU)	34%	33%	33%

In the Medical/Surgical areas, the majority of the work conducted, is conducted on the day and evening shifts so patients can sleep at night. In the Critical Care areas, however, the workload is more evenly distributed across the three shifts due to the patients' high level of acuity and care requirements.

Skill mix and workload distribution percentages are used to calculate targeted staffing needed by skill level and shift on a daily basis.

C. Direct Care Percentage:

The amount of time nurses spend performing direct care activities varies by skill level, shift and specialty. Industry standards utilized are as follows:

	Med/Surg RN	LPN	NA	Critical Care RN	LPN	NA
Day	40%	50%	60%	50%	50%	60%
Evening	40%	50%	60%	50%	50%	60%
Night	35%	45%	55%	45%	45%	55%

The direct care percent is used to calculate the number of staff needed to meet patient care requirements. The higher the direct care percentage, the more time nurses spend with patients. Therefore, less staff are required to meet total patient care requirements.

D. Acuity Profile

Based on a 4-6 week pilot study period, where extensive audits were conducted to ensure accurate staff classification, a baseline acuity profile, e.g., the percent of patients which fall into each acuity class, was developed for each specialty area. These profiles are as follows:

	1	2	3	4	5	6	7
Medicine	22.1%	30.9%	29.7%	9.9%	7.4%		
Surgery	19.8%	37.3%	35.4%	6.2%	1.3%		
Critical Care	0	0	9.5%	11.2%	13.2%	18.9%	47.2%
Pediatrics	10.2%	16.2%	37.8%	22.5%	13.3%		
Rehabilitation	9.8%	19.8%	40.2%	20.5%	9.7%		
Psych/Substance Abuse	28.9%	29.2%	27.8%	7.6%	5.9%		
OB/NN	33.3%	51.1%	15.6%				
NICU	0	0	10.10%	21.4%	29.2%	33.2%	6.10%

This profile will be utilized by the patient classification system as a baseline for each specialty to compare actual classification on a daily basis by unit to the average baseline by specialty during the pilot study period.

E. Direct Care Minutes Per Acuity Class

The amount of direct care time varies by acuity class. This time is based on patient worksampling studies where patients are observed over a 24-hour period. These times are then merged with classification scores to determine acuity class breaks and direct care time associated with each acuity class.

F. Total Time by Acuity Class

Nursing hours per patient day by acuity class including direct and indirect care requirements are as follows:

1	2	3	4	5	6	7
2.59	3.45	5.18	7.94	13.82	16.58	20.03

Nursing care time standards are unique for each specialty area and are based on the acuity profile collected during the pilot study period. Based on this acuity profile, the standard (base) hours per patient day for each specialty are as follows:

Specialty	Std. Hours Per Patient Day (24 hrs)
Medicine	4.99
Surgery	4.31
Critical Care	15.44
Pediatrics	6.41
Rehabilitation	5.99
Psych/Substance Abuse	4.64
OB/NN	3.44
NICU	12.96

HANYS 4.4 4.8

Case Mix Adjust - CMI (DRG) + ICDM-9

1095/4/LS

PATIENT CLASSIFICATION SYSTEM

TRAINING SESSION GUIDE

I. Purpose of the Meeting

Over the past two months, representatives from each nursing division have been working with consultants from Ernst & Whinney to develop a patient classification system for
We plan to pilot test the new Patient Classification System during the upcoming 10 weeks. Today, we will review the Patient Classification System developed for
, how to classify the patients using the CRTs, and the uses of Patient Classification System.

II. What is a Patient Classification System?

Patient Classification System is a method of categorizing or grouping patients into different classes. These classes typically range from one to seven with classes six and seven being reserved for the sickest or most acutely ill patients (such as a one to one patient). Based on the outcome of the pilot test, we will be able to identify the number of classes our patients fall into, and how many patients fall into each category or acuity class.

III. Uses of Patient Classification System

Patient Classification System enables you to:

- Document the acuity level of patients (how sick they are). The higher the acuity class, the sicker the patient.
- Document the indicators of patient care that impact on the amount of time nurses spend on care. The higher the acuity level, the more nursing time required to care for the patient.
- Develop staffing plans and budgets based upon acuity levels and census.
- More equitably make patient assignments for the nursing staff.

IV. History of Patient Classification Systems

Nurses have been grouping patients according to care requirements since early Nightingale days when the "sickest" patients were placed nearest the "sister's desk" in the ward. In the first type of formal system where all patients on a unit were classified, nurses were asked to use their judgment as to whether patients were self care, assisted care, complete care, or complex care. The early Patient Classification Systems were very subjective in nature, and rarely included criteria for placing a patient into a specific group.

Today, there are several types of systems in use by hospitals which attempt to objectively measure nursing workload.

V. Ernst & Whinney's Patient Classification System

We are using a Patient Classification System developed by Ernst & Whinney. Ernst & Whinney utilizes a weighted checklist Patient Classification System. This means that critical indicators of nursing activities are checked for each patient and each indicator is assigned an integer relative value weight.

- The critical indicators address all of the major components of nursing care including nutrition, elimination, physical comfort measures, patient activity levels, assessments, medications, patient teaching, etc.

- The indicators are discrete nursing activities such as feeding, bathing, positioning, and counseling, as well as patient characteristics, such as level of consciousness, speech, hearing, or sight impairment.

- The weights provide a measure of impact the indicator has on nurse staffing requirements. Because the weights vary with each critical indicator, the number of checks on the Patient Classification System screen does not mean that the patient requires more nursing care.

- The critical indicators and corresponding weights are used to classify patients into classes. Each class has a corresponding amount of nursing care required by the patient for each nursing unit.

- The nursing care time standards include staff time for direct patient care (hands-on care); indirect care activities such as charting, preparing nursing care plans, report meetings, etc.; and an allowance for personal, standby, and fatigue time. A unit's mix of RNs, LPNs, and NAs was considered in developing the time standards as well as the following:

- Approach to delivery of care
- Physical layout
- Support departments' roles
- Type of Nursing Unit

It is important to note that it is assumed that each patient requires a base level of care or else he/she would not be in the hospital, so even if you only check one or two attributes, a base amount of care for that patient is assumed. Because of this, you won't see an attribute or critical indicator of care for each and everything you do for a patient. The critical indicators of care are attributes which, through statistical testing, have been found to identify differences in classes of patients, and in patient care requirements.

Ernst & Whinney's Patient Classification System was developed from:

Ten years of developing Patient Classification Systems based on the work of E&W consultants who are nurses and engineers. The standard system was designed and implemented in approximately 150 hospitals and tested and validated most recently in five Maryland Hospitals.

VI. How Patient Classification System was developed

- o Representatives from every unit have been organized as a Patient Classification Committee. We have been meeting the past few weeks.
- o The Patient Classification Committee looked at critical indicators used by Ernst & Whinney at other similar hospitals. Your committee refined the critical indicator definitions to apply to
  What we came up with was three classification systems for the Med Center: 1) Psych, 2) Maternal/Child, and 3) Med/Surg/Critical Care.
- o I want to reemphasize that there will not be a critical indicator for everything you do for a patient. This does not mean that your work is not recognized or does not take time. What this <u>does</u> mean is that all tasks performed by nurses do not help in discriminating the class of the patient. (For example, all patients are admitted, so admitting one patient would not distinguish him from another).

- The definitions of each critical indicator are found on the unit. Your NCC can provide you with that information. For this training session you should have a copy of the attributes and their definitions. These definitions are very important to proper classification of patients. Please read them carefully. Eventually, as you classify patients, you will have these definitions memorized.

There are some things to remember related to classifying patients. These are indicators for Nursing, so if respiratory therapy does incentive spirometry with a patient, the respiratory preventive care attribute should be not checked. If Nursing does I.S., you should check this attribute.

- Definitions are very important - Normally you may not think of a specimen collection as I&O monitoring, but for classification purposes, if you collect a urine specimen, then I&O monitoring should be checked.

VII. Review the Pilot Implementation Plan

The pilot will last for ten weeks and will be the basis for testing the system and refining the process for final implementation.

The Ernst & Whinney consultants will be at the Medical Center every other week during the pilot to monitor our progress. In the meantime, if you have any questions, please ask your representative on the patient classification committee, your NCC, and they will try to answer your questions as soon as possible. Also, we will be including information in our nursing newsletter on the classification system so that all of you can keep informed of how we are doing.

VIII. Procedures for Classifying Patients

The pilot test will begin on

Registered nurses and licensed practical nurses caring for individual patients are to classify patients. Agency nurses and nursing assistants/orderlies will not be classifying patients, and it is the responsibility of the nurse in charge on each shift to assign another individual the responsibility of classification for those patients.

All patients on the evening shift must be classified before 10:30 p.m. At 11:00 p.m. a designated unit secretary will download all of the classification information you have input into the Nursing Department's computer, so it is imperative that the evening shift classify their patients by 10:30 p.m., otherwise we will not be able to capture the nursing care activities done for the patient on that shift.

Each shift will classify patients using the CRTs on the nursing units. A clean screen will appear on the night shift and additions to critical indicators of care should be made on the day and evening shift. Do not erase any of the critical indicators of care checked on a previous shift in the 24-hour period starting with the night shift. Only additions are to be made on the day and evening shifts.

All patients to be transferred to another unit must be classified on the CRT before notifying the admitting office of the pending transfer. If you transfer a patient to another nursing unit, if the patient expires on your shift, or the patient is a one-day stay, check attribute 56 to account for this.

IX. Important Points to Remember When Classifying Patients

- The bracketed items on your definition sheets are mutually exclusive attributes. If more than one critical indicator is appropriate in each bracket section, please check the more complex critical indicator. Do not erase any "X's" entered by previous shifts. The computer is programmed to take the heavier weighted attribute within mutually exclusive attributes.

- The critical indicators are not related specifically to physicians' orders. Nursing ordered activities may also be included.

- The activities performed for patients must be documented for audit purposes.

- Be sure to direct any questions or problems to the representatives of the PCS committee. We will be evaluating the definitions, general Patient Classification System information flow, ease of the system, and any need for retraining during the pilot test.

X. Practice Classifying Patients

Each of you should have a case study in front of you. Let's take about 10 minutes to read a case and write down the numbers of your selected indicators of care. (Many cases are provided, select those cases most similar to the unit that is being trained in the classification process). Then we will go through them together.

Review the results of the classification case studies.

XI. Summary

- The pilot will begin
  for 10 weeks.

PATIENT CLASSIFICATION INSERVICE OUTLINE

I. Introduction/Purpose of Meeting

II. What is Patient Classification System

III. Uses of Patient Classification System

- Staffing - Daily, shift by shift, patient care assignments
- Budgeting
- Trending
- Costing
- Quality Monitoring

IV. Ernst & Young's Patient Classification System

- Attributes/Critical Indicators
- Decision Rules
- Relative Value Weights
- Acuity Class Breaks
- Nursing Care Time Standards

  - Direct Care/Indirect Care
  - Workload Distribution
  - Skill Mix
  - Type of Nursing Unit
  - ADC
  - Acuity Profiles

V. How the Patient Classification System was developed at HHC

- Committee Process
- Procedures
- Chart Audit
- Education
- Pilot Studies
- Finalize PCS

VI. Case Study (Medical-Mrs. F.)

VII. Patient Classification System Output

- Reports

VIII. Questions

THE NEW YORK CITY HEALTH & HOSPITALS CORPORATION
PATIENT CLASSIFICATION
AUDIT PROCEDURE

AUDIT OBJECTIVES

The patient classification audit provides a mechanism to monitor the accuracy of the classification tool in assessing patient care needs. This monitoring is essential for several reasons including:

- To verify that the patient classification system is being correctly utilized.
- To ensure the accuracy and integrity of classification data reported.
- To quantify and qualify when the staff classification does not accurately reflect patient care needs.
- To determine if the care assessed as needed on the patient classification form was in fact delivered.
- To verify that documentation of patient care needs is complete and appropriate to each patient situation.
- To assure consistent application of the patient classification system across all units and from day to day.
- To identify discrepancies within the patient classification system and identify reasons and persons responsible.
- To provide timely, constructive feedback to nurses via private conference or training sessions as appropriate.
- To perform a follow-up audit to determine if problems have been resolved.

AUDIT PROCEDURES

The patient classification audit will include a retrospective comparison of a sample of completed patient attribute forms for the prior day and the corresponding nursing medical record documentation.

The audit includes a review of the patient's nursing documentation and the completed patient classification attribute forms for a specific day. The procedure measures compliance between the attributes marked on the form by the nursing staff and the nursing documentation.

Compliance occurs when the patient care attributes marked correspond with the patient care needs recorded in the nursing documentation in the patient's medical record. Compliance indicates the patient received the care marked on the patient acuity form. Compliance also indicates an acceptable outcome.

Noncompliance or unacceptable responses occur when attributes marked on the patient's acuity form, are not correspondingly documented in the nursing documentation in the medical record. Lack of documentation may or may not indicate that the nursing care was delivered. This would equate to an unacceptable response or noncompliance. An unacceptable response also occurs when care is indicated in the nursing documentation in the medical record, but not noted on the patient acuity form. Noncompliance indicates an unacceptable outcome requiring action.

Important Note: If the auditor knows for certain that care not documented was provided (i.e., observed, interviewed nurse), they may select the attribute but should make note of documentation problems to be addressed.

INTERRATER RELIABILITY AUDIT

The PCS auditor should be well trained regarding selection of attributes and decision rules and completion of the patient classification form. To ensure the interrater reliability of the patient classification system and its outputs, we recommend that the nursing department utilize two auditors from time to time to check classification consistency. In those cases, you will have an Auditor A and Auditor B and will calculate the variances between both auditors as well as the staff classification.

AUDIT GUIDELINES

The following guidelines should be used for all types of audits. More detailed information will be provided in the next section.

1. Documentation should be audited in the same manner that classification forms are used, e.g., 7:00 am to 7:00 am, 12:00 Midnight to 12:00 Midnight.

2. The auditor should classify the patient according to attributes documented in the nursing documentation section of the patient's medical record. This includes all permanent nursing documentation (narrative charting, flow sheets, activity and medication records). Do not use non-nursing documentation, e.g., physician orders, social work notes, etc.

3. Care not documented is assumed to not have been provided unless the auditor knows for certain that the care was in fact delivered. For example, if documentation does not support that the patient was suctioned, but you know that the patient has an endotracheal tube and was suctioned, mark the attribute for endotracheal suctioning.

