HB106—
THE PATIENT SAFETY ACT:
A Minimum Safety Standard for Nurses in PA Hospitals

The Crisis in Pennsylvania Hospitals—
More Than Half of PA Hospitals Have Substandard Nurse Staffing Resulting In Substandard Patient Care

There's a crisis in our hospitals right now. For decades, nurses have been intentionally staffed at unsafe levels in order to save money, leading to unsafe patient care. The pandemic greatly exacerbated the problem, and we are now in a full-blown crisis. House Bill 106, which establishes a basic patient safety standard in PA hospitals, will fix the problem, saving both lives and money.

PASNAP
PENNSYLVANIA ASSOCIATION OF STAFF NURSES & ALLIED PROFESSIONALS • www.PASNAP.com

Wide Variation in Nurse Staffing in Hospitals Across PA

There is an urgent need to enact a patient safety standard in Pennsylvania. Dr. Linda Aiken, founder of the Center for Health Outcomes and Policy Research at the University of Pennsylvania Nursing School and the leading global authority on safe staffing, has been studying the outcomes of PA hospital nurse staffing since 1999. The Center has found that there is significant variation in nurse staffing adequacy across Pennsylvania's acute care hospitals with substantial adverse outcomes for the public.

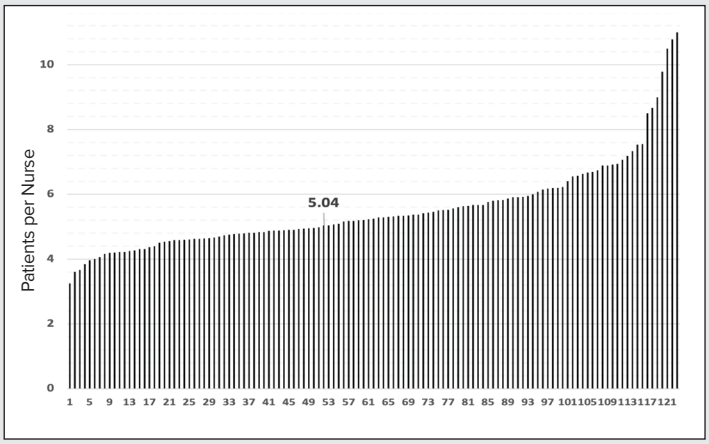
The Center's study of 114 PA hospitals found that nurse staffing on adult medical and surgical units averages 5.6 patients per nurse and varies among hospitals from 3 to 11 patients per nurse.

Medical-Surgical Staffing (Patients per Nurse) in PA Hospitals, 2016

Mean	5.4
Standard Deviation	1.2
Minimum	**3.3**
Maximum	**10.8**
Number of Hospitals	91

Data are from most PA hospitals of over 200 beds

Medical Surgical Patient-to-RN Ratios in PA Hospitals, 2016
Hospitals Arrayed from Best to Worst Staffing



Half the Hospitals in the State are at Significant Risk of Negative Patient Outcomes

The PA average of 5.6 patients per nurse means that half the hospitals in the state are at or not far from meeting the number of patients per nurse proposed by HB106—but the other half are significantly above that number, many far above, and those are the ones at the highest risk of negative patient outcomes. Hundreds of studies over decades have associated too many patients per nurse with a **wide range of negative patient outcomes, including mortality, failure to rescue patients with complications, hospital acquired infections, length of stay, readmissions, and patient safety**.

The Center has found that for every additional patient over the recommended standards:

- **In-hospital mortality increased by 7% for each additional medical patient and 8% for each surgical patient added to nurses' workloads.**
- **Readmissions increased by 2% for medical patients and 4% for surgical patients for each 1 patient increase in nurses' patient workloads.**

This means that patients in hospitals where each nurse has 11 patients (see graphic above)—or, 7 over the recommended 4—face an increased risk of mortality of 49 to 56%.

Will Legislated Staffing Standards Fix the Problem?

YES. Decades of research and the results from the places where patient safety standards have been implemented—in California, Massachusetts, and internationally—have shown that they work—that, in fact, they are the only approach that works. That's why **90% of the public support mandatory staffing standards**, and why momentum is growing to enact them in other states. A safe staffing bill much like ours in Pennsylvania just recently passed in Oregon. In addition to PA, the following states have pending safe staffing legislation: Connecticut, Georgia, Illinois, Maine, Michigan, and New Jersey.

