The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

Statement of The Hospital and Healthsystem Association of Pennsylvania

For the

Health Committee, Pennsylvania House of Representatives

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The Hospital and Healthsystem Association of Pennsylvania (HAP) advocates for approximately 240 member organizations across the commonwealth, as well as for the patients and communities they serve.

HAP appreciates the opportunity to provide comments about the need for Pennsylvania to have and maintain a robust and stable health care workforce.

HAP's vision is "A Healthy Pennsylvania," and HAP's mission is to empower hospitals and health systems as the leading advocates for improving health in their communities. To be able to do that, hospitals and health systems need to have a strong workforce to care for its patients.

HAP has embarked upon a journey to develop workforce strategies that will help to attract and retain the health care talent pool needed to provide quality patient-centered care to Pennsylvania communities.

To evaluate current health care workforce issues in Pennsylvania, HAP conducted a workforce survey of member hospitals and health systems to provide data that will support the association's future efforts to address the workforce needs of members.

HAP issued an executive summary of the survey findings to members, which included key findings such as:

- The most difficult positions to hire and, separately, to retain were nurses
- Inpatient care was the most commonly cited setting identified with staffing difficulties
- An aging workforce was identified as the top institutionalized barrier to workforce transformation
- Hiring per diem staff was the top reported strategy to address vacancies

HAP also has convened a task force that includes administrative and clinical leaders, health professional educators, and human resource professionals representing HAP-member hospitals and health systems. This task force will help HAP explore workforce needs, new models of care, and strategies to improve the ability of Pennsylvania hospitals to attract and retain the necessary health care talent to serve its communities.

It is anticipated that the task force will develop a report during December 2019 that will include suggested tactics and strategies to implement the report recommendations.

HAP also supported House Resolution 754, sponsored by Representative Kerry Benninghoff (R-Centre), that directed the Joint State Government Commission to conduct a study of the Commonwealth's health care workforce as well as the education and training pipeline required to meet the workforce needs during the next five years. HAP looks forward to reviewing the results of this study when it is released in April 2019.

In addition to HAP's task force, HAP is engaged across a range of efforts to address its members' workforce needs. Today, we would like to provide background information and HAP's perspectives relating to the following key workforce issues:

- Nurse Staffing Ratios
- Telemedicine Legislation
- Venue Proposal
- Workplace Safety
- Expanded Utilization of Advance Practice Professionals
- Insurer Credentialing Process

NURSE STAFFING RATIOS

HAP opposes legislation mandating nursing staffing ratios and nurse staffing requirements.[i]

While nurse staffing ratio legislation has only been implemented in the state of California, many nursing unions and other groups have been advocating for this type of legislation in Pennsylvania and other states. Pursuant to this legislation, hospitals would be required to maintain a minimum nurse-to-patient ratio, by hospital unit, at all times.

HAP believes that implementing this type of legislation is not in the public interest for the following reasons:

- **Hospitals are already required by federal and state law to meet safe staffing requirements.** When hospitals work together with nurse leaders to set individual staffing levels, they are using the knowledge of its own facility to make the best determinations for them. Continuing this flexibility allows hospitals to provide the best care as efficiently as possible

- **Every hospital is unique, and hospitals carefully weigh a number of variables when setting staffing levels for a shift.** Appropriate staffing levels should be adjusted based upon the following, rather than a "one-size-fits-all" requirement:
  - The number of available clinicians to meet the needs of the hospital's current patients
  - The number and acuity levels of current patients in the unit
  - Anticipated additional influx of patients during the shift (driven by external factors like flu season, time of day, and patient census in other units)

- **Nurses are integral to the patient's care team, but are only one part of that team.** Dictating nursing ratios limits hospitals' ability to efficiently balance care teams with other types of clinicians

- **Evidence from nurse ratio mandates in California suggests no systematic improvement to patient outcomes post-implementation of ratios.** A government-funded cost analysis of staffing ratios in Massachusetts also found that mandated nursing ratios would result in greater nurse shortages for high public payor hospitals, disproportionately stressing institutions that provide care to the most vulnerable populations

TELEMEDICINE

Telemedicine is the exchange of medical information from one site to another via electronic communications to improve a patient's clinical health status. Two-way video, smartphones, wireless tools, and other forms of telecommunications technology can be used to deliver high-quality health care through telemedicine.