4. Discrepancies in the audit should be analyzed by identifying the following:

   - Attributes marked on the Unit Acuity Report with Patients, but not documented in the medical record.

   - Care documented in the medical record, but not marked on the Unit Acuity Report with Patients.

5. After analysis of the audit(s), action steps should be initiated at the unit level. Action steps taken should be documented and reported back to the Project Coordinator. These may include:

   - Review of the attributes and decision rules with individuals or all staff members. Review can occur during regular staff meetings, each day at shift report, on an individual basis, or by holding in-service education sessions.

   - Review and update of documentation methods and tools including revisions to unit or hospital flowsheets.

   - Modifications to organizational or operating practices that support patient classification.

AUDIT INSTRUCTIONS

Pilot Study Reliability Checks

The purpose of the pilot study is to test the design of the patient classification system including the attributes, decision rules, standards and operating procedures. Auditing of the classification results and clarification of confusion up front, at the start of classification, is essential to the quality and integrity of the system outputs to avoid long-term problems. The audit provides the information necessary to identify where the staff are misclassifying (selecting the wrong attributes, yielding the wrong acuity class) or are not complying with classification procedures.

During the pilot study, classification forms should be reviewed daily to identify obvious problems, omissions, etc. In-depth audits should be performed daily on five patients/unit and results used to finalize attributes and decision rules, reeducate staff, make changes in documentation systems, operating procedures, etc. This should not be a time-consuming process as the auditor should be as comfortable with the classification process as the staff. Allow 30 minutes per day for auditing during the pilot study.

Ongoing Reliability Checks

Once the system is finalized, we recommend that audits be performed on all patients (100% sample) on a monthly basis. This will allow you to determine variances in overall target hours between actual and audit results based on unit classification practices. If the Hospital performs a 100% audit monthly, this eliminates the need for daily audits, In addition, Nursing Management should review and analyze ANSOS staffing reports incorporating patient classification data including:

- data variances (actual and scheduled/budget staffing levels to target);
- causes of variances; and
- action steps to address cause of variance.

The following instructions and Unit Reliability Check Form are the same for both the pilot and ongoing audit procedure, with the exception of the target hour variance calculation. This can only be computed if the auditor performs a 100% audit sample.

1. Print a Unit Acuity Report with Patients for each unit for the day before the scheduled audit.
2. Gather the scan forms for each unit for the corresponding period (not needed with Patient Tracking).
3. Randomly select six patients for each unit to be audited. Only five patients will be audited; however, six are selected in case one patient has been discharged or the chart is not available. One method for selecting patients is to select every seventh patient on a 40-bed unit. (For monthly audits all patients will be selected.)
4. Identify the page and column number for each patient in the sample and determine the patients name from the associated page and column on the scan form (not needed with Patient Tracking).
5. The auditor will audit the same patients on the same date and compare their results to the original staff classification.
6. The auditor should classify the pre-identified patients on a classification scan form labeled "Audit."
7. Enter the date audited, Unit Name, Patient Name, Nurse Name and Actual Class (A) for the staff's classification of the sample patients on the Unit Reliability Check Form.
8. If performing a monthly sample, enter the Actual HPPD (RVU) for the date audited in the designated area in the upper right-hand corner of the form.

9. Bring both the Audit Scan form and the Unit Reliability CHeck Form to the unit for auditing. Classify the same patients for the same time period using all available nursing documentation on the audit scan form.

10. Indicate the attribute number selected but not documented in the nursing documentation, the attribute number documented in the nursing documentation but not selected on the classification form and inappropriate attribute levels selected in the designated area on the Unit Reliability Check Form to allow for review of attributes, decision rules, documentation systems and for reeducation.

11. Sign onto the Audit area by loading Nursing Advantage (NA). Then choose Area 2 (Audit). Scan the audit scan forms for the unit audited. Print the Unit Acuity Report with Patients. Enter the Acuity Class (B) for the classified auditor's in the designated area.

12. If performing a monthly sample, enter the Audit HPPD (RVU) for the date audited in the designated area in the upper right-hand corner.

13. Indicate any and all class variations as shown on the Unit Reliability Check Form.

    The goal is to identify and act on any and all class variations.

    To compute compliance on a unit basis, indicate the number of class variances and % compliance in the designated area. For example:

    If three out of five classes between staff (actual) and auditor are the same, the compliance rate = 3/5 or 60%.

14. For monthly audits, compute the target hour variances. Example:

Actual Target	Auditor Target	Acceptable Range
HPPD (RVU)	HPPD (RVU)	(+ or - 5%)
5.2	4.9	.05 (4.9) = .25
		4.9 + .25 = 5.15
		4.9 - .25 = 4.65
		4.65 - 5.15 is the acceptable range

    Act on any variation that is not within the acceptable range.

15. When a variation in class, or target hours not within acceptable range has been identified, complete the bottom of the Unit Reliability Check Form (page 2) to document Problem Description, Action Taken or Problem resolution.

KARINES REYES
Assemblywoman 87th District

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Testimony from New York State Assembly Member Karines Reyes Before the New York City Council Committee on Hospitals Regarding Safe Staffing Ratios

Monday, June 24th, 2019

Good Afternoon, Chairperson Rivera and members of the committee. Thank you for allowing me the opportunity to share my testimony with all of you today.

My name is Karines Reyes, Registered Nurse and Assembly Member for the 87th District in the Bronx, representing the neighborhoods of Parkchester, Van Nest, Castle Hill, and West Farms.

Just days before I walked the halls of our state capitol, in Albany, I was a full time staff nurse on the oncology unit at Montefiore's Weiler Hospital in the Bronx. My experiences caring for the sickest members of my community were the impetus that made me decide to run for office. It's impossible to deny all the incredible medical advances that help us identify and treat diseases sooner, and help people live longer. However, these scientific advances could never supplant the human aspect of health care.

I would like to illustrate for you what a typical 12-hour shift for a nurse is like.

My day begins at 7 AM with a brief handoff report from the outgoing nurse. He/ She would update me on the overall medical history of the patient; the current problem or reason for admission; the plan of care; any medical interventions that have happened while admitted; any interventions that took place in the past 12-hours; any pending interventions that I need to execute during my shift. I would then perform a thorough assessment of my patient to establish a baseline at the time of handoff. This includes vital signs; auscultating breath and bowel sounds with my stethoscope; assessing circulatory status; verifying IV drips are consistent with doctor's orders; assessing any medical equipment connected to the patient; and physically inspecting any wounds or dressings that patient may have. Lastly, I would document my findings in the electronic record.

I would do this for every single one of the patients assigned to me. My assignment consisted of anywhere between 5 to 8 patients, each with varying degrees of acuity.

Imagine, that while I try to complete my baseline assessments, the call bells are going off- patients need to be helped to the bathroom, or medicated for pain, or transferred to a stretcher because they are leaving the unit for a test. Simultaneously, the kitchen has brought up breakfast for the patients. Many of my patients are unable to feed themselves, so the food will sit in front of them until someone has the time to feed them. By 9 AM, I had to have reviewed all of my patient's lab results and by 10 AM, I need to begin preparing and administering each patient's medications. Some patients can have tens of medications including multiple IV infusions due at 10 AM.

My day would continue at this pace with very little room for error. If there was an emergency that interrupted this very tight schedule, every patient under my care would feel the brunt of it. My fellow nurses would have to pitch

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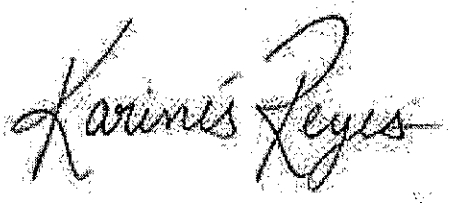
in at the expense of the patients under their care. So when we say that safe staffing saves lives, it's as simple as that.

The Journal of the American Medical Association (JAMA) published research that estimated five additional deaths per one thousand patients occurred in hospitals that routinely staff with a 1:8 nurse to patient ratio compared to those staffing with a 1:4 nurse to patient ratio and that the odds of patient death increased by 7% for each additional patient the nurse must care for at one time.

As a legislator I am tasked with the responsibility of weighing in on the state budget. We spent the beginning of this year fighting back cuts to Medicaid funding. Because CMS reimbursement is tied to patient outcomes and satisfaction scores, safe staffing makes fiscal sense. The Agency for Healthcare Research & Quality (AHRQ) has found that hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrests, urinary tract infections and upper gastrointestinal bleeds leading to higher costs and mortality from hospital acquired complications. Research shows that better staffing policies not only result in better patient outcomes, but also lower the operating costs of health care providers by (a) reducing the recruitment and training expenses resulting from staff burnout and turnover, (b) lowering the penalties and reduced reimbursements imposed to penalize poor patient outcomes and unnecessary readmissions, (c) lowering patient length of stay, (d) reducing legal and malpractice costs, (e) lowering staff productivity due to workplace injuries and fatigue, and (f) and lowering patient satisfaction scores and hospital quality ratings.

Safe staffing is the single most important thing we can do to ensure the safety and care of every patient in our state. There is no technology that can help us further improve patient outcomes without addressing staffing. Dr. Danielle Ofri stated in a New York Times article just last week that "Corporate medicine has milked just about all the efficiency it can out of the system. With mergers and streamlining, it has pushed the productivity numbers about as far as they can go." Health care is not an assembly line, we need to put the bodies in place to do the work of taking care of our loved ones- because we have to remember that at any given time that patient could be our mother, our father, our children, or us.

Best Regards,



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RESOLUTION

Date: March 5, 2019
Committee of Origin: Health & Human Services
Re: Nurse/patient staffing ratios at Mt. Sinai/St. Luke's.
Full Board Vote: 34 In Favor 0 Against 1 Abstentions 0 Present

Community Board 7/Manhattan is aware that there is a danger of an impending strike of the nurses at Mt. Sinai West and Mt. Sinai: St. Luke's Hospitals, which we understand would have a devastating impact on our community.

In the current contract negotiations between Mt. Sinai West and Mt. Sinai/St.Luke's and the New York State Nurses Association (NYSNA), the two sides have not agreed on staff levels per unit (the number of RNs per patient). It has been reported by representatives of the nurses that both hospitals have not complied with the previous contract guidelines.

Moreover, academic and specialty nurse associations recommend nurse/patient safe staffing ratios. For example, 1 RN per 3 patients in the emergency room is considered a safe ratio. However RNs in these hospitals report ratios of 1 RN to 7 patients in the emergency room. This differential, if confirmed is alarming.

The relationship of nurse/patient ratios to health outcomes has been documented in medical research found in the following reputable journals:

- American Journal of Infection Control: "There is a significant association between patient to nurse ratio and urinary tract infection in and surgical site infection."
- New England Journal of Medicine: "Staffing of RNs below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs in nursing care."
- Archive of Internal Medicine: "A national study of the quality of care for patients hospitalized for heart attack, congestive heart failure and pneumonia found that patients are more likely to receive high quality care in hospitals with higher registered nurse staffing ratios.
- Journal of the AMA: Patients in hospitals with 1:8 nurse to patient ratios have a 31% greater risk of dying than patients in hospitals with 1:4 nurse to patient ratio.

We resolve that Community Board 7/Manhattan urges NYSNA and Mt. Sinai West and Mt. Sinai: St. Luke's Hospitals to negotiate in good faith in order to agree in their collective bargaining agreements upon safe RN to patient ratios in each unit of their hospitals that will result in better patient outcomes.

Furthermore, we implore the leadership of the hospitals and the union to make every effort to prevent a strike.

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CONTINUING CARE LEADERSHIP COALITION CCLC

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Testimony of Scott Amrhein, President, Continuing Care Leadership Coalition
Concerning Proposed Resolution #396
June 24, 2019

Introduction

Good Afternoon. I am Scott Amrhein, President, Continuing Care Leadership Coalition (CCLC), which represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. Our members represent the full continuum of long term care services including skilled nursing care, home health care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. We appreciate the opportunity to offer testimony to the New York City Council on the implementation of staffing ratios in nursing homes and hospitals and our deep concern on the effects it will have on quality of care. While we oppose the bill - for reasons we will go into further - we align ourselves fully with what we believe is intended by the sponsors: ensuring that all who need care receive care that is safe, high-quality, and reflective of the needs and wishes of every patient.

KEY POINTS

- **Fixed staffing ratios undermine the ability of health care organizations to implement staffing plans based on specific care needs - especially in light of the diverse populations that nursing facilities serve.**

- **The Federal agency responsible for overseeing nursing home quality - CMS - rejected fixed staffing ratios as insufficiently flexible when updating its requirements for nursing homes participating in the Medicare and Medicaid programs.**

- **Within the new Federal Requirements of Participation, there now exists a National standard requiring nursing homes to develop and adhere to "Competency-Based Staffing Standards" - standards in place and applicable to all New York City nursing facilities. This is a better model, and one that should be given deference.**

- **Mandating staffing ratios would cost New York State nursing homes close to $1 billion to implement. This would be unsustainable and would accelerate the rate of closures and sales of not-for-profit nursing homes in NYS - with dire effects on care access and quality for New Yorkers.**

Inflexible Mandated Staffing Ratios Would Make it Impossible to Implement Staffing Plans that Meet the Needs of the Diverse Populations Served by Nursing Facilities in New York State

The proposed State legislation that is the subject of Resolution #396 would undermine the flexibility required in order to properly meet the needs of the wide range of populations served in New York's long term care organizations. Patient care decisions are influenced by a number of factors, including acuity of the patient, training of the nurses, and the availability of other health professionals and presence of certain technology. Because there are so many variables in staffing determinations, a key to a successful approach to nurse staffing must be flexibility. Requiring health care organizations to adhere to predetermined levels of nursing staff takes away their ability to operate efficiently and appropriately in light of their specific circumstances. In short, the so-called "Safe Staffing for Quality Care Act" would establish a "one size fits all" standard that is at odds with the diverse needs of New York's long term care patient population.

New York City's nursing facilities care for a wide variety of specialty populations including persons with dementia and mental illness, those requiring mechanical ventilation, those requiring special bariatric care, specialty wound care, IV therapy, palliative care, pediatric care, and many other special services. As a result, the care needs vary dramatically across nursing facilities. Because of these variations, there is no one "most appropriate" staffing configuration. To the contrary - what would be appropriate in one facility would be too little in a facility with more acutely ill patients - and it would be too much in another facility where the majority of patients require relatively lighter assistance in their activities of daily living. Having the ability to staff based on acuity level is essential to meet the daily needs of such a wide variety of patients.

