The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

Statement of

The Hospital and Healthsystem Association of Pennsylvania

for the

Pennsylvania House of Representatives Health Committee

submitted by

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Chairman Frankel, Chairwoman Rapp, members of the committee, thank you for inviting the hospital community to participate in today's public hearing on this important topic. The Hospital and Healthsystem Association of Pennsylvania is here today because every hospital in every community across the commonwealth is struggling under the weight of the health care workforce crisis. They share their voices through their association because this issue is fundamental to the stability of Pennsylvania's entire continuum of care.

There are many aspects to this bill but, in today's discussion, I will emphasize that:

- There is a national crisis in nursing. There are not enough nurses.
- Pennsylvania hospitals are aggressively working to fill existing vacancies and actively deploying strategies to reduce strain on current bedside nurses.
- Government-mandated ratios are not universally supported by nurses, would reverse innovations in care, and do not clearly achieve desired outcomes.
- Within the current context, there are very real concerns that statewide ratio mandates will diminish Pennsylvanians' access to care.
- Mandated ratios are not a solution. We must invest in recruiting, educating, training, and supporting Pennsylvania nurses—along with the many other health care professionals who support their vital work.

While we may disagree on the approach put forth in the legislation under consideration today, I know that every person in this room shares a deep and fundamental belief in the value of the commonwealth's nurses. They stood fast by the bedside throughout the most prolonged and devastating event of our lifetimes and they remain there now, caring for the people we love when they need it most.

Pennsylvania's nurses are exhausted and need help. We owe them more than thanks. We owe them lasting commitment and real investment.

There is a national crisis in nursing. There are not enough nurses.

Today's nursing shortage is not a "hospital issue" or a "Pennsylvania problem." It is a well-documented, nationwide crisis that threatens America's health care system. Just a few weeks ago, the National Council of State Boards of Nursing released a study[i] that found approximately 20 percent of the nation's nurses—including more than 600,000 registered nurses (RN)—intend to leave the workforce by 2027.

Pennsylvania's population is aging and requires more care. Many people who forewent health care in recent years now need a higher level of care. COVID-19 and the opioid crisis persist and seasonal illnesses that virtually disappeared during the pandemic have returned with record surges. Emergency department teams are on the front lines of responding to our nation's mental health crisis. They are also devoting unprecedented staff and resources to keep patients in crisis safe and stabilized as they experience often lengthy waits for psychiatric care. Hospitals have reported capacity information since mid-2020 and most have been at least 70 percent full for the majority of that time.[ii]

As Pennsylvania policymakers, you all are well aware of and frequently wrestle with the many implications that stem from older Pennsylvanians staying in the commonwealth while younger residents leave. That trend is among the reasons we lost a seat in the U.S. House of Representatives, for example. It also is among the primary reasons there is a growing mismatch between Pennsylvania's health care needs and the health care workforce.

Pennsylvania's shortage of RNs is projected to be the worst in the nation, with a shortfall of 20,345 nurses within the next three years.[iii] To help all of us envision the scale of the expected shortfall, it is more than the entire population of Carlisle (19,869), or of Bethlehem City (19,793), or of Johnstown (18,647), for example.[iv]

Pennsylvania hospitals are aggressively working to fill existing vacancies and actively deploying strategies to reduce strain on current bedside nurses.

Patient safety and quality care are the most important hallmarks of our health care system. Many Pennsylvania hospitals voluntarily participate in the American Nurses Credentialing Center's "Magnet" program, which evaluates and recognizes health care environments that collaborate with and invest in nursing professionals. Only 8 percent of U.S. hospitals achieve Magnet status. Of the 545 currently certified hospitals nationwide, 40 are in Pennsylvania—only Texas has more.[v]

Pennsylvania hospitals are working hard to recruit and retain nurses. In a recent survey, HAP found average vacancy rates for direct care RNs to be more than 30 percent across the state.[vi] One rural hospital notes that it is struggling to fill upward of 45 percent of its nursing positions at any given time.

Despite significant sign-on bonuses—imagine $30,000—increased wages, higher shift differentials, more flexible scheduling options, and other enticements, some small hospitals report RN vacancies in the 130 to 350 range, while larger organizations report RN vacancies in excess of 1,000.

Why? There simply are not enough nurses. Eighty-four percent of hospitals responding to HAP's survey reported that "finding qualified professionals" is the number one barrier to their recruitment activities.[vii]

More than ever, Pennsylvania hospitals are forced to rely on travel nurses to help deliver high-quality care to patients. We are certainly thankful for the dedicated professionals who fill these roles. However, they do not arrive pre-trained in unit or hospital-specific procedures. Relying on travel nurses can result in significant inequities as compared to their hospital-employed colleagues. To appeal to those nurses who prefer certain aspects of travelling employment, some health systems have established and manage their own programs that enable nurses to travel to sites within their networks.