Telemedicine provides access to quality, convenient health care, for a more efficient and less costly way in rural, suburban, and urban communities.

Thirty-eight states and the District of Columbia already have enacted this type of policy, including Pennsylvania's neighbors Delaware, Maryland, and New York.

During last year's legislative session, HAP supported Senate Bill 780 Printer's Number 1852, of the 2017–2018 legislative session, which defined the role of telemedicine to ensure Pennsylvanians receive the right care, at the right place, at the right time.[ii]

Telemedicine can:

- Eliminate long waits for in-person appointments
- Accommodate those who would normally travel far to see a specialist
- Save lives when seconds matter
- Help address school safety through in-school behavioral health services
- Improve access to both health care and home and community-based services, and increase a patient's choice of providers, especially in rural areas
- Increase access to counseling and treatment for opioid use disorders
- Increase flexibility for family caregivers who provide unpaid care to a friend or loved one who could benefit from broader access to telemedicine
- Assist insurers to keep pace with the technological advances in health care
- Address physician and specialist shortages

VENUE PROPOSAL

As a result of the passage of the Medical Care Availability and Reduction of Error (MCARE) Act, Act 13 of 2002, both the legislature and the Supreme Court adopted reforms that reduced the number of malpractice claims brought in Pennsylvania, especially Philadelphia and Allegheny counties. This was accomplished by limiting venue for medical liability actions to the county "where the cause of action arose." Previously, expansive venue rules allowed medical liability plaintiffs to sue defendants almost anywhere they did business, even if the alleged malpractice occurred elsewhere.

The MCARE Act established an Interbranch Commission on Venue, which studied how venue issues were driving unreasonable medical liability insurance rates and issued a report to the General Assembly. Based upon the report of the commission, on October 17, 2002, the legislature enacted Act 127 of 2002, which provided that medical liability cases shall be filed only in the county where the "cause of action arose." Later, during early 2003, the Supreme Court, by per curiam order, promulgated amendments to the Rules of Civil Procedure (Rule 1006) adopting the language of Act 127.

These reform efforts are widely seen as the most important step around Pennsylvania's efforts to address the medical liability insurance crisis, substantially reducing medical malpractice filings statewide.

The Pennsylvania Supreme Court Civil Procedural Rules Committee now is proposing an amendment to Rule 1006 to rescind subdivision (a.1), which limits venue to medical professional liability actions to the county in which the cause of action arose. Conforming and stylistic amendments also are being proposed to Rules 2130, 2156, and 2179.

The rules committee appears to argue that the Supreme Court made a special exception when it prohibited venue shopping during 2003 because there was a crisis, but that the system has since stabilized and the exception no longer is warranted.

Pennsylvania physicians and hospitals—and, most importantly, health care consumers—would be adversely affected by repealing medical professional liability venue reforms adopted during 2002.

By allowing venue in counties with little relation to the underlying cause of action, claimants could shop for verdict-friendly venues to file their suits. This would again lead to higher premiums for medical liability insurance, make Pennsylvania less attractive to physicians considering practicing in the state, increase medical costs, and adversely impact access to care for consumers. The proposal is not in the public interest.

HAP believes the rules committee's assumption is faulty and shortsighted because it ignores fundamental changes to Pennsylvania's health care market during the interim 16 years, such as hospital system consolidation, provider shortages, and an uncertain liability insurance environment.

HAP submitted a letter to the Pennsylvania Supreme Court Civil Procedural Rules Committee that provides additional details.[iii]

The letter was accompanied by a February 2019 Milliman Research Report about the impact of the proposed change upon medical liability costs and insurance rates.[iv] Based upon a review of publicly available documents, the Milliman report conservatively estimated the following impact:

- The current average statewide medical professional liability insurance costs and insurance rates for physicians in Pennsylvania will likely increase by 15 percent
- Many individual counties will likely see increases to physician Medical professional liability rates of 5 percent, while counties surrounding Philadelphia will likely see larger increases by 45 percent
- High-risk physician specialties, such as obstetrics/gynecology and general surgery, will likely experience additional cost and rate increases of 17 percent on top of the county change

The Association of American Medical Colleges (AAMC) released a report during 2017 that projected the demand will continue to grow faster than the supply of physicians.[v] Estimates show that Pennsylvania will need 10 percent more primary care physicians to meet health care needs in the coming decades.[vi]

The consequences outlined above as a result of the venue change could ultimately have a negative impact on physician supply in the commonwealth, resulting in diminished access to care.