The American Nurses Association (ANA) understands these varying demands and recognizes that effective staffing requires more than fixed, overly-prescribed staffing ratios - they require a flexible staffing model to address diverse care needs. In its *Principles for Nurse Staffing,* the ANA states:

> "*rigid staffing models fail to consider the hour-to-hour changes that are the norm in a patient care environment ... the concern is that other variables that impact the need for nursing staff such as severity of patient condition, nursing skill level, skill mix of staff, and actual or projected change in the census are given little or no consideration in this type of staffing plan.*"

The ANA, the largest and oldest nursing association, **does not** endorse fixed staffing ratios. It encourages a flexible care model that will be able to accommodate the varying needs of long term care patients and urges healthcare settings to instead consider the experience, expertise, and skill set of the a facility's staff.

The Federal Agency Responsible for Overseeing Nursing Home Quality - CMS - Rejected Fixed Staffing Ratios as Insufficiently Flexible When Updating its Requirements for Nursing Homes Participating in the Medicare and Medicaid Programs

In July of 2015, CMS introduced its proposed revision to the nursing home Conditions of Participation, the first step leading to the ultimate release (in October 2016) of a new set of Federal guidelines that nursing homes throughout the country must adhere to. The proposed regulation has pages of discussion covering the extensive deliberations that the agency undertook - including its review of the literature on optimal staffing and its consideration of how different approaches to ensuring appropriate staffing would fit with the realities of the care issues that nursing facilities deal with every day.

In the end, CMS rejected fixed ratios as too inflexible for application in the skilled nursing facility setting. In addressing the shortcomings of fixed staff ratios, the proposed rule stated:

> *"... we do not necessarily agree that imposing such a requirement is the best way to clarify what is "sufficient" to the exclusion of other factors that are important in improving the quality of care for each resident. We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and staffing abilities including professional characteristics, skill sets and staff mix."*

As a Result of CMS's Updating of the Nursing Home Requirements of Participation, There Now Exists a National Standard Requiring Nursing Homes to Develop and Adhere to "Competency-Based Staffing Standards" - Standards Already Applicable to All New York City Nursing Facilities

The final new nursing home Requirements of Participation (which officially went into effect on November 28, 2016) require that nursing homes develop facility-tailored staffing plans based on staff competency and education, and those staffing plans must be made available for public review, and evaluation by surveyors during annual inspections.

The final rule stated, in §483.35:

"The facility must have sufficient nursing staff with the appropriate competences and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individuals plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70."

The updating of the CMS requirements of participation (ROP's) is the largest change to nursing home standards and requirements since 1991. The overarching goal of the new rule is to focus on person-centered care, understanding the needs of the patients, and maintaining a diverse skill set of education and expertise across a facility's staff. Introducing a new State standard for staffing would conflict directly with the new Federal guidelines. Doing so would be incongruous with the new rule's person-centered care goals, and it would be out-of-step with the present realities of care delivery in nursing homes.

Mandating Staffing Ratios Would Cost New York State Nursing Homes Close to $1 Billion to Implement - Accelerating the Rate of Closures and Sales of Not-for-Profit Nursing Homes in NYS

The not-for-profit nursing homes that CCLC represents are quality pace-setters, delivering state-of-the-art care as measured by CMS's 5-star system. Fully 84% of our member facilities are 4 and 5-star facilities on measures of overall quality - and our members score at a 4 or 5-star level on measures of RN staffing at a rate that is 116% higher than that attained by other facilities in the State. If these facilities were not in the system, our State's quality ranking (compared to other States) would fall by 14 places.

What is especially concerning is that these very facilities - NYC's not-for-profits - are among the State's most financially vulnerable nursing homes. In the face of severe financial pressures (Statewide, nursing homes presently lose $64.00 a day on every Medicaid patient they serve) the State's high-quality not-for-profit nursing homes are closing or selling at a rate of more than one facility every two months.

This trend has been cited as a serious concern by the New York State Attorney General's Charites Bureau, which, in its 2018 report, "The Sale of Nonprofit Nursing Homes Pursuant to the Not-for-Profit Corporation Law," made the following back-to-back statements:

First, it emphasized, *"Research suggests that, on average, nonprofit nursing homes provide better care and achieve greater patient satisfaction than for-profit facilities."*

Then it went on to express, with concern, *"In New York, we have seen a significant increase in efforts to sell nonprofit nursing homes to for-profit entities since 2014. Within the past few years, about 5% of New York's nonprofit nursing homes were sold to for-profits annually."*

This trend is bad for access - and horrible for quality. If it continues it will fundamentally alter the range of care choices available to New Yorkers in their own communities.

One thing is assured: if the proposed staff ratio legislation is adopted - adding close to a billion in costs to the already unbalanced ledger of our State's nursing facilities - this trend of sales and closures will only accelerate, with devastating consequences for consumers and patients.

This legislation would do irreparable damage, and needs to be rejected.

CONCLUSION

Staffing ratio legislation was proposed approximately fifteen years ago in the New York State legislature. It is not appropriate or in alignment with the current healthcare realities in New York State. Safe staffing requires more than nurses, it requires a system of individuals who are committed to the care of those who are unable to care for themselves - a goal that can't be accomplished through a costly, inflexible standard that fails to account for the vast differences in every care setting.

I greatly appreciate the opportunity to provide these perspectives and recommendations. CCLC looks forward to working in partnership with the New York City Council in ensuring that essential long term care services remain strong and available to our State's older and disabled citizens as the demand for these services grows in the year ahead.

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Testimony of Doctors Council SEIU
Kevin Collins, Executive Director
Before the New York City Committee on Hospitals
June 24, 2019

Doctors Council SEIU represents thousands of doctors in the Metropolitan area, including in every NYC Health + Hospitals facility, the New York City Department of Health and Mental Hygiene, correctional facilities including Rikers Island, and other New York City agencies.

Thank you Chair Councilmember Rivera and all the members of the Committee on Hospitals for the opportunity to testify.

As a health care union of physicians, we support the amended Resolution No. 396 endorsing state enactment of the "Safe Staffing for Quality Care Act."

Quite simply, doctors care for patients for a number of reasons, including to make them better through treating an illness and to manage a chronic condition. The best way to do this is with the proper staffing of all the members of the patient care team, especially nurses. Doctors follow the adage of do no harm. The best way to avoid this is by not being short staffed.

Our doctors see every day how nursing care is critical to the delivery of quality and safe patient care. Having enough nurses to provide that care is vital.

Safe staffing saves lives. The Journal of the American Medical Association (JAMA) published research that estimated five additional deaths per one thousand patients occurred in hospitals that routinely staff with a 1:8 nurse to patient ratio compared to those staffing with a 1:4 nurse to patient ratio and that the odds of patient death increased by 7% for each additional patient the nurse must care for at one time.

Safe staffing improves patient outcomes. According to the United States Department of Health and Human Services (HHS), the inadequacy of nurse and other direct care staffing levels leads to poor patient outcomes and workplace injury rates.

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According to a report published by Health Services Research in 2012, nursing homes which have safe staffing ratios have better quality of care in their facilities and improved functional status of the residents.

If we put the patient at the center of making our health care policy decisions then we would put safe staffing of nurses at the top of any list to make sure that patients receive the best possible care and that the patient experience and satisfaction is as best as can be.

With a properly staffed department, division, unit or so on, we can have:

-better patient outcomes,
-reduced unnecessary readmissions,
-less nursing turnover and burnout,
-lower patient length of stay and
-reduced legal and malpractice costs.

It has been found that that hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrests, urinary tract infections and upper gastrointestinal bleeds leading to higher costs and mortality from hospital acquired complications.

We also agree in calling upon the City of New York to consider pursuing similar local legislation requiring the New York City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

We recognize that Health + Hospitals has committed to hiring more nurses and applaud the system for that. It has also committed to hiring more doctors, especially Primary Care Physicians, and we appreciate that as well.

The "Safe Staffing for Quality Care Act," would ensure that acute care facilities and nursing homes meet appropriate minimum staffing ratios for nurses and direct care staff.

The proper staffing of all members of the patient care delivery team is needed for the delivery of quality care, be it doctors, nurses, aides, clerks, techs and others. Nurses are crucial to that worthwhile endeavor and this Act will aid not only nurses but the patients and communities health care workers serve.

Thank you for the opportunity to submit this testimony.

Metro New York Health Care for All

Community and Labor United for Health Care Justice

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1199SEIU United Healthcare Workers East

Robert Score
Theatrical Stage Employees, Local 1, IATSE

Mark Hannay, *Director*

June 24, 2019

Testimony Presented to New York City Council, Committee on Hospitals
Re: Oversight of Safe Staffing in Hospitals (T2019-4485)

My name is Mark Hannay and I am Director of Metro New York Health Care for All, a citywide coalition of community groups and labor unions that advocates for universal health care and strategic steps toward that goal. The New York State Nurses Association has long been a member of our coalition's Steering Committee.

We strongly support the establishment of staffing ratios for nurses in all hospitals and nursing homes through legislation, regulation, and/or negotiated contracts between employers and their workers' unions, especially in our city's public hospital system and in other in-patient facilities with whom the City may contract. We are pleased to learn that the Council is poised to support Safe Staffing and Quality Care Act (S.1032/Rivera, A.2954/Gunther) now before the New York State Legislature, and we support the Council's adoption of Resolution 396 introduced by Councilmember Cabrera.

Our coalition's core mission is having the city, state, and federal government, either individually or collectively, assure health care for all New Yorkers, ideally through a universal public program for all residents. However, even once comprehensive insurance coverage is in place, that does not necessarily mean that needed services are available in one's community, nor that quality services are provided.

One of the key factors in assuring timely access to quality hospital care is appropriate levels of clinical staff appropriate to a given department. Proper staffing also saves money for our overall health care system, and prevents additional and unnecessary morbidity and mortality for individual patients, additional stress and burdens for their informal family caregivers, and protects the public's health.

While the oversight of our city's hospitals and nursing homes primarily lies with state government, local City government also has a leadership role to play. It can set proper standards for our city's public hospitals and use them as a prime example that the standards proposed by the Safe Staffing and Quality Care Act are feasible, economic, and effective. Further, it can require all health care facilities it contracts with to also adhere to the bill's standards, since not all New Yorkers receive services solely from public hospitals.

Thank you for the opportunity for us to speak with you about this matter, and we thank you for the Council and your Committee taking up this issue and your leadership on it.

Testimony of Mario Henry
Oversight – Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019

Chairman Rivera, Members of the Committee on Hospitals, Council Members:

I am a senior citizen, a member of New York State Wide Senior Action Council, and for these reasons a supporter of amending Resolution 396. Senior citizens by the very nature of their age spend more time in medical facilities. Seniors are at greater risk for more frequent and more severe adverse reactions to medications. Seniors are at greater risk of contracting pneumonia. They are at greater risk of getting pressure sores. They are at greater risk of falls and fractured bones.

They, more than any other age group need adequate numbers of nurses present to monitor their conditions and alert Physicians Assistants and Doctors to problems in a timely fashion. The periodic visit by a Doctor or Physician's Assistant will not be enough to assure a timely response to an unanticipated change in a medical condition. By the time a Doctor or Physician's Assistant see a problem the senior might very well be dead. Nurses are the first line of defense for patients and sometimes the difference between life and death.

Senior citizens have a right to know that in their so called golden years they will received proper care in a timely manner. Seniors have a right to know that when they are most vulnerable they will not be neglected.

The New York State Nurses Association has shown, based on publicly available documents, that the additional cost of adequately staffing medical facilities is not prohibitive. The cost of adequately staffing would be only 1.25 % of the total revenues of the New York State hospitals and only 6.25 % of the money hospitals spend on none patient care. I do not think that is too much to ask to avoid neglecting our senior citizens when they are most vulnerable.

Testimony of Alizia McMeyers , RN
Oversight – Intro. 396 - Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019

My name is Alizia McMyers, I would like to thank committee chair Carlina Rivera as well as Councilmembers Cabrera and Salamanca for their work on Resolution 396. I'm testifying in support of Resolution 396 with amendments.

For the past 27 years, I have worked as a registered professional nurse. 22 of those 27 years have been spent at H+H Harlem Hospital. I have risen through the ranks from staff nurse, nursing supervisor, and now I am an accountable care manager. My background specializes in critical care and emergency services. I have been on the front line as a direct care provider. I am knowledgeable about the challenges many direct care RNs face. I am also the NYSNA membership chairperson at H+H Harlem. I have the distinct privilege of welcoming and orienting all newly hired RNs to H+H Harlem as a NYSNA member. I tell them about the advantages of being an H+H nurse. I tell them that their experience here will take them anywhere. I tell the nurses that this line of work is a labor of love and it can be extremely rewarding.

I want to relay the recurring story of some of our new nurses. The cardiac care unit is a 6 bed critical care unit. This unit is utilized for patients with severe heart conditions. They all require continuous heart and rhythm monitoring. Some patients may require breathing tubes with machines breathing for them. Some require tubes to pass urine from their kidneys. Most patients require complex medications to control and or regulate their blood pressure or blood sugar that can only be given via an IV pump while being monitored continuously. There are times when a patient has a critical procedure being performed hourly such as filtering their blood and urine or cooling down a body after their heart has stopped and been revived. Critical patients are admitted into critical care units because they need intensive care and monitoring.

This same cardiac care unit hired 3 new nurses within the past year. 1 of the nurses came to me within 4 months and expressed her concern about staffing and working short. She resigned. What could I say? I try to tell new nurses that we are striving for better outcomes. The second nurse came to me 4 months after the 1st nurse resigned and stated that she too was going to resign. She also expressed concerns about working from 7:30 am until 9pm or 10pm at night in order to document. She expressed her frustrations openly to me. As a new person how would she take care of 1 – 3 patients? I actually convinced her to stay for another month. She too felt overwhelmed, underappreciated, and too stressed to continue this pattern. She resigned as well.

I am the membership chairperson at my institution. I orient members to the facility as a union member in NYSNA. I also consistently speak to seasoned members within the facility. I have never heard so many nurses talk about how difficult it is to provide the quality of care our patients deserve. Nurses are tired of working in all the critical areas with 1-4 patients each. In the Cardiac unit a nurse may find herself alone for 11.5 hours without a bathroom or meal break. What do I tell them, it will get better? This is truly a labor of love. We need the City of NY to express that same labor of love to the nurses, direct care professionals and the patients we care for.