You also have experienced hospitals' efforts to reduce or better sequence the patient population to better align with current staffing constraints. I know that many of you have heard from your frustrated constituents that hospitals are increasingly "closing beds," delaying procedures, reducing services, or putting their emergency departments on "divert" status to incoming patients. Such measures are due, in large part, to align available staff with high-quality care delivery.

Another widespread approach is hospitals' work to fundamentally change their care models to better support bedside RNs. Many have worked with their RNs to pivot to team-based nursing.

This is happening on a large scale, with some level of this work happening in many hospitals across the state. One good example comes from a hospital in the Northern Tier. They started with a pilot and have since expanded to a system-wide transition from a primary RN model to team nursing model that includes RNs, licensed practical nurses (LPN), and other care partners. They began by bringing their RNs together to discuss tasks the RNs believed could safely be delegated to LPNs, within the allowable scope of practice. The idea was to empower RNs to dedicate more of their time practicing at the top of their professional abilities, while other professionals more widely shared much of the day-to-day, direct care burden.

The outcomes of the pilot program are remarkable. Every single quality-of-care measure they tracked improved. Patient satisfaction increased. Nurse satisfaction increased. Their vacancy rate fell to zero. They completely eliminated the need for travel nurses.

As I noted, variations of this work are happening statewide. Some hospitals are experimenting with organizing some non-RN work by task, rather than by patient. Others are creating, recruiting, and training new classifications of non-licensed positions and offering substantial support for career advancement.

Imagine a scenario where a person can join a hospital staff as a "patient companion," then—while earning and learning—they progress to a "patient care technician" with increasing levels of responsibility. This is a career path to LPN and RN advancement, if the person so chooses. And it is becoming nearly standard that hospitals cover the cost of education for high-need professions. One system offers free tuition in its degree granting nursing program to any full- or part-time employed staff person or member of their family. One member of that hospital's housekeeping staff recently discussed her desire to advance her career into the field of social work, but decided to put it off—for now—until her daughter finishes up her BSN.

A number of hospitals are beginning to test various virtual options for nurses in the hospital setting. Discharge counseling, for example, requires expert insight and significant clinical documentation. In a Zoom world, this may become an effective and comfortable virtual interaction for many patients. As the staffing crisis requires younger nurses to progress more rapidly than in the past, having experienced nurses available for real-time, virtual mentoring can be an effective patient-care and skill-building approach. Options like these may be particularly attractive for active nurses who have previously chosen to leave the bedside.

If you are interested in additional data or more examples, there is no shortage of either and we are certainly happy to provide both. But while hospitals are striving to support their current RNs, everyone in this room knows that they have and continue to carry a heavy load and they need help. Pennsylvania needs more nurses by the bedside—on this we all agree.

Government-mandated ratios are not universally supported by nurses, would reverse innovations in care, and do not clearly achieve key desired outcomes.

State-mandated RN staffing ratios will not produce more nurses and the evidence is not clear that they would achieve many of the other benefits that have been claimed.

Worse, mandated ratios would effectively force hospitals to revert to staffing models of the past rather than continue to advance innovations and flexibilities that reduce strain on health care teams, increase nurses' satisfaction with their work, and ultimately increase the accessibility of—and in many cases improve—care.

To meet mandated ratios, hospitals would have to staff units with primarily—if not entirely—RNs, reducing or eliminating positions for LPNs and support staff who have taken on many of the most manually intensive tasks and empowered RNs to focus on patient care that uses their skills, training, and experience. HAP regularly hears from Pennsylvania nursing leaders that mandated RN staffing ratios would disrupt innovations they have put in place to support their teams, such as career advancement programs that enable nurses to split their time between patient care and training for leadership roles.

The nursing community is not unified behind mandated staffing ratios. Pennsylvania Organization of Nurse Leaders is "adamantly opposed" to any legislation that would mandate nurse-to-patient ratios for all health care organizations.[viii] The American Nurses Association supports models that encourage flexible staffing levels and incorporate inter-professional teams.[ix] The American Organization for Nursing Leadership asserts that mandated nurse staffing ratios are a static and ineffective tool that cannot guarantee a safe health care environment, limit innovation, and increase stress on a system already facing a shortage of educated nurses.[x]

At the practice level, some Pennsylvania hospitals already have nurse-to-patient ratios established through collective bargaining agreements. In at least one health system that operates a hospital with ratios and others without, recent nurse satisfaction metrics were lower in a facility that required strict nurse-to-patient ratios than in its counterparts within the system.