The Supreme Court announced that it will delay its decision about the venue reform proposal until it has reviewed the results of a Legislative Budget and Finance Committee study examining the potential impacts of the rule change. The study was authorized by Senate Resolution 20, which was sponsored by state Senate Judiciary Chair Lisa Baker (R-Luzerne).[vii]

The results are due January 2020, and the Civil Procedural Rules Committee will make its determination during February 2020.

WORKPLACE SAFETY

Many patients and visitors experience high-stress, emotionally charged situations during their time in the hospital that can sometimes lead to aggressive behavior. As such, hospitals and health systems make significant investments around infrastructure, staff, and training in order to keep their workers, patients, and visitors safe. According to the American Nurses Association, 42 states designate penalties for assaults on nurses—but Pennsylvania does not.[viii]

During July 2017, Milliman Research produced a report for the American Hospital Association (AHA) about the impact of community violence at hospitals.[ix] Milliman estimated that proactive and reactive violence response efforts cost U.S. hospitals and health systems approximately $2.7 billion during 2016.

Health care facilities institute protocols meant to keep everyone safe. HAP estimates that a large category of costs for hospitals and health systems is associated with protecting the safety of employees, hospital patients, and visitors.

HAP supports the AHA Hospitals Against Violence initiative, which provides resources for hospitals related to community and in-facility violence.[x]

HAP also supports state legislative efforts to address violence. HAP supported legislation introduced during the last legislative session (2017–2018)—Senate Bill 445[xi] and House Bill 646[xii]—that sought to add all health care practitioners to a protected class in the event of assault, and raise the penalty for an assault upon a health care practitioner while in the performance of duty. HAP will continue to support this type of legislation.

HAP also is seeking to promote workplace safety for health care practitioners by securing the enactment of legislation to allow the omission of health care practitioners' last name from their ID badges. HAP believes that having last names on employee badges is not necessary. It is not a requirement of the Joint Commission[xiii] and, in fact, OSHA recommends badges without last names in its Workplace Violence Prevention Guidelines.[xiv]

EXPANDED UTILIZATION OF ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals (APP) include physician assistants and advanced practice registered nurses (APRN). APRN is an umbrella term for professionals who have at least a bachelor of science degree and a master of science degree in nursing, and includes nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

The Hamilton Project, an economic policy initiative of the Brookings Institution, published a policy brief[xv] outlining the ways that limitations in scope of practice are impacting health care in the United States. The policy brief advocates for reforms to reduce scope of practice restrictions for APPs.

In its review of recent research, the brief's authors found that scope of practice restrictions are associated with:

- Higher costs of care
- Delays in care and reduced care coordination
- Increased administrative burden and documentation requirements
- Barriers to entering advanced practice fields and lower employment of APPs

Researchers also suggest that restrictive scope of practice laws could run counter to the spirit of health care innovation efforts, including value-based payment models, accountable care organizations, global budget pilots, and telemedicine programs.

Reducing scope of practice restrictions, the authors assert, can help bring more APPs into the labor market and improve efficiency by allowing professionals to specialize in the services and procedures for which they are best-suited to perform. Additionally, with a higher supply of trained professionals who are qualified to provide the necessary care, patients have more options to access primary care providers, especially across rural areas.

The brief's comparative analysis shows that Pennsylvania currently lags behind other states in reducing scope of practice restrictions, limiting the practice authority of physician assistants and APRNs.

New care models involve teams to serve specific patients or patient populations. HAP supports the use of all health care practitioners in accordance with their scopes of practice and has advocated for changes to state and federal facility laws and regulations that allow hospitals to utilize these professionals to the full extent of their education and training. The expanded use of APPs helps hospitals alleviate workforce shortages; deliver timely, high-quality care to patients; and ease burdens on physicians.

HAP supports Senate Bill 25 of the 2019–2020 legislative session,[xvi] sponsored by State Senator Camera Bartolotta (R–Beaver), which will permit certified nurse practitioners to practice to the full scope of their license without the need for physician supervision after they have worked under such supervision for three years and 3,600 hours.

HAP supports the utilization of advanced practice professionals, including nurse practitioners, to effectuate and advance the delivery of quality team-based and patient-centered care.

