Pennsylvania House Health Committee Hearing: Nurse Staffing Legislation
May 2, 2023

Testimony of Stephanie Pollock, BSN, RN, CCRN, Pediatric Intensive Care Unit Patient Care Manager, St. Luke's University Health Network

Thank you to Chairman Dan Frankel, Chairwoman Kathy Rapp, and members of the House Health Committee for inviting me to testify today. On behalf of the over 4,000 nurses at St. Luke's University Health Network, I thank you and all the legislators and administrators of the Commonwealth for your concern for, and commitment to, patient safety and the nursing profession.

My name is Stephanie Pollock and I am a registered nurse at St. Luke's University Hospital in Bethlehem. St. Luke's University Hospital is the tertiary care facility in the St. Luke's University Health Network system. St. Luke's is a non-profit, regional, fully integrated, nationally recognized network providing services at 14 campuses and more than 300 sites in Lehigh, Northampton, Carbon, Schuylkill, Bucks, Montgomery, Berks, Monroe and Luzerne counties in Pennsylvania, as well as Warren and Hunterdon counties in New Jersey.

I am the currently the patient care manager of the Pediatric Intensive Care Unit (PICU). I also provide direct patient care on a routine basis by choice and by necessity. I graduated from Luzerne County Community College and received a BSN from Misericordia University. I have a critical care certification through the AACN and am currently pursuing a Doctorate of Nursing Practice degree from Penn State University. I have over ten years of experience in pediatric and neonatal intensive care. While I currently work in Lehigh County, I am a lifelong resident of Hanover Township, Luzerne County, and I have provided healthcare to patients in Luzerne, Lackawanna, Montour, and Dauphin counties.

As a network fully committed to safe staffing and quality care, as evidenced by our nationally and internationally recognized quality outcomes, St. Luke's respectfully opposes House Bill 106.

The proposed legislation requires additional regulations related to nurse staffing similar to what is already required by CMS, The Joint Commission, and the PA Department of Health. Federal regulation 42CFR specifically requires hospitals participating in Medicare to "have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all patients as needed".

The staffing challenges we face today are reflective of a supply issue, not the absence of mandated staffing ratios. In the past 15 months, St. Luke's University Health Network has hired over 1,000 nurses and would have hired more if they were available. Since the opening of our PICU in 2020 until today, I have been authorized to hire as many nurses as I need to ensure optimal staffing for our 8 bed PICU. This authorization included the use of external agency nurses. Despite our best efforts and aggressive recruitment strategies, we continue to have vacancies.

During that three-year time frame, I was authorized to divert patients to other Pediatric Intensive Care Units as a strategy to assure safe staffing was maintained. This type of analysis occurred daily in consultation with my medical staff colleagues and partners. This decision does not come lightly, as transfers to other facilities place undue psychological, emotional, and financial burdens on families. A length of stay in a PICU could be days or weeks, requiring families to be away from home and extended family for prolonged periods of time.

When evaluating staffing and patient care needs, it is essential the evaluation include all resources available. This proposed bill fails to address all the factors that impact nursing's operations. It does not address the invaluable contributions of Licensed Practical Nurses (LPN)s and Nursing Assistants, defined as "Direct Care Staff". There is one sentence that describes their additive benefit when only one RN is present, but their value goes far beyond a "second person present". This approach minimizes the skills, abilities, and critical patient interactions that these team members provide. In many areas of the hospital, the LPNs and Nursing Assistants are a highly valued and essential part of the care team, allowing RNs to work to the highest scope of their practice.

This proposed legislation also doesn't account for the fact that many hospital units can only be staffed with nurses who hold specific certifications. Nurses from different specialties require varying certifications, competencies, and credentials, meaning they cannot be rotated among specialty units. While I would love to have more nurses available for my unit, I can only staff the PICU with nurses that have pediatric advanced life support (PALS) certification. The issue I am describing here can pertain to any sub-specialty. For example, nurses working on the med/surg floor cannot cover for Labor & Delivery nurses, as L&D nurses need to have neonatal resuscitation program certification. It has proven difficult to acquire agency nurses that have specialized certifications.