Hospital staffing is complex. No two units are the same—no two hospitals, no two patients, no two nurses. Even the same type of unit can be wildly different between. For example, an academic medical center in Philadelphia and a critical access community hospital along the Northern Tier. Clinical teams and leaders carefully consider nurse staffing based on numerous factors, including patients' acuity levels, demands on unit staff, availability of support staff on the unit, and the skill levels and experience of nurses and other care team members. A one-size-fits-all government mandate is not an effective solution; nor should it be a substitute for the professional judgement of clinicians.

More than a dozen states have addressed nurse staffing in laws or regulations and most have opted for more flexible, hospital-based approaches. Only one—California—mandates strict nurse staffing ratios across acute care hospitals.

California's experience seems to suggest that statewide ratio mandates do not solve staffing shortfalls. A study by University of California San Francisco estimated that California has a current shortage of 40,567 RNs and that only 8,500 California RNs were seeking employment in late 2020—which would fill about 20 percent of the shortfall.[xi] Along the same lines, nurse vacancies also persist at the Pennsylvania hospitals that already have nurse staffing standards in place, as negotiated within their collective bargaining contracts. When measured as a percentage, California ranks only slightly behind Pennsylvania in its current demand for travel nurses.

California ratios also do not appear to have alleviated nurses' staffing concerns. So far this year, for example, nurses have protested staffing levels at 26 facilities operated by a San Francisco-based health system. A San Diego health system has hired extra nurses and says that it is staffing above required nurse ratios when possible, but there are still not enough nurses to meet patient demand, according to current nurses.

Among the 50 states, California ranks close to last—46th—for hospital beds per capita, while Pennsylvania ranks 18th.[xii] And California's cost per non-profit hospital in-patient day is 52 percent higher than the national average, while Pennsylvania's is 4 percent lower.[xiii]

Pennsylvania's health care quality is better than California's. A federal government analysis of overall health care quality from 2015–2020 placed California among the worst states nationally. Pennsylvania ranked in the top half of states.[xiv] From 2015–2021, Pennsylvania, on average, performed better or on par with California in 6 out of 7 infection-prevention measures that are often associated with nursing quality.[xv]

Within the current context, there are very real concerns that statewide ratio mandates will diminish Pennsylvanians' access to care.

While we must work together to improve the future for patients and providers, we cannot ignore the effect of COVID-19 on our current situation. The pandemic exposed cracks in America's health care system, exacerbated an already worsening health care workforce shortage, and fundamentally changed the environment in which hospitals are providing care.

Even before the pandemic and record inflation, Medicare and Medicaid reimbursed Pennsylvania hospitals only 84 cents and 81 cents respectively for every dollar that they spent providing care. More than two-thirds of Pennsylvania hospitals receive at least half of their patient revenue from these programs.

From January 2010 to April 2022, 30 Pennsylvania hospitals closed their doors. Many others were forced to cut specific services—such as OB/GYN—in order to remain financially viable.

Last year was the most challenging year for hospitals' financial stability in recent memory. About half of U.S. hospitals operated in the red[xvi] in 2022, and many Pennsylvania health systems reported steep losses. Estimates suggest that U.S. hospitals paid about $135 million more in expenses during 2022 than they did during 2021. Financial experts see this trend continuing as rising costs of providing care outpace payments.

The workforce crisis is a leading contributor to this strain. As of March, U.S. hospitals' total labor expenses, adjusted per discharge, remained 17 percent higher than March 2020.[xvii] By fall of last year, U.S. hospitals were on course to pay $86 billion more for staffing for 2022 than they did for 2021.[xviii]

Hospitals are investing more in their teams, including nurses—sharply increasing pay and offering bonuses, loan forgiveness, and other benefits. Still, the primary driver of surging costs is increased reliance on staffing agencies due to workforce shortages. A national study found hospitals' reliance on agency staff increased about 139 percent—180 percent for nurses—from 2019 to 2022.[xix] During that same time, the study found hospitals' expenses for staffing contracts increased 258 percent.

Continuing to rely on staffing agencies to fill nursing roles is not sustainable. Increasing that reliance even more is simply not an option hospitals can take and keep their doors open.

