SEIU
Stronger Together

ANDREW L. STERN
International President

ANNA BURGER
International Secretary-Treasurer

PATRICIA ANN FORD
Executive Vice President

ELISEO MEDINA
Executive Vice President

TOM WOODRUFF
Executive Vice President

SERVICE EMPLOYEES
INTERNATIONAL UNION
AFL-CIO, CLC

1313 L Street, N.W.
Washington, D.C. 20005

202.898.3200
TDD: 202.898.3481
www.SEIU.org

8105-1000

COMMENTS REGARDING HEARINGS ON HEALTH CARE AND COMPETITION LAW AND POLICY

Good afternoon. My name is Cathy Stoddart, and I am a registered nurse working in the transplant unit of Allegheny General Hospital in Pittsburgh, Pennsylvania. I am also a member of District 1199P/Service Employees International Union. I appreciate the opportunity to talk about the importance of providing patients and their families with relevant, easy-to-use and easy-to-understand information regarding the quality of care in hospitals.

Because I am a transplant nurse, I know the factors that affect transplant outcomes: the underlying health of the patient, the experience and teamwork in the operating room, thorough and timely wound care and medication administration done by nurses, and the careful infection control practices of everyone in the hospital. And finally, patients and their families must be given extensive education and preparation before discharge.

In theory, if patients are given accurate information about the quality and price of hospital and physician services, they will choose the providers that offer the best value for them.

In Pennsylvania, for example, we have an excellent independent state agency, the Pennsylvania Health Care Cost Containment Council, known as PHC4, which collects and publishes a large amount of price and quality data from Pennsylvania hospitals. PHC4 adjusts the data for underlying patient risks, measures mortality rates for over two dozen procedures, measures lengths of stay, and even readmission rates. The data is very useful in identifying outliers—hospitals or procedures that stand out from their peers on these measures. It has helped policymakers quantify the cost of manageable and preventable diseases such as diabetes. It has helped hospitals and physicians examine underlying reasons behind their performance on the measures.

But the data has limits. It remains very difficult, for instance, to judge the relationship between costs, quality, and price. Small community hospitals and rural hospitals are worried that the data can be used by larger, consolidated hospital systems to eliminate competition. By the time the data is published, it is a few years old and may not reflect the most current hospital conditions.

urthermore, information alone is not enough to encourage better price and quality on among hospitals. Health care, in general, and hospital care, in particular, are not services that we buy. We don't always have a large number of choices in hospital re and more, employers are offering a limited number of health insurance choices to with different co-pays, deductibles, and other coverage limits. More and more, surance plans limit the number of hospitals or merged hospital systems that are in their network. Often, patients are limited to the hospital where their physician has admitting privileges. In an emergency, of course, they might be taken to the nearest hospital without regard to what kind of grade or ranking the hospital may have received on a consumer report card. Once patients

are admitted to a hospital, it becomes difficult to "vote with their feet" and transfer to another hospital if they are not satisfied with their care.

Because of these limitations of information to improve hospital competition on the basis of quality and price, many nurses and nurse unions believe we need stronger regulatory standards for hospitals. Specifically, we conclude that there is now strong research evidence to support minimum nurse to patient staffing requirements for acute care hospitals as an effective way to improve patient outcomes. Much of the research that demonstrates the link between nurse staffing levels and patient outcomes has been sponsored by the federal government. I will summarize only a small amount of the growing body of evidence linking nurse staffing to patient outcomes.

- Research funded by the federal Agency for Healthcare Research and Quality (AHRQ) and carried out by Jack Needleman, Ph.D. and Peter Buerhaus, Ph.D. reveals a strong and direct link between the RN staffing levels and time spent with patients and whether patients develop serious complications or die while in the hospital.[1] Needleman, Buerhaus and their colleagues found that low levels of RN staffing were associated with higher rates of complications such as pneumonia, upper gastrointestinal bleeding, shock, sepsis and cardiac arrest, including deaths from these complications. These complications occurred 3% to 9% more often in hospitals with low RN staffing compared to levels with higher RN staffing. Urinary tract infections were higher in hospitals with lower RN staffing patterns, and lengths of stay were also longer.