That is why I support and encourage the implementation of the amended version of Resolution 396 which includes nurses and all direct care staff.

Testimony of Ari Moma, RN
Oversight – Intro. 396 - Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019

Good Afternoon. My name is Ari Moma. I have been working as a registered nurse in the Department of Psychiatry at Interfaith Hospital in Brooklyn for 23years.

Thank you to the Chair Carlina Rivera for highlighting this very important issue. I am testifying in support of an amended Resolution 396 and support of Bill 1352.

Interfaith is a safety net hospital caring for vulnerable New Yorkers. There was a report on Health Disparities in NYC published by the NYC Department of Health and Mental Hygiene. According to this report Mental Health problems are, generally, more common among the poor in Brooklyn.

For example, those with lowest income levels are 2 to 6 times more likely to experience serious emotional distress than those with the highest incomes.

The “Safe Staffing for Quality Care Act" ensures that all acute care facilities and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff.
This would greatly impact our Emergency Department where many of our inpatient population are forced to wait for a bed to become available.

When psychiatric patients are forced to wait in the ED it becomes unmanageable. Many patients have behaviors related with their mental health. Giving patients the appropriate attention is difficult. It is an ongoing safety concern for nurses and direct care providers.

I support Bill 1352 for a local law in relation to conducting a study by the department of health and mental hygiene on the causes of rising wait times in emergency rooms. I believe the shortage on staffing has an impact on wait times.

In 2004 California passed their staffing law which required hospitals to institute minimum nurse to patient ratios where studies have shown that nurses in California have reported improved patient care outcomes and lower workplace injury rates. Workplace injuries on a Psychiatric unit are common and enhance the issue of nurse shortages.

We need appropriate staffing levels for all direct care staff to ensure the safety of everyone on the Psych unit. Our patient population need and deserve the addition.

What I spend my time doing for my patients differ depending on staff levels. We are usually short staffed and it is our patients that suffer. We are unable to give them the time and attention to detail that they require.

I support and encourage the implementation of an amended version of Resolution 396 which includes all direct care staff ratios.

Testimony of Judy Sheridan Gonzales, RN
President, NYSNA Board of Directors
Oversight – Intro 396 - Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019 1:00PM

Good Afternoon esteemed council members, speakers and observers.

My name is Judy Sheridan-González, president of NY State Nurses Association and an ER nurse for over 35 years in the Bronx, the county with the worst health indices in NY State. Thus my concerns are viscerally linked to my everyday experiences in caring for my community.

NYSNA's support for Resolution 396 (with the suggested amendments) is built upon several planes: **clinical, moral and financial.**

CLINICAL
Countless reputable scientific studies, anecdotal reports--and common sense--informs us that patient outcomes, recovery and lives improve qualitatively and quantitatively when safe staffing levels are ensured. A recent study, reported in Crains, evaluated 100,000 patients from 2007-2012. The Columbia University researchers found that the risk for infection was **15% higher in areas understaffed** on all shifts.

Weakened by illness, trauma or surgery, patients can easily succumb to such infections—and die from sepsis and system failure as a result. Medical errors are the third leading cause of mortality in the United States with over **400,000 deaths** reported annually—and many unreported. RNs are single most effective mitigator of such errors—when we have enough staff (and therefore time, energy and support to fully evaluate potential complications and errors).

So when we speak of safe staffing, we're not talking about a backrub, we're talking about saving lives—perhaps the life of a member of your own family.

MORAL
Wealthy, well-insured patients are cared for in facilities and special so-called "amenities" units, wherein adequate staff *is* provided., with superior outcomes. Poor patients in the same facility, but with reduced staff, suffer worse outcomes. Staffing legislation would *level the playing field*—remanding all hospitals to uphold the same standard via minimum nurse-patient ratios.

Safety net hospitals struggle to counter these obstacles, yetsome perform surprisingly well. The Leapfrog Group reported in 2016 that the five NYC facilities with the highest ratings were in H & H, which also serves a disproportionate number of uninsured, provides most mental health and trauma care and serves as first responder and key promoter of the Public's Health.

FINANCIAL
The myth of unspeakable costs associated with safe staffing is countered by multiple longitudinal studies. A Dall study, published in *Medical Care*, estimated that adding 133,000 RNs to the U.S. workforce—the number needed to achieve the 75th percentile—would produce savings of $6.1 billion.

Locally, H & H is far more cost-effective than the private hospitals--if analyzed comprehensively. Hidden costs, built upon the co-dependency of the two structures, wherein NYC funds contracted services and pays indirect subsidies to private systems--as well as provides hundreds of millions in tax exemptions to them. Such data is elaborated in a 2017 White Paper by renowned researchers Barbara Caress and James Parrott.

Safe staffing legislation, on any government level, would assist in creating a common ground from which to evaluate the two systems' efficiencies and functioning, in addition to providing higher quality care across the board.

IN CONCLUSION
The passage of amended Resolution 396 will be one critical step in beginning to address the health care crisis that plagues our communities and burns out compassionate caregivers who only want to do one thing: give the best that we can to our most vulnerable communities.

THANK YOU.

Testimony of Pat James, RN

Oversight- Intro. 396 - Safe Staffing Ratios in Hospitals

Council Chambers - City Hall

June 24, 2019

Good Afternoon. My name is Patricia James, I am an RN, at Kings County Hospital for 35 years in the Maternal / Child Unit. I serve as Vice-President of the Executive Council of H+H and Mayorals and as VP of the Local Bargaining Unit.

Thank you to Hospitals Committee Chair Carlina Rivera for holding today's hearing on the critical issue of safe staffing. I am testifying in support of an amended Resolution 396 and support of Resolution 723.

In my specific area of work safe staffing is key to the well-being of mothers and families and to all aspects of child birth. The optimum staffing level in this setting is one nurse for three mothers and three babies, which accounts for a total of six patients. Presently, in some cases there are five or six mothers and babies totaling ten to twelve patients per nurse, which is not advisable for best practice of quality healthcare.

A critical aspect to all, is the serious increase in maternal and infant mortality rates. We need safe staffing that protects patients and save lives. Safe staffing saves lives. Also of importance is the need for direct care staff to assist mothers and babies at the bedside particularly in cases after a undergoing a C-section. Direct care professionals help moms lift babies and provide other necessary aide in the beginning days of motherhood.

NYC H&H is striving to be the premier mother/baby friendly Health system and Safe Staffing helps us to get closer to our primary goal of creating a safe environment of overall health, including: mother and family education such as breast feeding and components that create a baby friendly environment.

We need safe staffing to ensure the best possible health care and outcomes for our patients. Evidence has shown that adequate staffing is the correct number of nurses scheduled for the number of patients, based on area of specialization and acuity. This leads to better outcomes for patients and our community, including lower mortality rates, fewer readmissions, fewer incidents of harm occurring while in the hospital and better quality of care.

Safe staffing is also better for nurses and the hospitals, because it causes (1) Better revenue earnings (2) Higher HCAPHS scores, how patients rate the care they receive (3) Good Patient satisfaction (4) Good Staff outcomes, with less stress and burnout and (5) Better staff retention. But the most important thing is that safe staffing saves lives.

Safe staffing of nurses and direct care professionals lends itself to more patient education, which may lead to good self-management of chronic conditions, decreased emergency room visits, increased compliance to clinic appointments and adherence to taking their medications, required diets, exercise and rest. These can all lead to a better quality of life and a healthier community and may play a crucial role in decreasing maternal mortality.

That's why I support Resolution 396 which includes nurses and direct care providers.
Thank you.

Testimony re: Safe Staffing to NYC Council Committee on Hospitals

My name is Mark Hannay and I am Director of Metro New York Health Care for All, a citywide coalition of community groups and labor unions that advocates for universal health care and strategic steps toward that goal. The New York State Nurses Association has long been a member of our coalition's Steering Committee.

We strongly support the establishment of staffing ratios for nurses in all hospitals and nursing homes through legislation, regulation, and/or negotiated contracts between employers and their workers' unions, especially in our city's public hospital system and in other in-patient facilities with whom the City may contract. We are pleased to learn that the Council is poised to support Safe Staffing and Quality Care Act (S.1032/Rivera, A.2954/Gunther) now before the New York State Legislature, and we support the Council's adoption of Resolution 396 introduced by Councilmember Cabrera.

Our coalition's core mission is having the city, state, and federal government, either individually or collectively, assure health care for all New Yorkers, ideally through a universal public program for all residents. However, even once comprehensive insurance coverage is in place, that does not necessarily mean that needed services are available in one's community, nor that quality services are provided.

One of the key factors in assuring timely access to quality hospital care is appropriate levels of clinical staff appropriate to a given department. Proper staffing also saves money for our overall health care system, and prevents additional and unnecessary morbidity and mortality for individual patients, additional stress and burdens for their informal family caregivers, and protects the public's health.

While the oversight of our city's hospitals and nursing homes primarily lies with state government, local City government also has a leadership role to play. It can set proper standards for our city's public hospitals and use them as a prime example that the standards proposed by the Safe Staffing and Quality Care Act are feasible, economic, and effective. Further, it can require all health care facilities it contracts with to also adhere to the bill's standards, since not all New Yorkers receive services solely from public hospitals.

Thank you for the opportunity for us to speak with you about this matter, and we thank you for the Council and your Committee taking up this issue and your leadership on it.

DRAFT

Testimony of Jalisa Saud, RN

Oversight – Intro. 396 - Safe Staffing ratios in Hospitals

Council Chambers-City Hall

June 24, 2019

Good Afternoon. My name is Jalisa Saud. I am a nurse practitioner, a health professional for 16 years. Eleven of those years were spent as a RN in the Pediatric Department at Elmhurst Hospital in Queens.

Thank you Chair Carlina Rivera as well Councilmembers Cabrera and Salamanca for today's hearing and for their important work on this issue that greatly impacts New York City patients. I am testifying in support of an amended Resolution 396 and support of Resolution 723.

When I worked as a Pediatric Nurse caring for our most vulnerable population, our patients ranged from 7 days old to 17 years old. They all had different needs and concerns related to their health. We need time to inform and educate parents. Primary prevention visits should be 30 minutes. Our patient load is so great the most time we can spend with each patient is 15 minutes. Each patient then feels rushed after a long wait. We see 20-24 patients in a 7 hour shift.

Nurses working in the Emergency Department care for 12-13 patients at a time. The Pediatric ED patients have to be moved to the Peds Clinic for triage. This practice became so common, that we were forced to set up our own triage space in the pediatric clinic. I remember in the middle of flu season there was a school bus accident full of patients we had to triage. When we triage emergency patients, patients who were previously in the clinic are forced to wait even longer. During this time I worked 13 hour shifts for three days.

The “Safe Staffing for Quality Care Act," ensures that acute care facilities and nursing homes meet appropriate minimum staffing ratios for nurses and direct care staff, and that the New York City Council commits to pursuing the implementation of minimum safe staffing ratios and standards in the NYC Health & Hospitals system and in all other acute care hospitals and nursing homes that receive funding from or contract to provide patient care services for the City of New York.

Safe staffing give new parents time for education, gives parents time to learn how to care for sick children. Babies cannot speak or advocate for their own needs improper parental care can lead to death and/illness. We are not begging for money. We are begging to save lives. Sometimes I go home feeling helpless thinking did I do a good job? There will always be excuses for the staffing shortage and we must mandate safe staffing for the safety of all New York City patients.

That’s why I strongly support and encourage the implementation of an amended version of Resolution 396 which includes all direct care staff ratios. I also support Resolution 723.

Testimony of Mario Henry
Oversight – Safe Staffing ratios in Hospitals
Council Chambers-City Hall
June 24, 2019

Chairman Rivera, Members of the Committee on Hospitals, Council Members:

I am a senior citizen, a member of New York State Wide Senior Action Council, and for these reasons a supporter of Resolution 396 with amendments. Senior citizens by the very nature of their age spend more time in medical facilities.

Seniors are at greater risk for more frequent and more severe adverse reactions to medications. Seniors are at greater risk of contracting pneumonia. They are at greater risk of getting pressure sores. They are at greater risk of falls and fractured bones.

They, more than any other age group need adequate numbers of nurses and direct care providers present to monitor their conditions and alert Physicians Assistants and Doctors to problems in a timely fashion. The periodic visit by a Doctor or Physician's Assistant will not be enough to assure a timely response to an unanticipated change in a medical condition. By the time a Doctor or Physician's Assistant see a problem the senior might very well be dead. Nurses are the first line of defense for patients and sometimes the difference between life and death.

Senior citizens have a right to know that in their so called golden years they will received proper care in a timely manner. Seniors have a right to know that when they are most vulnerable they will not be neglected.

The New York State Nurses Association has shown, based on publicly available documents, that the additional cost of adequately staffing medical facilities is not prohibitive. The cost of adequately staffing would be only 1.25 % of the total revenues of the New York State hospitals and only 6.25 % of the money hospitals spend on none patient care.

I do not think that is too much to ask to avoid neglecting our senior citizens when they are most vulnerable.

Testimony of Patricia Kane, RN

Treasurer, NYSNA Board of Directors

Oversight – Intro 396 - Safe Staffing ratios in Hospitals

Council Chambers-City Hall

June 24, 2019

Thank you for your attention to this very important issue, because safe staffing saves lives... and if we all work together we can bring a higher standard of care to all New Yorkers.. and save lives.

My name is Pat Kane and I am treasurer of the New York State Nurses Association. We are the oldest association and union of nurses in the nation. I am here today speaking in support of the amended Resolution 396.

I have worked at Staten Island University Hospital for 20 years.. most recently in the Operating Room.

Just recently, Columbia released a study that supported safe staffing: the finding was that there is an increase of 15% in infection rate at hospitals linked to nurse staffing. That is a very substantial finding. We know from other peer reviewed studies that patient death rates are tied to nurse staffing.

With minimum nurse-to-patient ratios we can save lives.

And we can keep experienced nurses on the job. That's how important staffing is to our members.

What makes this city great is our commitment to equality.

Having a single standard of safe RN staffing ratios is ultimately about equality... equality of care in acute hospitals.. public and private... so that ALL patients receive care from their bedside nurses, working the front lines of care, that is the same.

What indicator of equality could be more meaningful? A care ratio linked to mortality rates!