St. Luke's PICU generally runs at a 1:1 or 1:2 ratio, depending on the acuity of the patients. This past fall we had a surge of RSV patients, and our PICU was full. During this critical care time, there was a point where there were only five pediatric critical care beds open in the entire state. Two of those beds were in our unit, but we didn't have the nurses available to safely open those beds. This is an example of the exercise that I go through on an hourly basis, based on nursing availability and the acuity of the patients that we have on the floor. I work closely with the nurses and the providers on whether the assignment can be doubled or in some cases, even tripled. Going to a 1:3 ratio is not a routine occurrence, but we need the flexibility to employ this option when the staff deems it appropriate. If we have a patient that is improving or being downgraded to the pediatric med/surg floor, we discuss if we are safely able to add another patient to the nurse's assignment. Our nurses have the autonomy to decide whether they can safely take on additional patients.

The legislation proposes a ratio of 1:3 for the pediatric med/surg floor. Our pediatric med/surg floor has 17 beds and is staffed with nurses that are also required to have PALS certification. The staffing ratio is usually 1:4, but they can range from 1:3 to 1:5 depending on the patient acuity and overall workload.

We have situations where the PICU and the peds floor are full. If the PICU patient is ready but can't get downgraded to the peds floor for the lack of staffed beds, they will stay in the PICU bed, which means that we can't take care of any new patients.

The legislation also doesn't address the status of Graduate Nurses (GN)s. St. Luke's is privileged to have the oldest continuously operating nursing school in the country. This tremendous asset enables us to have a robust pipeline of GNs. Upon graduation, these nurses work in our hospitals while pursuing their RN licensure. Given the current delays in the processing of RN licenses, our nurses often wait weeks or even months to receive their license following successful completion of their NCLEX tests. These delays prevent these RNs from practicing to the full extent of their expertise until their license is received.

If hospitals are forced to maintain rigid ratios across the Commonwealth, the number of patients who have access to healthcare services will shrink without the immediate injection of thousands of new RNs, which simply do not exist. The limitations on patient care units will keep more patients holding in the Emergency Departments (ED)s, which are not suited to manage long term maintenance of care. Holding patients in the ED will lead to dissatisfaction for all involved: ED nurses, ED physicians, ambulances, and most importantly, our patients and the citizens of the Commonwealth.

Attempting to implement the proposed staffing ratios will most assuredly bottleneck the entire continuum of care and will have implications beyond just the assignments of hospital nurses. The Ambulance Association of Pennsylvania has recently voted to oppose this legislation because of the severe impact this bill will have on the Commonwealth's Emergency Management System, further burdening the current lack of resources and staffing. Waiting in ED parking lots or traveling further to hospitals that are not on divert status will leave patients waiting unreasonably long times, sometimes life-threatening periods, for ambulances to arrive.

This brings me to another concern of this proposed legislation, which is the timely availability of care across the commonwealth. Imagine a scenario where your family member may need urgent care. Today's pre-hospital protocols require EMS to bring your loved one to the nearest available hospital. What if that hospital does not have the stated ratios to accept your family member? What if the next closest facility does not have the ratios required? And the next? This is a very real possibility given the current lack of RNs in the Commonwealth, and without the collaboration of the government, nurses, healthcare, and educational systems, this deficit will not resolve anytime soon. As a wife, daughter, and mother of two boys under the age of 14, this is a real concern of mine.

St. Luke's has examined publicly reported hospital quality performance data to assess the impact of regulated nurse staffing requirements in states with and without mandated staffing ratios. The data yielded the following:

- 8 states require hospitals to have staffing committees responsible for identifying nurse-driven ratios and staffing policy;

- 5 states require some form of disclosure and/or public reporting;
- **Minnesota** requires a Chief Nursing Officer or designee to develop a core staffing plan with input from others. The requirements are similar to Joint Commission standards;
- **Massachusetts** mandates 1:1 or 1:2 nurse to patient ratios in the ICU depending on patient acuity;
- **California** is the only state that has legislated a required minimum nurse to patient ratio be maintained at all times, with ratios varying by unit.

As the charts below demonstrate, Pennsylvania has better quality patient care ratings than California's, proving that nurse staffing legislation does not improve the quality of patient care.