- Last year, the *Journal of the American Medical Association* reported results from Linda H. Aiken, and colleagues showing that for each additional patient that is assigned to a nurse above four patients, risk-adjusted mortality rates rose 7%, and "failure to rescue" patients with complications also rose 7%. In addition, nurses working on units with "short staffing" had lower job satisfaction and higher rates of burnout.

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently reported that inadequate staffing levels were implicated in 24% of the "sentinel events"—unanticipated events that result in death, injury, or permanent loss of function—it investigated through March 2002. Other contributing factors in these sentinel events implicated nursing problems as well.[2]

- An expert panel convened by the California Department of Health Services in 2002 reviewed research related to nurses, nursing, and patient outcomes. Using strict criteria, the panel reviewed 37 studies, and concluded that nurse staffing is related to patient in-hospital mortality rates and several patient complications, including pneumonia and nosocomial infections. They also concluded that fewer nurses were associated with longer patient lengths of stay. The panel was convened to advise the California DHS as it wrote regulations to carry out state legislation enacted in 1999 to require nurse-patient ratios in all acute care hospitals.[3]

---

[1] www.ahrq.gov/news/press/pr2002/dilinkpr.htm

[2] JCAHO, "Health Care at a Crossroads: Strategies for Addressing the Evolving Nursing Crisis", August 2002

[3] http://www.applications.dhs.ca.gov/regulations/store/Regulations/Section%201%20Literature%20Review.pdf

Minimum nurse staffing levels, set by unit within hospitals, would set a minimum safe standard and provide assurance for patients that they would receive a minimum level of quality care regardless of which hospital they may be admitted to. Of course, hospitals and nurses should also be encouraged to work together to tailor staffing levels and mix to patient acuity and any special factors affecting their hospital's situation and setting. We think state legislation, as part of states' authority to license hospitals, is an important way for states to raise hospital quality. We also think federal Medicare hospital conditions of participation should be updated to reflect the link between nurse staffing levels and patient outcomes.

We think that Medicare and other payers should begin to reward hospitals financially if they improve staffing levels and patient outcomes. We note that other respected health care experts, such as the Institute of Medicine, also recommend new reimbursement approaches that pay hospitals for demonstrated higher quality outcomes. Since higher nurse staffing has also been linked to lower lengths of stay, there are likely to be significant economic benefits to payers in addition to quality improvement for patients. Because nurse staffing levels cut across all aspects of hospital care, they are an important measure that reflects quality.

Some critics of mandating nurse staffing levels may say that mandates limit hospital flexibility, and won't accommodate improvements in technology.

But setting *minimum* safe nurse staffing standards will not prevent hospitals from tailoring nurse staffing levels to meet patient needs. Hospitals and nurses will also continue to be free to work together to design innovative staffing plans.

Nor will minimum safe staffing standards limit hospitals' ability to substitute new technology for nurses. Most technological improvements in health care lead to a *greater* need for nurses because technological improvements make it possible for sicker patients to receive procedures and treatments that they never would have been candidates for in the past. This is one of the reasons behind the current nurse staffing crisis—the acuity level of hospital patients has risen over the last decade as a direct result of technological change, requiring more direct nursing care.

In summary, while we support any policy that would provide patients and their families with easy to use and understand information about the quality of care in hospitals, we ask that you recognize the limitations of such information—primarily that patients, unlike consumers of other services, aren't always able to choose their hospital.

We feel that it is vital for states to establish minimum, safe nurse staffing levels that all hospitals must follow. Reimbursement plans should reward those hospitals with better nurse staffing levels and subsequent better patient outcomes. These are policies that will ensure the quality of care for all patients—regardless of their ability to make informed choices. Only by ensuring sufficient numbers of registered nurses on the front lines can we ensure the quality of care for *all* patients in *all* hospitals.