But today, unfortunately, this fundamental equalizer of care governing the lives of New Yorkers, is out of whack.

We must work together to change that.

And so we ask for your support of a resolution put forward today so that the legislature and governor will hear your voice.

The voice of the New York City Council can be heard not just in Albany, but throughout the country, that is how important is the role is of the New York City Council.

With a vote for this resolution you stand for equality.. fundamental equality... so that every New Yorker, no matter his or her stature, wealth or position, will receive proper care from hospital nurses working according to professionally-supported minimum nurse-to-patient ratios in all our hospitals.

Thank you, again, for the opportunity to come before you.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Testimony of Carol Lynn Esposito, Ed.D., JD, MS, RN-BC, NPD

Director of Nursing Education and Practice

New York State Nurses Association

In Support of Amended Intro 396 - Safe Staffing ratios in Hospitals

Council Chambers-City Hall

June 24, 2019

I am Dr. Carol Lynn Esposito. I am currently employed as the Director of Nursing Education, Practice and Research at the New York State Nurses Association. In that role, I conduct independent studies into the RN staffing levels in the 165 public and private sector hospitals and nursing homes around the state in which NYSNA represents nurses for collective bargaining purposes.

Our overarching finding is that only 2 percent of those hospitals and nursing homes currently meet the proposed staffing requirements denoted in the Safe Staffing for Quality Care Act, and, additionally, only 4 percent meet contractually agreed-to staffing requirements. NYSNA has found through its independent studies, through information received in negotiations hospital and nursing home employers, and through review of RN Protest of Assignment Forms filed by nurses in their workplaces that health care facilities consistently, deliberately and consciously understaff their patient care units, refrain from filling budgeted positions, and routinely post schedules with known “holes” in staffing levels.

Presently, I'm sure you are all cognizant of the fact that hospitals and nursing homes in New York are generally required by current State law and regulation only to have “sufficient" staffing levels necessary to meet patient care needs, with no specified ratios or other concrete standards required,[i] though there are some mandatory minimum staffing standards in place for nurses or other care givers in specific clinical settings or types of hospital units.[ii]

Federal requirements regarding nurse staffing in hospitals and nursing homes are similarly lacking in concrete standards, requiring only that the facility provide sufficient staffing to meet the care needs of hospital patients[iii] and nursing home residents.[iv]

The lack of specific staffing standards specified in state and federal regulations comes despite voluminous research, much of it funded and/or conducted by the federal Centers for Medicare and Medicaid Services, showing that the quality of care and negative patient outcomes increase when nurses and other caregivers are assigned too many patients to care for.

For example, an internal 2001 CMS study of nursing home staffing and its impact on patient care identified three staffing thresholds below which the quality of care of nursing home patients was found to suffer. The study concluded that a minimum staffing threshold of 0.75 hours per resident day (45 minutes) for RNs, 0.55 hours per resident day for licensed vocational or practical nurses (LPNs/LVNs), 2.8 hours per resident day (2 hours, 48 minutes) for nursing aides/assistants (CNAs), for a total of 4.1 hours per resident day (4 hours, 6 minutes) of total nursing care was minimally required to avoid the most drastic patient outcomes.[v] Furthermore, according to more recent data from the federal Centers for Medicare and Medicaid Services, only 49 of the 619 nursing homes in New York State — or 8 percent — now meet the staffing requirements recommended in the CMS study. These studies indicate that from 2004 to the present day, 92 to 98 percent of our state's nursing homes staff at levels where the quality of care for long-stay residents was shown to result in adverse and negative patient outcomes.[vi]

The relationships between staffing levels and quality of care have been studied empirically, with findings from numerous research studies over many decades. Over the past 25 years, numerous research studies have documented the important relationship between nurse staffing levels, particularly RN staffing, and the outcomes of patient care.

The benefits of higher staffing levels, especially RN staffing in *acute care facilities,* can include a reduction in patient deaths as evidenced by a research study published in the *Journal of the American Medical Association (JAMA)* that concluded that an estimated five additional deaths per one thousand patients will occur in hospitals that routinely staff with a 1:8 nurse to patient ratio compared to those staffing with a 1:4 nurse to patient ratio, and that the odds of patient death will be increased by 7% for each additional patient the nurse must care for at one time. Similarly, a study conducted in 2015 by Dr. Linda Aiken and published in the *International Journal of Nursing Studies* concluded that each additional patient per nurse was associated with a 5% increase in the

odds of patient death within 30 days of admission, and the odds of patient mortality are 50% lower in hospitals with better nurse work environments. In a third study conducted by Dr. Peberdy and published in *JAMA*, the researcher found that poor night shift staffing resulted in a 20% higher risk of death from cardiac arrest.

The benefits of higher staffing levels, in long-term care facilities, include lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, fewer catheterized residents, fewer urinary tract infections; lower hospitalization rates; and less weight loss and dehydration.

To explore the relationship between exposure to understaffed shifts and nurse-sensitive outcomes at the patient level, a study was conducted in 2014 by Dr. Diane Twig and was a secondary analysis of administrative data from a large acute care hospital in Western Australia. The sample included 36,529 patient admissions over a two-year period from October 2004–November 2006. Results of the study showed strong associations between low nurse staffing and increased surgical wound infection, urinary tract infection, pressure injuries, pneumonia, deep vein thrombosis, upper gastrointestinal bleed, sepsis, and physiological metabolic derangement. Other research studies show a strong correlation between low nurse staffing and increased patient falls, medication errors, shock, congestive heart failure, cardiac arrests, unit acquired pressure ulcers, central line blood infections, lengths of stay, and negative patient satisfaction scores.

In a study published in 2011 in the *New England Journal of Medicine*, Dr. Jack Needleman found that risk of patient death increased 4% for each high-turnover shift to which a patient was exposed, and Dr. Matthew McHugh published research studies in 2013 that found that hospitals with higher nurse staffing had 25% lower odds of being penalized under the ACAs Hospital Readmission Reduction Program compared to otherwise similar hospitals with lower staffing, and that the consequences of low nurse staffing resulted in a 7% readmission rate for heart failure patients, a 9% readmission rate for myocardial infarction patients, and a 6% readmission rate for pneumonia patients for each additional patient added to a nurse's assignment. And Dr. Stone reported in her research article published in the journal *Medical Care* that higher RN staffing levels were associated with a 68 percent less likelihood for a patient to acquire any kind of infection. Dr. Weisman reported in that same journal that a 10% increase in the number of patients assigned to a nurse leads to a 28% increase in adverse events overall.

In a study published by the AHRQ, Dr. Kane found that for every additional patient assigned to an RN, there is an associated 7% increased of hospital-acquired pneumonia, a 53% increase in respiratory failure, and a 17% increase in medical complications.

Other research studies by Drs. Encinosa and Hellinger have shown a correlation between higher nurse staffing and lower operating costs of the healthcare providers. For example, a study published in the journal *Health Services Research* found that the large difference in calculations for medical error expenses might mean that interventions to increase patient safety - like adding more nursing staff - was more than cost effective. The study found that insurers paid an additional $28,218 (52 percent more) and an additional $19,480 (48 percent more) for surgery patients who experienced acute respiratory failure or post-operative infections, respectively, compared with patients who did not experience either error. The researchers concluded that preventing these and other preventable medical errors by investing in more nurses would reduce loss of life and could reduce healthcare costs by as much as 30 percent.

Similarly, in a study conducted by Dr. Mark and published in the *Journal of Healthcare Finance*, the researcher found that increased staffing of RNs does not significantly reduce a hospital's profit margins, even if it does boost the hospital's operating costs. Indeed, the National Institute of Health and other researchers have reported significant savings are reaped from the reduction in recruitment and retention of RN staff who suffer from burnout, lowered patient lengths of stay, reduced legal and malpractice costs resulting from avoidable patient injuries, increased staff productivity due to increased staff satisfaction scores and lowered workplace injuries and fatigue, and increased hospital reimbursements due to increased patient satisfaction scores and hospital quality ratings.

For these, and many other reported reasons rooted in sound research studies[vii], it is imperative that hospitals and long-term care facilities in New York City and across the state ensure adequate nursing coverage for all patients. Nurses are the vanguard of public health, and improving the quality of care in NY's acute care hospitals and nursing homes by instituting mandated nurse to patient ratios would not only facilitate nursing's social and ethical imperatives of patient autonomy, justice, equal access to healthcare, it would also ensure the health and ultimate productivity of our state's and our nation's populace.

Accordingly, we ask the NYC Council to call upon the NYS legislature to pass, and the governor to enact, the Safe Staffing for Quality Care Act[viii] and thus ensure that all acute care

facilities and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff.

We further ask that the City of New York to consider pursuing similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from, or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

The council should enact amended Resolution No. 396.

[i] 10 N.Y.C.R.R. Section 405.5 requires the following general staffing and patient care standards that are applicable in all hospitals:

- There shall be a director of nursing services who is a licensed RN;
- RNs, LPNs and other personnel shall be employed in sufficient numbers "to provide nursing care to all patients as needed;"
- Supervisory and staff personnel shall be provided "for each department or nursing unit to ensure, when needed in accordance with generally accepted standards of nursing practice, the immediate availability of a registered professional nurse for bedside care of any patient;"
- The nursing service shall "monitor and evaluate the quality and appropriateness of patient care and the resolution of identified problems."

It is readily apparent that these staffing standards leave almost total discretion to the hospital management to determine what it considers to be the level of nursing care needed by its patients and what it means to have a registered professional nurse immediately available for the bedside care of any patient. This purely subject standards leads to wide variations in the level of nursing and other caregiver personnel available within hospital units, shifts and time periods. It also leads to wide variations in the level of care received in different hospitals and communities. This immediately poses serious questions. Is it fair or justified for patients with similar diagnoses and needs within a hospital or in different hospitals or communities to receive higher levels of care than others? What is the justification for stratified levels of care, beyond sheer luck, availability of more resources or ability of the patient to pay?

[ii] Examples of types of units or services for which concrete minimum nurse staffing are established under state law and regulations include the following:

- 10 N.Y.C.R.R. Section 405.22(b) requires pediatric intensive care units to maintain one in-house physician on a 24/7 basis, a qualified physician, physician assistant or nurse practitioner assigned to the unit on a 24/7 basis, an attending physician exercising oversight of the unit, and that the hospital "shall provide registered professional nursing staff sufficient to meet critically ill or injured pediatric patient needs, ensure patient safety and provide quality care;"
- 10 N.Y.C.R.R. Section 405.22(d) establishes minimum nurse-to-patient ratios for burn units, requiring one registered nurse for every two intensive care burn patients at all times and one registered nurse for every three non-intensive care burn patients at all times;
- 10 N.Y.C.R.R. Section 405.31(p)(5) establishes minimum nurse-to-patient ratios for liver transplantation services, requiring one registered nurse for every two ICU/PACU patients and one registered nurse for every four non-ICU/PACU patients;
- 10 N.Y.C.R.R. Section 405.19(d)(2) establishes minimum nurse staffing levels in emergency services facilities which require one supervising RN to be present on the unit on a 24 hour basis and additional registered nurses depending

on the average volume of patients, with at least 1 RN if the average ER census is 25 or less, an additional RN if the average census is more than 25, and "as patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet patient care needs;"

- 10 N.Y.C.R.R. Section 405.18(d) requires that spinal cord injury programs have at least one registered nurse available and assigned to the unit at all times;
- 10 N.Y.C.R.R. Section 405.21 requires that perinatal services units that each maternity patient "when present in a labor, delivery, birthing room or birthing center shall be under the care of a registered professional nurse available in accordance with the patient's needs" (See also: 10 N.Y.C.R.R. Section 721.7, which requires that nursing care for all mothers and newborns be supervised by a registered nurse and that "assessment and monitoring activities shall remain the responsibility of a registered nurse or advanced practice nurse in obstetric-neonatal nursing, even when personnel with a mixture of skills are used;"
- 10 N.Y.C.R.R. Section 405.12 requires the operating room shall be supervised by a registered professional nurse or physician, that nursing personnel "shall be on duty in sufficient number for the surgical suite in accordance with the needs of patients and the complexity of services they are to receive," and that a registered nurse be present as the circulating nurse in all operating rooms where surgery is being performed for the duration of the surgical procedure.

Outside of these specific units or settings, the general, non-specific criterion of having enough nurses and other staff to meet patient care needs set forth in footnote 1 supra is the only applicable standard.

[iii] Pursuant to 42 CFR § 482.23, in order for hospitals to qualify for and receive payment from CMS under the Medicare and Medicaid programs, only the following general, non-specific nursing standards must be complied with:

"The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

(a) *Standard: Organization.* The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.
(b) *Standard: Staffing and delivery of care.* The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

(1) The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under § 488.54(c) of this chapter.
(2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.
(3) A registered nurse must supervise and evaluate the nursing care for each patient.
(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.
(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service."

[iv] Pursuant to 42 CFR § 483.35 Nursing services, long term care facilities (nursing homes) must meet the following requirements to participate in Medicare and Medicaid programs:

"The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).

(a) *Sufficient staff.*

(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

(b) *Registered nurse.*

(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents……

(g) *Nurse staffing information* -

(1) *Data requirements.* The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) *Posting requirements.*

(i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater."

[v] U.S. Centers for Medicare and Medicaid Services, Abt Associates Inc . Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final. Volumes I–III. Baltimore, MD: CMS; 2001

[vi] Office of the Attorney General Medicaid Fraud Control Unit. (2006). Staffing Levels in New York Nursing Homes: Important Information for Making Choices. Retrieved from http://ag.ny.gov/sites/default/files/press-releases/archived/final.pdf.

[vii] See the following additional studies relating to the effect of staffing on patient care, nurse productivity and working conditions and hospital financial performance:

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Linda H. Aiken, PhD, RN; Sean P. Clarke, PhD, RN; Douglas M. Sloane, PhD; Julie Sochalski, PhD, RN; Jeffrey H. Silber, MD, PhD; *JAMA.* 2002; 288(16):1987-1993, available at: https://jamanetwork.com/journals/jama/fullarticle/195438?version=meter%20at%20null&module=meter-links&pgtype=article&contentId=&mediaId=&referrer=&priority=true&action=click&contentCollection=meter-links-click

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[viii] NYS Legislature Bill No. A2954/S1032

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June 24, 2019

Dear Council Member Carlina Rivera, Chair, Hospitals Committee,

The Professional Staff Congress represents over 30,000 faculty and staff at the City University of New York (CUNY) and the CUNY Research Foundation and is a leading advocate for access to high quality health care for our members and the entire New York community.