The Leapfrog Group is a nonprofit industry watchdog committed to improving safety in the U.S. health care system. As part of their efforts, Leapfrog analyzes hospital performance and assigns a grade to nearly 3,000 hospitals across the country twice annually. The Leapfrog Hospital Safety Grade is comprised of more than 30 measures, including sufficient nurse staffing, selected from publicly reported national data sources, e.g., Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Management (CDC), Joint Commission (TJC), American Hospital Association's Annual Survey, and their own annual Leapfrog Hospital Survey. Leapfrog uses these performance measures to assign a single letter grade to represent a hospital's overall performance in keeping patients safe from preventable harm and medical errors.

St. Luke's University Health Network hospitals received straight A's in Leapfrog's Fall 2022 Hospital Safety Grade report.

Table 1: Comparison of Five State's Leapfrog Safety Grades – Fall 2022

State	Rank (of 50)	Eligible Hospitals	Grade "A"	Grade "B"	Grade "C"	Grade "D"	Grade "F"	Not Graded
Colorado	#4	47	23 (49%)	10 (21%)	9 (19%)	4 (9%)	0	1
New Jersey*	#6	70	33 (47%)	20 (29%)	14 (20%)	3 (4%)	0	0
Pennsylvania	#9	134	53 (40%)	43 (32%)	33 (25%)	2 (1%)	0	3
California**	#25	284	80 (28%)	77 (27%)	106 (37%)	17 (6%)	4 (1%)	0
New York*	#39	151	19 (13%)	19 (13%)	79 (52%)	33 (22%)	0	1

* States with staffing laws
** States with legislated minimum nurse staffing ratios

Source: The Leapfrog Group
www.hospitalsafetygrade.org

The Hospital Acquired Conditions (HAC) program withholds 1% of Medicare reimbursements for hospitals with the highest rates of infections and patient injuries. For FFY2022, 764 hospitals (25% of participating) were penalized under this program.

Table 2: Comparison of Five State's HAC Penalties – FFY2022

State	Eligible Hospitals	Hospitals Penalized	Hospitals Not Penalized
Colorado	50	11 (22%)	39
Pennsylvania	140	38 (27%)	102
California**	281	80 (28%)	201
New Jersey*	63	18 (29%)	45
New York*	138	52 (38%)	86

* States with staffing laws   Source: khn.org/news/hospital-penalties
** States with legislated minimum nurse staffing ratios   10/31/2022

The CMS Overall Star Rating for Hospitals summarizes 57 of the quality measures found on the CMS Care Compare website. Important topics, e.g., readmissions and deaths after heart attacks, pneumonia, and other common conditions are included. The overall rating, between 1 and 5 stars, summarizes various measures across 5 areas of quality into a single star rating for each hospital. The 5 measure groups include: Mortality, Safety of Care, Readmission, Patient Satisfaction, and Timely & Effective Care. The overall star rating shows how well each hospital performed when compared to other U.S. hospitals. The more stars, the better a hospital performed according to these objective measures.

Table 3: CMS Overall Star Ratings – Q4 CY2022 Update

U.S. States	5 & 4 Stars (Best)	3 Stars (Avg.)	2 & 1 Stars (Worst)
Colorado	68.8%	22.9%	8.3%
Pennsylvania	54.3%	30.2%	15.5%
California**	35.2%	26.1%	38.7%
New York*	24.2%	25.0%	50.8%
New Jersey*	23.8%	33.3%	42.9%

* States with staffing laws   Source: CMS Hospital General Information
** States with legislated minimum nurse staffing ratios   10/26/2022

This comparison of objective publicly reported data reinforces that regulated nurse staffing laws have little to no impact on patient outcomes.