Safe Staffing Standards in PA Hospitals Will Save Lives...and Money

The Center for Health Outcomes and Policy Research at UPenn estimates that HB106, if implemented in PA, would have the following positive impacts on patient care. Just looking at med surg units alone (impacts across all units would be much greater):

- **1,155 hospital deaths would be prevented annually.**
- **771 hospital readmissions would be avoided annually.**
- **Length of stay would be reduced by 34,919 days annually.**

These patient care impacts would lead to substantial cost savings for hospitals (again, these estimates consider med surg units only and would be much greater across all hospital units):

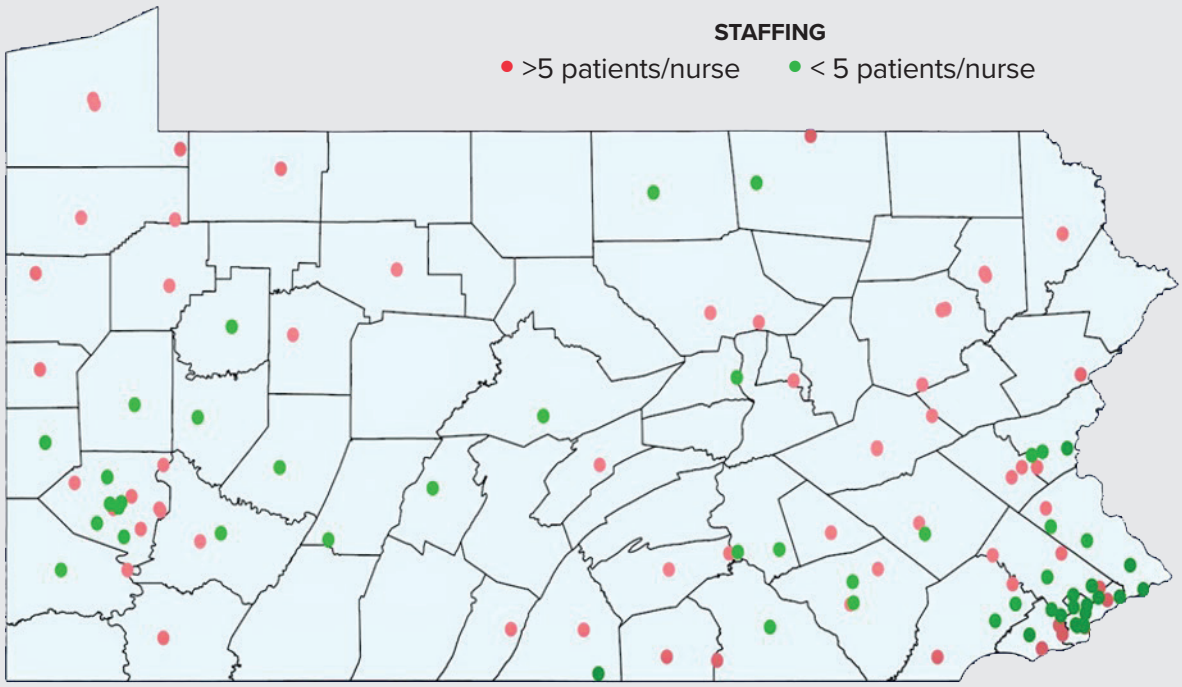
- **Reducing length of stay by 39K days annually—would save $93 million**
- **Hospitals would see additional savings from higher satisfaction, avoiding readmission penalties, reducing turnover, and reducing burnout**

Further cost reductions would come from reducing nurse turnover. The estimated cost of replacing a nurse is $88K. If the current turnover rate of 30% were cut in half to 15%, it would save hospitals $650 million per year.

Can We Do It?

YES—40% of hospitals in Pennsylvania are already either meeting the standards, or close to meeting the proposed standards (5 patients per nurse or better). And, as shown in the map below, these hospitals are spread out across the state, in rural, urban, and suburban areas.

PA Study—Hospitals with Nurse Staffing Greater Than 5 Patients Per Nurse and Less Than 5 Patients Per Nurse, by County



Source: Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing

Hospital Arguments Against Safe Staffing Standards

Like automobile manufacturers in the 1960s who argued against legislation requiring seat belts in cars, hospitals and hospital associations across the country have fought against legislation that would enact basic patient safety standards for nurse staffing in hospitals. Most of what they say is misleading, flat-out untrue, or largely recycled talking points from similar efforts in other states with no objective evidence to back them up. There are simply no good reasons not to implement basic safety standards, and it is frankly unfortunate that some Hospitals and the Hospital Association in Pennsylvania are arguing against such standards that will improve outcomes and avoid unnecessary deaths in PA hospitals.

WHY SOME (BUT NOT ALL) HOSPITALS ARE AGAINST HB106, WHAT THEY WILL SAY—AND WHY THEY'RE WRONG

"It costs too much. Hospitals are going to close if we do this."

This has not happened anywhere ratios have been implemented. This is simply a scare tactic being used by hospitals to avoid the imposition of basic safety standards.