The Professional Staff Congress supports passage of amended City Council Resolution 396 to protect patient quality of care in our hospitals and nursing homes and to ensure that patients and communities are all guaranteed minimum standards of care, regardless of where they live, their income, or their ability to pay for health services.

As amended, City Council Resolution 396 would call upon the State of New York to enact the "Safe Staffing for Quality Care Act" (A2954/S1032) which requires all acute care hospitals and nursing homes to meet minimum safe staffing ratios and standards for nurses and other direct care staff.

In addition, City Council Resolution 396 would also commit the City of New York to enact similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

Research shows that better nurse and other direct care staffing in hospitals and nursing homes greatly improves patient outcomes. The more patients that are assigned to nurses and other staff, the more likely it is that patients will die, that they will suffer from falls, be subject to hospital acquired infections or other serious health threats, be readmitted after being treated, suffer from pressure ulcers and other serious conditions, and receive poorer quality of care. When nurses and other direct care workers have too many patients, patients and our communities suffer.

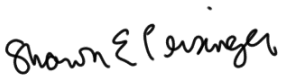
Research also shows that setting minimum ratios or other standards generates offsetting cost savings to hospitals, including lower rates of reimbursement penalties or unreimbursed services, lower lawsuit settlement costs, fewer on the job injuries resulting in lost work time and workers' compensation costs, higher worker morale and efficiency, lower worker turnover costs, and lower community costs for unnecessary or avoidable illness and complications.

Finally, we note that patients and communities served by NYC Health + Hospitals and other safety net providers are deserving of the same health care resources and access to quality care as more affluent patients. It is not right or fair that NYC Health + Hospitals,

which serves a disproportionately high share of communities of color, of the working poor, of immigrants, and of people with psychiatric and other chronic health conditions, should be starved of resources and struggling to provide high quality care on tight budgets. The council should act to ensure that all New Yorkers have equal access to high quality care and that our safety net hospitals and nursing homes have the resources to meet the needs of New Yorkers.

Accordingly, for these reasons, we support the amended version of Resolution 396.

Sincerely,



Sharon E. Persinger
Treasurer
Professional Staff Congress

New York City Council Committee on Hospitals

Hearing Testimony: “Safe staffing ratios in hospitals”

Lorraine Ryan, Senior Vice President, Legal, Regulatory, and Professional Affairs

Introduction

Chair Rivera, Council Members Levine, Ayala, Moya, Reynoso, Eugene, and Maisel, my name is Lorraine Ryan, Senior Vice President for Legal, Regulatory, and Professional Affairs at the Greater New York Hospital Association (GNYHA). GNYHA's members include every hospital in New York City (both public and not-for-profit) as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

Thank you for the opportunity to speak at this hearing. New York's hospitals, GNYHA, and I, as a nurse, have the deepest respect and admiration for our registered nurses (RNs), but we strongly oppose forced, inflexible nurse staffing ratios. The bill before the State Legislature (A.2954/S.1032) mandates unit-based ratios, at all times, in all hospitals and nursing homes in New York State.

My responsibilities at GNYHA include oversight of clinical quality improvement initiatives and programming. I can say without reservation that New York's health care providers are deeply committed to providing safe, high-quality care that leads to the best possible health outcomes. But no hospital or nursing home is exactly alike, and no single staffing formula works in every situation. Legislation mandating nurse staffing ratios belies the proven ability of hospitals and unions to agree on staffing plans on their own through good-faith contract negotiations, as was done earlier this year between several New York City hospitals and the New York State Nurses Association (NYSNA).

Forced nurse staffing ratios would crowd out other essential members of the health care team, undermine real-time patient care decisions, and deny hospitals the workforce flexibility they need to respond to emergencies. Health care delivery has never been more complex, and we have learned that the only way to ensure optimal outcomes of care is through a multidisciplinary approach that involves not only nurses and physicians, but also physical therapists, dieticians, clinical pharmacists, lab technicians, social workers, and others. Mandatory nurse staffing ratios that must be met at all times would force hospitals, many of which already operate with scarce resources, to eliminate these other team members, who are essential to delivering safe and effective care.

It would cost New York's hospitals and nursing homes a staggering $3 billion annually to comply with the nurse staffing ratios bill—money they don't have for a mandate they don't need. Many of these financially struggling institutions would be forced to reduce services, lay off staff, or even close their doors for good, impacting access to care for those with the most need. Our principal objections to this deeply misguided legislation are described below.

Quality Care Is About Teamwork

A high-performing health care team is widely recognized as an essential tool in the delivery of patient-centered, coordinated, effective health care.[1] In a 2019 evaluation by the Centers for Medicare & Medicaid Services (CMS), New York ranked second among all CMS Partnership for Patients contractors on reducing hospital-acquired conditions and readmissions.[2] This is because of New York hospitals'

[1] Mitchell, P, et al., "Core Principles and Values of Effective Team-Based Health Care," *Institute of Medicine of the National Academy of Sciences* (October 2012).
[2] Mathematica Policy Research, Program Evaluation Contractor, "Formative Feedback Report, Submitted to the Department of Health and Human Resources, Centers for Medicare & Medicaid Services" (April 2019).

multidisciplinary, team-based approach to health care delivery, which includes physicians, nurses, pharmacists, physical therapists, dieticians, environmental services workers and others. By working together, these teams have delivered tremendous results for patients. The 2017 New York State Department of Health *Hospital-Acquired Infections Reports* documents reductions ranging from 2% to 21% in surgical site infections, catheter-associated urinary tract infections, and Methicillin-resistant Staphylococcus aureas (MRSA). These improvements are the result of multidisciplinary teams of health care professionals working together to implement evidence-based best practices.[3]

Forced nurse staffing ratios will crowd out other essential members of the health care team and compromise high-quality patient care. That is one of the reasons the RN who chaired President Obama's National Health Care Workforce Commission called staffing ratios a "bankrupt idea."[4]

In November 2018, Massachusetts voters, by a resounding margin of 70% to 30%, rejected a ballot initiative to impose nurse staffing ratios on Massachusetts hospitals. They determined that nurse staffing ratios would be cost prohibitive, lead to hospital closures, eliminate high cost-service lines, increase wait times, reduce non-health care workforce staffing, and compromise access to care.

Leave Staffing Decisions to the Experts

Chief Nursing Officers (CNOs) and their experienced leadership teams are responsible for ensuring that appropriate staffing plans are in place on all units, and at all times, in their hospitals. Nurse staffing ratio legislation would eliminate that invaluable expertise and replace it with rigid, arbitrary staffing levels that must be maintained at all times, even during breaks, depriving these professionals of the flexibility necessary to respond, in real time, to the needs of their patients.

Hospitals and CNOs need the flexibility to prepare for and manage the unexpected—unplanned absences, natural disasters, power failures, other emergencies, etc.—and adjust staffing accordingly. Emergency situations brought on by weather, seasonally related disease onset (e.g., influenza), the recent uptick in emergency department (ED) visits caused by measles, and other emergency situations often require special units to isolate patients and prevent the spread of disease, as well as reassigning staff to deal with unique circumstances. Forced nurse staffing ratios would make it very difficult for hospital leaders to respond effectively to these situations.

Recent contract negotiations between NYSNA and several hospitals in New York City resulted in a commitment to maintain the number of nurses per unit, per shift via agreed-upon staffing plans. The ratified contracts also include a provision giving hospital nursing leadership and RN staff the flexibility to allocate patients among nurses according to their professional determination of appropriate patient care.

In addition to recognizing the need for flexibility in staffing, the hospitals and NYSNA agreed to fill vacant positions and hire additional RNs who will be included in staffing plans, resulting in an increase in

[3] New York State Department of Health, *Hospital Acquired Infections in New York State, 2017 Report, Summary for Consumers* (October 2018).
[4] Douglas, K., Kerfoot, K. M., "A Provocative Conversation with Peter Buerhaus," *Nursing Economics* (July-August 2011).

the nursing workforce at each hospital. With the input of RN staff, the additional nurses will be allocated as necessary by a drop or increase in patient census or acuity affecting patient and staffing needs.

These hospitals also agreed to create RN float pools to respond to sick calls, leaves of absence, and other unplanned staffing needs, retaining the flexibility for nursing leadership and RN staff to allocate patients among nurses according to their professional determination of appropriate patient care. The hospitals and NYSNA also agreed to the enforcement of staffing guidelines to address systemic failure to meet the guidelines, and use of a third-party mediator and dispute resolution procedures, when and if necessary.

Studies: Ratios Don't Improve Care

California is the only state in the nation that imposes forced RN staffing ratios on every unit of every hospital, but more than a decade after the law was implemented, there is no credible evidence that patient care has improved.

According to a 2013 study in *Medical Care and Research Review*, "California's minimum nurse-to-patient staffing regulations were intended to improve the quality of patient care, but to date there is only mixed evidence that they achieved this goal." The study concluded with a warning that "policy makers should tread cautiously as they consider new nurse staffing regulations."[5]

Even after more than a decade of nurse staffing ratios in California, several national databases show comparable hospital quality in New York and California, and some show New York hospitals performing better than California hospitals. A 2013 study describes the impact of the California law on patient level outcomes as mixed, and the findings suggest the positive impacts have not been as significant as predicted.[6] In 2015, Dave Regan, president of SEIU United Health Workers West in California, said ratios "have not improved patient care" and have "forced hospitals to downsize."[7] The bottom line: there is no reliable evidence that nurse staffing ratios improve patient care.

Earlier this year, the New York State Legislature charged the New York State Department of Health with conducting a study to ensure safe patient safety in hospitals and nursing homes. The study will examine how staffing enhancements and other initiatives can be used to improve patient safety and the quality of health care delivery, as well as their potential fiscal impact.

Ratios Will Cost Billions, Threaten Jobs, and Damage Labor Peace

It would cost New York's hospitals an estimated $2 billion annually, and nursing homes $1 billion annually, to comply with nurse staffing ratios. Hospitals would have no choice but to cut costs. Fewer positions would remain for non-RN members of the care team, and RNs would be forced to perform more and more non-clinical tasks ordinarily done by other care team members, such as transporting patients and administrative work. Many financially struggling institutions would have no choice but to cut non-RN positions.

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[5] Spetz, J., Harless, D.W., Herrera, C.N., Mark, B.A. "Using Minimum Nurse Staffing Regulations to Measure the Relationship between Nursing and Hospital Quality of Care" *Medical Care Research Review* (2013).
[6] Serratt, T., "California's Nurse-to-Patient Ratios, Part 3: Eight Years Later, What Do We Know about Patient Level Outcomes?" *The Journal of Nursing Administration* (November 2013)
[7] Goldberg, D., "Health Union Split Complicates Nurses Jobs Push" *Politico* (March 30, 2015).

That is exactly what happened in California. After forced nurse staffing ratios went into effect in 2004, significant tension between unions representing nurses and those representing other types of health care workers emerged, and non-nurses have feared the loss of jobs. Nurse staffing ratios will create tension in New York between and among caregivers who must work together to improve quality and reduce costs.

Ratios Would Increase ED Wait Times and Impact Access to Care

Compliance with forced 24/7 nurse staffing ratios would lead to increased wait times in EDs.[8] This could force hospitals to go on diversion for ED arrivals in the event of a mass casualty or other emergency involving a large number of people. The cost of complying with forced nurse staffing ratios could preclude hospitals from taking steps to reduce ED wait times such as hiring additional primary care doctors and specialty physicians, upgrading existing infrastructure, and investing in new or expanded facilities. This is particularly problematic because hospitals are currently working to reduce avoidable ED visits as part of the State's Delivery System Reform Incentive Payment (DSRIP) program. As part of DSRIP, hospitals collaborate with ambulatory care and other community-based providers to reduce avoidable hospital use and expand outpatient services. Forced nurse staffing ratios would threaten to undo the work that hospitals and other providers have already done to ensure that their communities have greater access to health care services in the most appropriate settings.

Staffing Rules Already Exist

Forced nurse staffing ratios are unnecessary because multiple staffing rules are already in effect. New York State regulations require the director of nursing services to develop a staffing plan, approved by the governing body, for determining the types and number of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. Federal authorities survey hospital staffing, and New York State law requires the disclosure of staffing plans and quality indicators—information that is available to anyone upon request.

Conclusion

Staffing levels are best made in real time by expert, experienced clinicians. This is also why the American Nurses Association and the American Organization of Nurse Executives oppose forced nurse staffing ratios.

For these reasons and many others, GNYHA strongly opposes forced nurse staffing ratio legislation. We remain committed to the well-being of all New Yorkers, and we stand ready to work with Governor Cuomo, the State Legislature, and the City Council to make sure that all health care workers provide the highest quality patient care possible.

I am happy to answer any questions you may have.

[8] Weichenthal, L., Hendey, G.W., "The Effect of Mandatory Nurse Ratios on Patient Care in an Emergency Department," *Administration of Emergency Medicine* (February 2009).

CONTINUING CARE LEADERSHIP COALITION CCLC

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Testimony of Scott Amrhein, President, Continuing Care Leadership Coalition
Concerning Proposed Resolution #396
June 24, 2019

Introduction

Good Afternoon. I am Scott Amrhein, President, Continuing Care Leadership Coalition (CCLC), which represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. Our members represent the full continuum of long term care services including skilled nursing care, home health care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. We appreciate the opportunity to offer testimony to the New York City Council on the implementation of staffing ratios in nursing homes and hospitals and our deep concern on the effects it will have on quality of care. While we oppose the bill – for reasons we will go into further – we align ourselves fully with what we believe is intended by the sponsors: ensuring that all who need care receive care that is safe, high-quality, and reflective of the needs and wishes of every patient.