INSURER CREDENTIALING PROCESS

Health insurers have an obligation to ensure that providers within its network are appropriately licensed and qualified to provide quality care to consumers enrolled in its health plan. Insurers do this through a process known as "credentialing," where insurers evaluate the history and qualifications of providers before adding them to the network.

The current credentialing process is complex and lengthy, resulting in reduced access for patients, while fully licensed and qualified practitioners await credentialing. It does not require credentialing decisions to be made within a specific timeframe. Further, it places an unnecessary administrative burden upon hospitals and other practitioners who must complete a multitude of long and redundant credentialing forms.

This can be especially difficult for rural communities. For instance, rural and urban areas with vulnerable communities, where physicians can be in short supply, often feel the impact most keenly. The credentialing process can mean the difference between getting a doctor's appointment within a few weeks or waiting for months.

Unnecessary delays around the credentialing process negatively impact both patients and provider practices.

This legislative session (2019–2020) HAP supports House Bill 533,[xvii] sponsored by Representative Clint Owlett (R-Tioga). House Bill 533 requires all insurers to use a common application form, and it calls for "provisional credentialing"—an expedited process to issue credentialing decisions within 45 days. Insurers would be required to begin reimbursing for services if they had not approved a completed application within the 45-day period. The bill will not prevent insurers from rejecting an application if the situation warrants such an action. House Bill 533 also will minimize the current administrative burdens for hospitals and providers.

HAP supports a credentialing process that balances the needs of insurers and providers, and increases patients' access to care.

Thank you for this opportunity to share HAP's perspective on key issues related to the commonwealth's health care workforce. Please feel free to contact us should you have any questions or need any additional information.

1. [i] HAP Nurse Fact Sheet http://www.haponline.org/Portals/0/docs/Reports-FactSheets/PA-Nurses-More-Than-a-Number-March2019.pdf

2. [ii] Senate Bill 780, Printer's Number 1852 (2017-2018 legislative session) https://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2017&sessInd=0&billBody=S&billTyp=B&billNbr=0780&pn=1852

3. HAP letter to the Pennsylvania Supreme Court Civil Procedural Rules Committee https://www.haponline.org/Portals/0/docs/Advocacy/HAP-Rules-Committee-Letter-2-21-19.pdf

4. [iv] Milliman Research Report—Impact of Venue Change https://www.haponline.org/Portals/0/docs/Advocacy/Final-PA-Venue-Analysis-20190220.pdf

5. [v] Association of American Medical Colleges (AAMC) Report https://news.aamc.org/press-releases/article/workforce_projections_03142017/

6. [vi] Data outlining Pennsylvania will need 10 percent more primary care physicians https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Pennsylvania.pdf

7. [vii] Senate Resolution 20 https://www.haponline.org/Newsroom/News/ID/4975/State-Senate-Passes-Senate-Judiciary-Chair-Bakers-Resolution-Calling-for-Study-on-Venue-Rule-Change

8. [viii] American Nurses Association Data on States who Designate Penalties for Assaults on Nurses https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/

9. [ix] Milliman Research Report about impact of community violence at hospitals https://www.aha.org/system/files/2018-01/community-violence-report.pdf

10. [x] American Hospital Association's (AHA) Hospitals Against Violence Initiative https://www.aha.org/websites/2017-12-17-hospitals-against-violence-news

11. [xi] Senate Bill 445 (2017-2018 legislative session) https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2017&sInd=0&body=S&type=B&bn=0445

12. [xii] House Bill 646 (2017-2018 legislative session) https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2017&sInd=0&body=H&type=B&bn=0646

13. [xiii] Joint Commission—Employee Badges https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1115&ProgramId=46

14. [xiv] OSHA Workplace Violence Prevention Guidelines https://www.osha.gov/Publications/osha3148.pdf

15. [xv] Hamilton Project Policy Brief https://www.brookings.edu/research/improving-efficiency-in-the-health-care-system-removing-anticompetitive-barriers-for-advanced-practice-registered-nurses-and-physician-assistants/

16. [xvi] Senate Bill 25 (2019-2020 legislative session) https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2017&sInd=0&body=S&type=B&bn=0025

17. [xvii] House Bill 533 (2019-2020 legislative session) https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2019&sInd=0&body=H&type=B&bn=533