Professor Linda Aiken, Ph.D., founding director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania and the foremost expert on nurse staffing and patient safety as it relates to nurse staffing in the world, estimates that length of stay reductions alone would save PA hospitals $93 million annually. Plus, additional savings would accrue to hospitals for achieving higher patient satisfaction, avoiding Medicare readmission penalties, and reducing nurse turnover, which currently costs PA hospitals many millions of dollars annually.

"Length of stay reductions alone would save PA hospitals $93 million annually. Plus, additional savings would accrue to hospitals for achieving higher patient satisfaction, avoiding Medicare readmission penalties, and reducing nurse turnover, which currently costs PA hospitals many millions of dollars annually."

$93M
savings in length of stay reductions

No one wants to see hospitals succeed more than nurses. We know some hospitals are having a hard time financially and may need some help—particularly rural hospitals. They should get it. But that's not a reason to not put into place basic safety standards that are proven to work.

"Rural hospitals are special/different and REALLY can't afford it; they don't have the same level of care as an academic medical center like Penn."

When we implement a basic safety standard, we do it across the board, because it's just not acceptable to allow unsafe practices to occur anywhere, especially in acute care hospitals. While smaller rural hospitals may not take all the advanced cases that a larger urban hospital may take, the **standard of care for the patients they do take is the same**. Patients in rural hospitals deserve the same protections and the same basic assurance that minimum standards of care are being met as those in large urban medical centers.

Already included as part of the bill is a longer on-ramp for rural hospitals. Some may need help getting to the standard, and the state must be willing to provide help where it's needed. We need to make sure all PA hospitals are both sustainable, and safe.

"We won't be able to find the nurses. Especially in rural areas of the state."

The problem isn't that we don't have enough nurses. We actually have plenty of licensed RNs in Pennsylvania—more than the national average and more than most other states. The national average is 9.19 RNs per 1,000 population; Pennsylvania has 11.48 RNs per 1,000 population. California, at 8.20 RNs per 1,000 population, successfully implemented ratios with a significantly lower nurse supply than PA.

That goes for rural areas of the state as well. As you can see in the graphic on page 6, there are about the same number of nurses per 100,000 residents in rural and urban areas.

Pennsylvania Licensed Health Care Providers per 100,000 Rural and Urban Residents, 2020

DENTIST
Rural: 42.4
Urban: 69.2

PHYSICIAN & SURGEON (MD & OD)
Rural: 191.9
Urban: 393.2

PHYSICIAN ASSISTANT
Rural: 89.1
Urban: 80.1

REGISTERED NURSE
Rural: 1,339.8
Urban: 1,493.1

NURSE PRACTITIONER
Rural: 68.8
Urban: 101.6

PHARMACIST
Rural: 112.4
Urban: 146.6

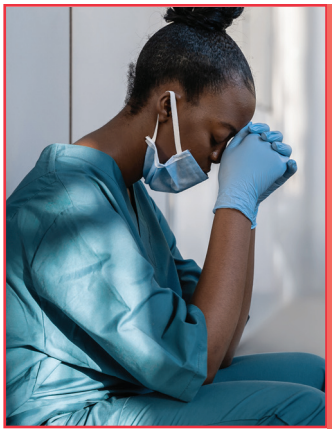
PHYSICAL THERAPIST
Rural: 84.1
Urban: 107.5

PSYCHOLOGIST
Rural: 18.6
Urban: 48.6

Source: Pennsylvania Department of State, Presentation from Lisa Davis, MHA, Director and Outreach Associate Professor of Health Policy and Administration, given to the Pennsylvania Organization of Nurses Leaders (PONL), September 2023

The PA Chamber of Business and Industry has claimed that we have a nurse shortage in PA, citing a study by the Hospital and Healthsystem Association of Pennsylvania that shows that more than 30 percent of registered nurse positions in PA hospitals are currently vacant. Dr. Linda Aiken has said that the Chamber is wrong about the nurse supply in PA: "Hospital vacancies do not equate with a supply problem and evidence suggests that vacancies are due to poor work environments that are not acceptable by enough nurses rather than a nurse shortage."

The real problem isn't a shortage of nurses, it's turnover. According to the Hospital Association's own numbers, there is a 30% turnover rate among nurses in PA Hospitals. That equates to the 30% vacancy rate. Hospitals are indeed hiring nurses, but they can't keep them due to poor working conditions, primarily unsafe staffing. It's a revolving door.



30%
turnover rate among nurses in PA Hospitals

The real problem isn't a shortage of nurses, it's turnover.

Understaffing is the single biggest cause of nurse burnout.