KEY POINTS

- **Fixed staffing ratios undermine the ability of health care organizations to implement staffing plans based on specific care needs – especially in light of the diverse populations that nursing facilities serve.**

- **The Federal agency responsible for overseeing nursing home quality – CMS – rejected fixed staffing ratios as insufficiently flexible when updating its requirements for nursing homes participating in the Medicare and Medicaid programs.**

- **Within the new Federal Requirements of Participation, there now exists a National standard requiring nursing homes to develop and adhere to "Competency-Based Staffing Standards" – standards in place and applicable to all New York City nursing facilities. This is a better model, and one that should be given deference.**

- **Mandating staffing ratios would cost New York State nursing homes close to $1 billion to implement. This would be unsustainable and would accelerate the rate of closures and sales of not-for-profit nursing homes in NYS – with dire effects on care access and quality for New Yorkers.**

Inflexible Mandated Staffing Ratios Would Make it Impossible to Implement Staffing Plans that Meet the Needs of the Diverse Populations Served by Nursing Facilities in New York State

The proposed State legislation that is the subject of Resolution #396 would undermine the flexibility required in order to properly meet the needs of the wide range of populations served in New York's long term care organizations. Patient care decisions are influenced by a number of factors, including acuity of the patient, training of the nurses, and the availability of other health professionals and presence of certain technology. Because there are so many variables in staffing determinations, a key to a successful approach to nurse staffing must be flexibility. Requiring health care organizations to adhere to predetermined levels of nursing staff takes away their ability to operate efficiently and appropriately in light of their specific circumstances. In short, the so-called "Safe Staffing for Quality Care Act" would establish a "one size fits all" standard that is at odds with the diverse needs of New York's long term care patient population.

New York City's nursing facilities care for a wide variety of specialty populations including persons with dementia and mental illness, those requiring mechanical ventilation, those requiring special bariatric care, specialty wound care, IV therapy, palliative care, pediatric care, and many other special services. As a result, the care needs vary dramatically across nursing facilities. Because of these variations, there is no one "most appropriate" staffing configuration. To the contrary – what would be appropriate in one facility would be too little in a facility with more acutely ill patients – and it would be too much in another facility where the majority of patients require relatively lighter assistance in their activities of daily living. Having the ability to staff based on acuity level is essential to meet the daily needs of such a wide variety of patients.

The American Nurses Association (ANA) understands these varying demands and recognizes that effective staffing requires more than fixed, overly-prescribed staffing ratios – they require a flexible staffing model to address diverse care needs. In its *Principles for Nurse Staffing,* the ANA states:

> "*rigid staffing models fail to consider the hour-to-hour changes that are the norm in a patient care environment … the concern is that other variables that impact the need for nursing staff such as severity of patient condition, nursing skill level, skill mix of staff, and actual or projected change in the census are given little or no consideration in this type of staffing plan."*

The ANA, the largest and oldest nursing association, **does not** endorse fixed staffing ratios. It encourages a flexible care model that will be able to accommodate the varying needs of long term care patients and urges healthcare settings to instead consider the experience, expertise, and skill set of the a facility's staff.

The Federal Agency Responsible for Overseeing Nursing Home Quality – CMS – Rejected Fixed Staffing Ratios as Insufficiently Flexible When Updating its Requirements for Nursing Homes Participating in the Medicare and Medicaid Programs

In July of 2015, CMS introduced its proposed revision to the nursing home Conditions of Participation, the first step leading to the ultimate release (in October 2016) of a new set of Federal guidelines that nursing homes throughout the country must adhere to. The proposed regulation has pages of discussion covering the extensive deliberations that the agency undertook – including its review of the literature on optimal staffing and its consideration of how different approaches to ensuring appropriate staffing would fit with the realities of the care issues that nursing facilities deal with every day.

In the end, CMS rejected fixed ratios as too inflexible for application in the skilled nursing facility setting. In addressing the shortcomings of fixed staff ratios, the proposed rule stated:

> *"… we do not necessarily agree that imposing such a requirement is the best way to clarify what is "sufficient" to the exclusion of other factors that are important in improving the quality of care for each resident. We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and staffing abilities including professional characteristics, skill sets and staff mix."*

As a Result of CMS's Updating of the Nursing Home Requirements of Participation, There Now Exists a National Standard Requiring Nursing Homes to Develop and Adhere to "Competency-Based Staffing Standards" – Standards Already Applicable to All New York City Nursing Facilities

The final new nursing home Requirements of Participation (which officially went into effect on November 28, 2016) require that nursing homes develop facility-tailored staffing plans based on staff competency and education, and those staffing plans must be made available for public review, and evaluation by surveyors during annual inspections.

The final rule stated, in §483.35:

"The facility must have sufficient nursing staff with the appropriate competences and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individuals plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70."

The updating of the CMS requirements of participation (ROP's) is the largest change to nursing home standards and requirements since 1991. The overarching goal of the new rule is to focus on person-centered care, understanding the needs of the patients, and maintaining a diverse skill set of education and expertise across a facility's staff. Introducing a new State standard for staffing would conflict directly with the new Federal guidelines. Doing so would be incongruous with the new rule's person-centered care goals, and it would be out-of-step with the present realities of care delivery in nursing homes.

Mandating Staffing Ratios Would Cost New York State Nursing Homes Close to $1 Billion to Implement – Accelerating the Rate of Closures and Sales of Not-for-Profit Nursing Homes in NYS

The not-for-profit nursing homes that CCLC represents are quality pace-setters, delivering state-of-the-art care as measured by CMS's 5-star system. Fully 84% of our member facilities are 4 and 5-star facilities on measures of overall quality – and our members score at a 4 or 5-star level on measures of RN staffing at a rate that is 116% higher than that attained by other facilities in the State. If these facilities were not in the system, our State's quality ranking (compared to other States) would fall by 14 places.

What is especially concerning is that these very facilities – NYC's not-for-profits – are among the State's most financially vulnerable nursing homes. In the face of severe financial pressures (Statewide, nursing homes presently lose $64.00 a day on every Medicaid patient they serve) the State's high-quality not-for-profit nursing homes are closing or selling at a rate of more than one facility every two months.

This trend has been cited as a serious concern by the New York State Attorney General's Charites Bureau, which, in its 2018 report, "The Sale of Nonprofit Nursing Homes Pursuant to the Not-for-Profit Corporation Law," made the following back-to-back statements:

First, it emphasized, *"Research suggests that, on average, nonprofit nursing homes provide better care and achieve greater patient satisfaction than for-profit facilities."*

Then it went on to express, with concern, *"In New York, we have seen a significant increase in efforts to sell nonprofit nursing homes to for-profit entities since 2014. Within the past few years, about 5% of New York's nonprofit nursing homes were sold to for-profits annually."*

This trend is bad for access – and horrible for quality. If it continues it will fundamentally alter the range of care choices available to New Yorkers in their own communities.

One thing is assured: if the proposed staff ratio legislation is adopted – adding close to a billion in costs to the already unbalanced ledger of our State's nursing facilities – this trend of sales and closures will only accelerate, with devastating consequences for consumers and patients.

This legislation would do irreparable damage, and needs to be rejected.

CONCLUSION

Staffing ratio legislation was proposed approximately fifteen years ago in the New York State legislature. It is not appropriate or in alignment with the current healthcare realities in New York State. Safe staffing requires more than nurses, it requires a system of individuals who are committed to the care of those who are unable to care for themselves – a goal that can't be accomplished through a costly, inflexible standard that fails to account for the vast differences in every care setting.

I greatly appreciate the opportunity to provide these perspectives and recommendations. CCLC looks forward to working in partnership with the New York City Council in ensuring that essential long term care services remain strong and available to our State's older and disabled citizens as the demand for these services grows in the year ahead.

UN WOMEN NATIONAL COMMITTEE UNITED STATES
Metropolitan New York Chapter

June 21, 2019

Att: ebalkan@council.nyc.gov.

To the New York City Council:

The Metropolitan New York Chapter of the US National Committee for UN Women is an advocate for high quality health, respectful care for everyone in the community.

We support passage of amended City Council Resolution 396 to protect patient quality of care in our hospitals and nursing home, to ensure that patients and communities are all guaranteed minimum standards of care, regardless of where they live, their income or their ability to pay for health services.

As amended City Council Resolution 396 would call upon the State of New York to enact the "Safe Staffing for Quality Care Act" (A2954/S1032) which requires all acute care hospitals and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff.

In addition, City Council Resolution would also commit the City of New York to enact similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

Research shows that better nurse and other direct care staffing in hospitals and nursing homes greatly improve patient outcomes. The more patients that are assigned to nurses and other staff, the more likely it is that patients will die, that they will suffer from falls, be subject to hospital acquired infections or other serious health threats, be readmitted after being treated, suffer from pressure ulcers and other serious conditions, and receive poorer quality of care. When nurses and other direct care workers have too many patients, patients and our communities suffer.

Research also shows that setting minimum ratios or other standards generates offsetting cost savings to hospitals, including lower rates of reimbursement penalties or unreimbursed services, lower lawsuits settlement costs, fewer on the job injuries resulting in lost work time and worker comp costs, higher worker morale and efficiency, lower worker turnover costs, and lower community costs for unnecessary or avoidable illness and complications.

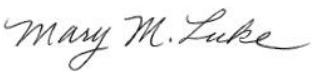
Finally, we note that patients and communities served by NYC Health + Hospitals and other safety net providers are deserving of the same health care resources and access to quality care as more affluent patients.

This is particularly important to the patients served by NYC Health + Hospitals. It is not right or fair that NYC Health + Hospitals, which serves a disproportionately high share of communities of color, of the working poor, of immigrants, and of people with psychiatric and other chronic health conditions, should be starved of resources and struggling to provide high quality care on tight budgets.

The council should act to ensure that all New Yorkers have equal access to high quality care and that our safety net hospitals and nursing homes have the resources to meet New Yorker's needs.

Accordingly, for these reasons, we support the amended version of Resolution 396.

Sincerely



Mary M. Luke, RN, MS, MBA

Co-President

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Working Theater represents working people throughout New York City and is an advocate for our community's access to high quality health care.

Working Theater supports passage of amended City Council Resolution 396 to protect patient quality of care in our hospitals and nursing home, to ensure that patients and communities are all guaranteed minimum standards of care, regardless of where they live, their income or their ability to pay for health services.

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The council should act to ensure that all New Yorkers have equal access to high quality care and that our safety net hospitals and nursing homes have the resources to meet New Yorker's needs.

Accordingly, for these reasons, we support the amended version of Resolution 396.

Laura Monarque

Working Theater

520 8th Avenue #303

New York, NY 10018

City Council Hospital Committee: Oversight –
on Nurse Staffing Ratios

June 24, 2019

Good afternoon,

My name is Anthony Feliciano; I am the Director of the Commission on the Public's Health System (CPHS). We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. We like to thank the City Council Hospital Committee for holding this hearing today on

My statements today are not aimed at any hospital system, except for some of the myths that certain hospital executives make around staff ratios. And I think we always must assess the public hospitals system differently from profitable hospitals because of the unique and significant circumstances of their historical role of taking care of all New Yorkers, especially vulnerable communities.

A Federal regulation has been in place for some time, 42 Code of Federal Regulations (42CFR 482.23(b) which requires hospitals certified to participate in Medicare to "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed". This unclear language and the continued failure of Congress to enact a federal law, The Registered Nurse Staffing Act, has resulted in states acting to ensure there is optimal nurse staffing appropriate to patients' needs.

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A hospital's patients will be better off when there are more experienced nurses to tend to them—all health experts agree with that. But just how many nurses should there be? Is there an ideal patient-nurse ratio? And should we require hospitals to strive for it? These are all points of ongoing debate, which has been both a political battle as well as conflicting views and studies on the best form or policies to improve delivery of health care. Many times, especially with the private voluntary hospitals (mostly academic medical centers) it has been very political and many times at the detriment of patient center care. We would note that is simply not true from the hospital association that this is costly unfunded proposal, will force hospitals to make deep cuts to critical programs. That hospitals will not be able to absorb the added cost and will be forced to close. Patient choice will be compromised, and they would be forced to hire less skilled nurses is another falsehood we have heard before too.

They are so many other factors that impact the viability of the hospital and solely would not be because of staff ratios. In addition, they are other environmental factors influence patient outcomes, regardless of staff ratios. It's time for hospital executives to put patient care over profits."

Foremost, nurse staffing ratios and patient maximums are a question of care quality. Advocates for enforced ratios say patient safety and care quality suffers when nurses take on too many patients. Nurses become stressed and run the risk of making medical mistakes. A 2017 study published in the Annals of Intensive Care found that higher nurse staffing ratios were tied to decreased survival likelihood. The analysis of 845 patients found that patients were 95 percent more likely to survive when nurses followed a hospital-mandated patient-nurse ratio. The Agency for Healthcare Research and Quality (AHRQ) has also acknowledged the link between nurse staffing ratios and patient safety.

"Nurses' vigilance at the bedside is essential to their ability to ensure patient safety," AHRQ says on its website. "It is logical, therefore, that assigning increasing numbers of patients eventually compromises nurses' ability to provide safe care.

Other studies have demonstrated the link between nurse staffing ratios and patient safety, documenting an increased risk of patient safety events, morbidity, and even mortality as the number of patients per nurse increases.

The formula to determined nurse per patient which the New York State Nurses Association has advocated for has seriously thought about shift time and patient acuity. It also empowering policy to create staffing plans specific to each unit or department. What we would ask the city council to think about is

the key factors that influence nurse staffing and not be distracted by just costs such as:

- Patient complexity, acuity, or stability.
- Intensity of patient's needs
- Number of admissions, discharges, and transfers.
- Professional nursing and other staff skill level and expertise.
- Physical space and layout of the nursing unit.
- Availability of technical support and other resources (e.g., ancillary staff, technology).

Finally, when it comes to safe staffing, we want to ensure that they are nurse driven staffing committees that create staffing plans that are reflective of the needs of the patient population and match the skills and experience of the staff. And facilities to disclose staffing levels to the public and to the State and City DOH.

Thank you again for giving advocates like ourselves the opportunity to be heard and valued for our work, which is community driven and led.

NEW YORK IMMIGRATION COALITION

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New York, NY 10001
(212) 627-2227
www.nyic.org

June 26, 2019

Emily Balkan
250 Broadway
New York, New York 10007

Dear Emily,

The New York Immigration Coalition (NYIC) is an umbrella organization representing more than 200 groups throughout New York State. We are a leading advocate for immigrant communities at the local, state, and national levels and serve one of the largest and most diverse newcomer populations in the United States. Our multi-ethnic, multi-racial, and multi-sector membership base includes grassroots community organizations, nonprofit health and human services organizations, religious and academic institutions, labor unions, and legal, social, and economic justice organizations. No other organization in New York State brings together such a diverse network.

The NYIC supports passage of amended City Council Resolution 396 to protect patient quality of care in our hospitals and nursing home, to ensure that patients and communities are all guaranteed minimum standards of care, regardless of where they live, their income or their immigration status.