The health care workforce crisis affects the entire continuum of care. The commonwealth has nearly twice as many medically underserved areas and 62 percent more medically underserved populations than the average state. Pennsylvania also has twice the number of primary care health professional shortage areas than the region's average, and one-third more than the national average[xx]. While our nursing shortfall is estimated to be the most severe in the nation, our mental health professional crisis is not far behind at third worst among the 50 states.[xxi]

Ambulance, in-home, personal care, nursing home, skilled nursing, rehabilitation, mental health, and other providers also are struggling to find staff. They are stretched too thin to be able to meet all of Pennsylvania's health care needs.

One significant effect of this shortage is that, increasingly, patients remain in hospitals even after their acute care needs are met because there is no other available setting in which they can receive appropriate care. This is referred to as "boarding" and it does not only happen in acute care units. When acute care units are full, patients must stay longer in emergency departments until beds become available. Boarding has dramatically increased, both in terms of the number of patients affected and the time it takes to find a placement. It is heartbreakingly common for some patients to be in emergency departments for weeks and in acute care wards for months.

Because RNs are scarce, mandating more of them be required at the hospital bedside will, of necessity, pull them from other care settings and exacerbate these backlogs.

One hospital in the northern part of the state described rigid, mandated ratios as a "frightening situation for patient care." They often have 15 or more patients waiting in the emergency department because there are no open beds and other hospitals are also at capacity. They routinely have to close three to four pediatric beds because they are not able to staff them. They already work to maintain safe ratios with input from staff and use a team nursing approach. RNs provide oversight and focus on more advanced patient care tasks while delegating other duties that LPNs can safely take on. Mandating RN-based ratios would force them to close additional beds and would put emergency care in crisis throughout the region.

That's just one example. We are hearing similar concerns all over the commonwealth. If hospitals are unable to meet mandated ratios due to the scarcity of available RNs, they will have to reduce beds and close certain patient services in order to remain compliant with Pennsylvania law.

Mandated nurse staffing ratios are not a solution. We must invest in Pennsylvania's health care workforce pipeline, with immediate and expedited emphasis on nurses.

Pennsylvania's hospitals have been deeply committed to this work for years. In 2018, they convened a multi-disciplinary task force that included clinical and administrative leaders, health professional educators, human resource professionals, as well as experts in workforce planning and economics.

They updated their work in 2023, in part to reflect post-pandemic realities, and provided recommendations to the governor, the legislature, and their hospital colleagues that would:

- Prioritize the health care talent infrastructure
- Support health care workers
- Strengthen the health care community

Examples of these priorities include:

- Creating an executive level "Pennsylvania Health Care Workforce Council" to develop short- and long-term strategies to address the commonwealth's health care workforce shortage. The council would assess current and projected workforce needs; establish a health care data center; coordinate workforce-related policies, programs, and initiatives across agencies; and facilitate the talent pipeline of a diverse and culturally competent workforce. The council also should be charged with establishing a "one-stop shop" for health care employers and educators to meet the requirements of multiple state agencies.

- Increasing Pennsylvania's ability to educate nurses by assessing clinical experience as a viable pathway to credentialing nurse educators; reducing disparities between higher bedside pay versus lower nurse educator pay; and incentivizing preceptorship. Pennsylvania has more than 1,700 health care training programs, 400 nursing programs, and nine medical schools. Among HAP members who also manage nursing programs, several indicated they have waiting lists and could serve more students if they could attract additional instructors and offer more clinical opportunities.

- Targeting any financial proposals you enact—scholarships, discounted tuition, student loan relief, tax incentives—toward current and future nurses and nurse educators who commit to remaining in Pennsylvania and working by the bedside.

- Working closely with the Governor to operationalize the interstate licensing compacts already authorized by the General Assembly and to reform the commonwealth's licensing and credentialing processes. Pennsylvania hospitals—particularly those near borders with other states—report losing qualified candidates during the hiring process because job seekers find it easier and faster to become licensed and start work elsewhere.

Solutions such as these, not mandated ratios, will bring more nurses to the bedside to deliver high-quality and safe care to Pennsylvania patients. HAP and Pennsylvania's hospital community stand ready to work with you on these efforts and others to support and grow Pennsylvania nurses, and the entire health care workforce.

Thank you again for providing Pennsylvania's hospital community an opportunity to share their experiences and perspectives today. I am happy to answer your questions.

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[i] https://www.ncsbn.org/news/ncsbn-research-projects-significant-nursing-workforce-shortages-and-crisis
[ii] https://www.cnn.com/2022/12/08/health/hospitals-full-not-just-covid/index.html
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[xvi] https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2023
[xvii] https://www.kaufmanhall.com/sites/default/files/2023-03/KH-NHFR_2023-03-V2.pdf
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