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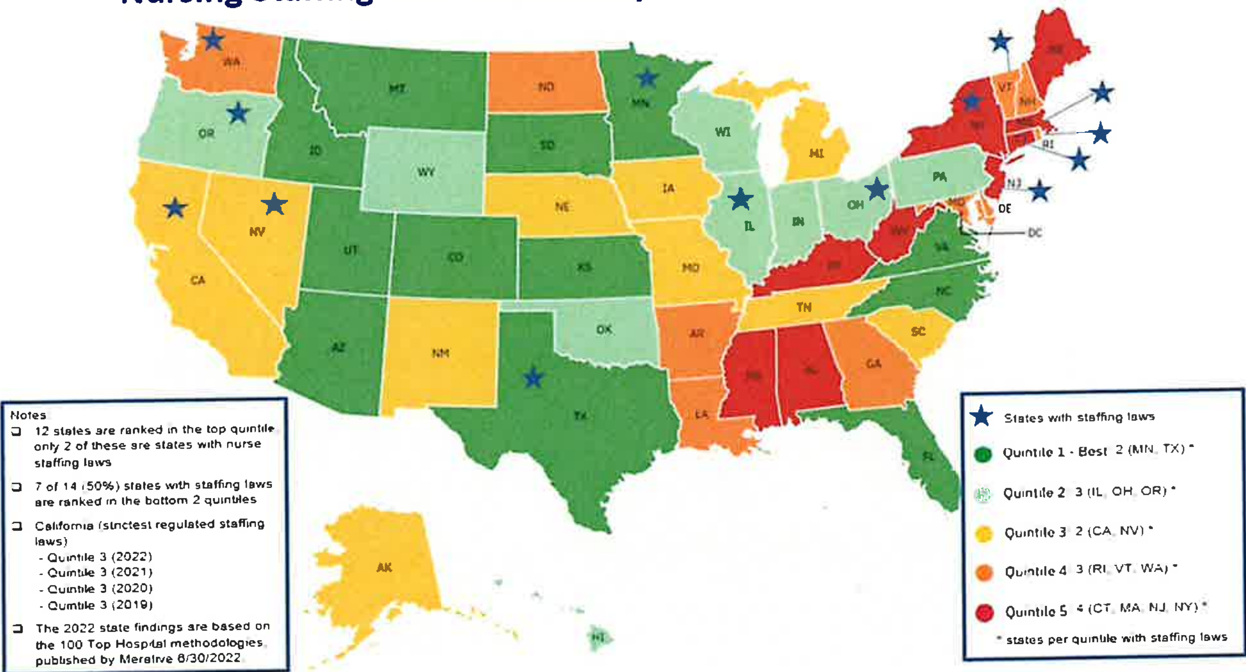
The following is a map from the 2022 Merative™ (formerly IBM Watson Health) 100 Top Hospitals report, comparing the performance of hospitals in states with and without staffing laws in place. This research is based on the following public data sets: Medicare cost reports, Medicare Provider Analysis and Review (MEDPAR) data, and core measures and patient satisfaction data from the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website.

As you can see, of the 12 states ranked in the top quintile, only two of these are states with nurse staffing laws. Half of the states that have staffing laws in place are ranked in the bottom two quintiles.

State-Level Performance Comparisons

Nursing Staffing Laws 2022 Study



In addition to the quality data mentioned, St. Luke's is currently at the 80th percentile in patient satisfaction. We view that as one important indicator that our patients in the region acknowledge the great work our nurses, physicians, and other clinical staff do on a daily basis, and reflects their view that they receive excellent care, and all within the current staffing parameters.

As a Registered Nurse I am passionate and deeply committed to my profession. I wholeheartedly support any efforts that will bring more individuals into our wonderful profession and to the bedside where they are desperately needed. There are countless opportunities for the Commonwealth, hospital, nursing, and educational facilities and communities to work together to improve the quality of patient care, improve provider resiliency, and increase the number of nurses in our hospitals. The following lists a few examples of those opportunities:

- Programs that encourage or incentivize hospitals to partner with colleges and universities to educate new nurses;
- Investment in nurse student loan repayment programs, faculty bonus payment initiatives, nurse mentoring programs for novice nurses, grant programs for higher education, and scholarship programs for individuals pursuing nursing careers;
- Incentives, like tax credits, to reward nurses for remaining active in clinical nursing;
- Support for the development of co-op programs;
- Funding for research initiatives focused on evidence-based practices and innovations to enhance excellence in patient care and staffing;
- Support for efforts to launch an investigation into potential anti-competitive activity or violation of consumer protection laws from nurse-staffing agencies; and
- Assess/enhance the Pennsylvania State Nurse Practice Act and Pennsylvania State Rules and Regulations to assure RN/LPN/CRNPs may practice to the full scope of their educational preparation to maximize their contribution to health care.

Thank you for allowing me the time to testify today.

Respectfully submitted,

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