As amended, City Council Resolution 396 would call upon the State of New York to enact the “Safe Staffing for Quality Care Act" (A2954/S1032), which requires all acute care hospitals and nursing homes to meet minimum safe staffing ratios and standards for nurses and other direct care staff.

In addition, City Council Resolution 396 would commit the City of New York to enact similar local legislation requiring the NYC Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements. Research shows that better nursing and other direct care staffing in hospitals and nursing homes greatly improve patient outcomes. The more patients that are assigned to nurses and other staff, the more likely it is that patients will die, that they will

NEW YORK IMMIGRATION COALITION

131 West 33rd Street, Suite 610
New York, NY 10001
(212) 627-2227
www.nyic.org

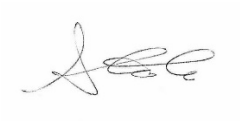
suffer from falls, be subject to hospital-acquired infections or other serious health threats, be readmitted after being treated, suffer from pressure ulcers and other serious conditions, and receive poorer quality of care. When nurses and other direct care workers have too many patients, those patients and our communities suffer.

Research also shows that setting minimum ratios or other standards generates offsetting cost savings to hospitals, including lower rates of reimbursement, penalties or unreimbursed services, lower lawsuit settlement costs, fewer on-the-job injuries resulting in lost work time and worker comp costs, higher worker morale and efficiency, lower worker turnover costs, and lower community costs for unnecessary or avoidable illness and complications. Finally, we note that patients and communities served by NYC Health + Hospitals and other safety net providers are deserving of the same health care resources and access to quality care as more affluent patients.

This is particularly important to the patients served by NYC Health + Hospitals. It is not right or fair that NYC Health + Hospitals, which serves a disproportionately high share of communities of color, of the working poor, of immigrants, and of people with psychiatric and other chronic health conditions, should be starved of resources and struggling to provide high quality care on tight budgets.

The Council should act to ensure that all New Yorkers have equal access to high quality care and that our safety net hospitals and nursing homes have the resources to meet New Yorkers' needs.

Accordingly, for these reasons, we support the amended version of Resolution 396.



Steven Choi, Esq.
Executive Director
New York Immigration Coalition

WE CARE...WE COUNT...WE'RE PROUD
DISTRICT COUNCIL 1707
AFSCME
AFL-CIO

Community and Social Agency Employees Union

District Council 1707, AFSCME, AFL-CIO

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The NYSNA represents Nurses and is a leading advocate for our community's access to high quality health care.

DC 1707 supports passage of amended City Council Resolution 396 to protect patient quality of care in our hospitals and nursing home, to ensure that patients and communities are all guaranteed minimum standards of care, regardless of where they live, their income or their ability to pay for health services.

As amended City Council Resolution 396 would call upon the State of New York to enact the "Safe Staffing for Quality Care Act" (A2954/S1032) which requires all acute care hospitals and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff.

In addition, City Council Resolution would also commit the City of New York to enact similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

Research shows that better nurse and other direct care staffing in hospitals and nursing homes greatly improve patient outcomes. The more patients that are assigned to nurses and other staff, the more likely it is that patients will die, that they will suffer from falls, be subject to hospital acquired infections or other serious health threats, be readmitted after being treated, suffer from pressure ulcers and other serious conditions, and receive poorer quality of care. When nurses and other direct care workers have too many patients, patients and our communities suffer.

Research also shows that setting minimum ratios or other standards generates offsetting cost savings to hospitals, including lower rates of

receive poorer quality of care. When nurses and other direct care workers have too many patients, patients and our communities suffer.

Research also shows that setting minimum ratios or other standards generates offsetting cost savings to hospitals, including lower rates of reimbursement penalties or unreimbursed services, lower lawsuits settlement costs, fewer on the job injuries resulting in lost work time and worker comp costs, higher worker morale and efficiency, lower worker turnover costs, and lower community costs for unnecessary or avoidable illness and complications.

Finally, we note that patients and communities served by NYC Health + Hospitals and other safety net providers are deserving of the same health care resources and access to quality care as more affluent patients.

This is particularly important to the patients served by NYC Health + Hospitals. It is not right or fair that NYC Health + Hospitals, which serves a disproportionately high share of communities of color, of the working poor, of immigrants, and of people with psychiatric and other chronic health conditions, should be starved of resources and struggling to provide high quality care on tight budgets.

The council should act to ensure that all New Yorkers have equal access to high quality care and that our safety net hospitals and nursing homes have the resources to meet New Yorker's needs.

Accordingly, for these reasons, we support the amended version of Resolution 396.

In Solidarity,

Kim Medina
Executive Director

Res. No. 396

Resolution calling upon the New York City Council to endorse state enactment of the "Safe Staffing for Quality Care Act" to ensure that all acute care facilities and nursing homes meet minimum safe staffing ratios and standards for nurses and other direct care staff, and further calling upon the City of New York to consider pursuing similar local legislation requiring the NY City Health + Hospitals system and other providers receiving funding from or contracting to provide services for the City of New York to meet equivalent minimum staffing requirements.

By Council Members Cabrera and Salamanca

WHEREAS, according to the United States Department of Health and Human Services (HHS), the inadequacy of nurse and other direct care staffing levels leads to poor patient outcomes[1]; and

WHEREAS, research funded by the federal Agency for Healthcare Research & Quality (AHRQ) has found that hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrests, urinary tract infections and upper gastrointestinal bleeds leading to higher costs and mortality from hospital acquired complications[2]; and

WHEREAS, the Journal of the American Medical Association (JAMA) published research that estimated five additional deaths per one thousand patients occurred in hospitals that routinely staff with a 1:8

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[1] See: Evidence Report/Technology Assessment Number 151 Nurse Staffing and Quality of Patient Care Prepared for: Agency for Healthcare Research and Quality U.S. Department of Health and Human Services, AHRQ Publication No. 07-E005 March 2007, available at:
https://archive.ahrq.gov/downloads/pub/evidence/pdf/nursestaff/nursestaff.pdf

[2] See: Hospital Nurse Staffing and Quality of Care: Research in Action, Issue 14, Agency for Healthcare Research and Quality Pub. No. 04-0029, 2004, available at:
https://archive.ahrq.gov/research/findings/factsheets/services/nursestaffing/nursestaff.pdf
See also AHRQ funded study: Nurse-Staffing Levels and the Quality of Care in Hospitals, Needleman J., Buerhaus P., Mattke S., Stewart M. and Zelevinsky K., N Engl J Med 2002; 346:1715-1722, available at
https://www.nejm.org/doi/pdf/10.1056/NEJMsa012247?articleTools=true

nurse to patient ratio compared to those staffing with a 1:4 nurse to patient ratio and that the odds of patient death increased by 7% for each additional patient the nurse must care for at one time[3]; and

WHEREAS, research shows that better staffing policies not only result in better patient outcomes, but also lower the operating costs of health care providers by (a) reducing the recruitment and training expenses resulting from staff burnout and turnover, (b) lowering the penalties and reduced reimbursements imposed to penalize poor patient outcomes and unnecessary readmissions, (c) lowering patient length of stay, (d) reducing legal and malpractice costs, (e) lowering staff productivity due to workplace injuries and fatigue, and (f) and lowering patient satisfaction scores and hospital quality ratings;[4] and

WHEREAS, according to a report published by Health Services Research in 2012, nursing homes which have safe staffing ratios have better quality of care in their facilities and improved functional status of the residents;[5] and

---

[3] See: **Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction** Linda H. Aiken, PhD, RN; Sean P. Clarke, PhD, RN; Douglas M. Sloane, PhD; Julie Sochalski, PhD, RN; Jeffrey H. Silber, MD, PhD; *JAMA.* 2002; 288(16):1987-1993, available at: https://jamanetwork.com/journals/jama/fullarticle/195438?version=meter%20at%20null&module=meter-Links&pgtype=article&contentId=&mediaId=&referrer=&priority=true&action=click&contentCollection=meter-links-click

[4] See: **Hospitals with higher nurse staffing had lower odds of readmissions than hospitals with lower staffing,** Matthew McHugh, Julie Berez and Dylan Small, Health Affairs (Millwood), 2013 October; 32(10): 1740–1747; available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4315496/pdf/nihms657136.pdf ; **Quality and Cost Analysis of Nurse Staffing, Discharge Preparation, and Postdischarge Utilization,** Marianne E. Weiss, Olga Yakusheva, and Kathleen L. Bobay, Health Services Research, 2011 Oct; 46(5): 1473–1494; available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3207188/pdf/hesr0046-1473.pdf ; **2019 National Health Care Retention & RN Staffing Report,** NSI Nursing Solutions, Inc., available at http://www.nsinursingsolutions.com/Files/assets/library/retention-institute/2019%20National%20Health%20Care%20Retention%20Report.pdf ; **Cost Savings Associated with Increased Staffing in Acute Care Hospitals: Simulation Exercise,** T. Shamliyan, et al, *Nursing Econ* 2009 Sep-Oct;27(5):302-14, 331; available at https://www.scopus.com/record/display.uri?eid=2-s2.0-72449176945&origin=inward&txGid=5b38beef7ac45a75ff6728101f533c7e ; **Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction** Linda H. Aiken, PhD, RN; Sean P. Clarke, PhD, RN; Douglas M. Sloane, PhD; Julie Sochalski, PhD, RN; Jeffrey H. Silber, MD, PhD; *JAMA.* 2002; 288(16):1987-1993, available at: https://jamanetwork.com/journals/jama/fullarticle/195438?version=meter%20at%20null&module=meter-Links&pgtype=article&contentId=&mediaId=&referrer=&priority=true&action=click&contentCollection=meter-links-click ; **California's nurse-to-patient ratio law and occupational injury,** J.P. Leigh, C.A. Markis, A. Iosif, P. Ramano, International Archives of Occupational and Environmental Health 2015:88(4)477-484. Available at http://link.springer.com/article/10.1007/s00420-014-0977-y .

[5] See: **Keeping Patients Safe: Transforming the Work Environment of Nurses,** Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety; Editor: Ann Page. Washington, DC (2004), available at https://www.ncbi.nlm.nih.gov/books/NBK216190/

WHEREAS, in 2004 California passed the which required hospitals to institute minimum nurse to patient ratios where studies have shown that nurses in California have reported improved patient care outcomes and lower workplace injury rates;[6] and

WHEREAS, the Safe Staffing for Quality Care Act would require all acute care hospitals and nursing homes in New York State to comply with specific minimum nurse-to-patient ratios and staffing requirements, submit a facility staffing plan to the State Department of Health, and require public disclosure of actual hospitals and nursing home staffing levels;[7] and

WHEREAS, ensuring adequate nursing coverage for all patients is an important public health goal that will improve the quality of care in acute care hospitals and nursing homes; now, therefore, be it

RESOLVED, that the New York City Council calls upon the legislature to pass and the governor to enact the "Safe Staffing for Quality Care Act," to ensure that acute care facilities and nursing homes meet appropriate minimum staffing ratios for nurses and direct care staff, and be it further

RESOLVED that the New York City Council commits to pursuing the implementation of minimum safe staffing ratios and standards in the NYC Health & Hospitals system and in all other acute care hospitals and nursing homes that receive funding from or contract to provide patient care services for the City of New York.

---

[6] **California's nurse-to-patient ratio law and occupational injury**, J.P. Leigh, C.A. Markis, A. Iosif, P. Ramano, International Archives of Occupational and Environmental Health 2015:88(4)477-484. Available at http://link.springer.com/article/10.1007/s00420-014-0977-y.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jill Furillo, RN

Address: NYSNA Executive Director

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Judith Catchin, RN

Address: NYSNA

I represent: H+H President

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 4676 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anthony Feliciano - Safe Staffing

Address: _____

I represent: CPHS

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Migna Tavenas

Address: 205 Lexington Ave NY NY 10016

I represent: Arch Care

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 0396-2018

☐ in favor ☒ in opposition

Date: 6/24/2019

(PLEASE PRINT)

Name: Lorraine Ryan

Address: _____

I represent: Greater New York Hospital Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 0396

☐ in favor ☒ in opposition

Date: 6/24/2019

(PLEASE PRINT)

Name: Scott Amrhein

Address: 355 West 57th

I represent: Continuing Care Leadership Coalition

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6.24.19

(PLEASE PRINT)

Name: Natalia Cinco

Address: _____

I represent: N.Y.C. Health + Hospitals

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6.24.19

(PLEASE PRINT)

Name: Mitchell Katz M.D.

Address: D.C.

I represent: Health + Hospitals

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Mahfuzur Rahman

Address: 1735 Madison Ave, Apt 8B

I represent: CB11 Manhattan

Address: 1664 Park Ave

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 396

☑ in favor ☐ in opposition

Date: 6/24/19

(PLEASE PRINT)

Name: Karines Reyes

Address: 1973 Westchester Avenue

I represent: NYS Assembly – 87th District

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Patricia Davis, RN

Address: _____

I represent: NYSNA

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Pat Davis, RN

Address: _____

I represent: NYSNA

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Pate Kane, RN

Address: MSNA Treasurer

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Judy Sheridan-Gonzalez

Address: MSNA President

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Pate Kane, RN

Address: 884 West End Ave Shaldon Fuel Treasurer

I represent: Community Board 7 Man

Address: 250 W 87 Street NYC

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anne Foye, RN

Address: NYSNA

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 396

☒ in favor ☐ in opposition

Date: 6-24-19

(PLEASE PRINT)

Name: Kevin Gallini

Address: 50 Bway NYC

I represent: Doctors Council

Address: 50 Bway NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☒ in favor ☐ in opposition

Date: 6/24/19

(PLEASE PRINT)

Name: Mark Hannay

Address: 420 W. 45th St. NYC 10036

I represent: Metro NY Heath Care for All

Address: Same

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lew Bell

Address: 131 W 33rd St. NY NY 10001

I represent: NY State Nurses

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Ari Moma, RN

Address: _____

I represent: NYSNA

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Alizia McMyers, RN

Address: _____

I represent: NYSNA

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 698

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: MARIO C. HENRY, R.N.

Address: 146-10 3 AVE, 1 ROAD FL 11357 QUEENS

I represent: NEW YORK STATEWIDE SENIOR ACT

Address: 4 N 43 ST NY NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Carrollyn ESPOSITO, RN-BC

Address: NYSNA Ed-D, SD MS, NBD, ESq

I represent: _____

Address: _____

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