Nurses are simply not willing to risk their licenses to work in the conditions at the bedside. Currently, there are approximately 233,000 RNs in Pennsylvania, yet only about 149,000 are employed. Nurses are leaving the bedside because of unsafe staffing.

Understaffing is the single biggest cause of nurse burnout. Nurses are not going to stay at the bedside or return to it unless decent staffing levels are in place. You can train and educate all the nurses you want, if more are leaving than coming in, you are not going to solve the problem.

Research shows that better staffed hospitals have greater success recruiting and retaining nurses. According to Dr. Aiken, there is much evidence that the current difficulties hospitals are experiencing recruiting and retaining nurses are due to chronic nurse understaffing and poor work environments that predated the pandemic.

Contrary to what hospitals are saying, putting in place safeguards on the number of patients a nurse can have is the only thing that is going to fix the staffing problem in PA hospitals. Safe staffing standards have been proven, in practice, to stop nurses from leaving the bedside and will in fact lure them back. That's what happened in CA—the number of nurses shot up after ratios went into effect. In the decade after the ratio law was signed, the number of actively licensed **RNs in California grew by more than 110,000 RNs**, tripling the average annual increase that was occurring prior to the law being passed. The state had been facing a nursing shortage, but after mandating safe staffing standards in 2004, the nursing shortage gradually but consistently improved as well, and California has enjoyed a nurse surplus since 2013.

"Ratios don't work."

They do—this is not a topic that is subject to real debate. The link between nurse staffing and improved patient outcomes has been proven by **decades of research and proven in practice by the examples of where ratios have been implemented (California, Massachusetts, and Queensland, Australia).** The data is clear:

- **Better nurse staffing leads to better outcomes (fewer deaths) and lower costs.**
- **Ratios are the only thing that leads to better nurse staffing.**

Dr. Linda Aiken's Center for Health Outcomes and Policy Research has found that every 1 patient increase in hospital inpatient nurses' workloads is associated with a 7% increase in failure to rescue patients experiencing complications, as well as a 23% increase in nurse burnout and a 15% increase in nurse job dissatisfaction, both of which are associated with expensive nurse turnover. If the Patient Safety Act passes, requiring nurses in PA hospitals to care for no more than four adult medical and surgical patients (outside ICUs) each, the Center estimates:

- **1,155 hospital deaths would be prevented annually.**
- **771 hospital readmissions would be avoided annually.**
- **Length of stay would be reduced by 34,919 days annually.**

"Ratios are too rigid. One size doesn't fit all. We need flexibility."

Ratios are minimum safety standards—so, yes, like all safety standards, they should be applied to all hospitals. That's the whole point of a standard. There's no reason for any hospital to be below the standard, but they are perfectly free to exceed it. In certain circumstances, for instance, there may be good reasons (higher acuity = a sicker patient who needs more care) for a nurse to have fewer patients. Hospitals can and should make adjustments based on increased patient care needs.

When hospitals make the argument that ratios are too rigid, what they are really saying is, "we want the flexibility to do worse than the standard," not better. They absolutely can do better within this legislation and should not be allowed to do worse.

"We're OK with staffing committees or public reporting, but not ratios."

Hospitals and hospital associations have long argued for committees that have no authority to avoid having an objective safety standard they are required to meet. It's precisely because there is no objective standard and no accountability that **committees and public reporting laws have been proven to be ineffective in the states that have them. Ratios are the only mechanism that has been shown to work to improve nurse staffing and patient safety.** (*Alternative Approaches to Ensuring Adequate Nurse Staffing, Oct. 2021, Han, X., Pittman, P., Barnow B. Medical Care, 2021; 59(10):S463)*

"Health care is best left up to doctors and hospitals; they know what's best, not legislators. Plus, we have great hospitals in PA. We're doing just fine."

We are not doing just fine. According to the University of Pennsylvania/CHOPR White Paper on Nurse Staffing in PA, half the hospitals in the state are at high risk of negative patient outcomes due to understaffing.

The fact that there is no safety standard for the number of patients a nurse can have is a blind spot in our regulations, especially when there is such clear research that: a) there's wide variation in staffing among PA hospitals; b) a high risk of negative outcomes because of it; and c) safe staffing works. **Childcare has safety standards, nursing homes have them—why shouldn't hospitals, where the stakes are MUCH higher?**

The 2015 report of the Pennsylvania Joint State Government Commission found: *"...though Pennsylvania has no shortage of nurses, the nurse staffing levels across PA Hospitals are highly variable and [that variability] has persisted over the last 14 years." That variability, the report goes on to say, has a serious negative impact on patient care.*

Not all hospitals in Pennsylvania staff appropriately—that is a proven fact. Hence, the need for a standard created by national nurse licensing organizations, not legislators, for the hospitals that don't or won't follow basic standards voluntarily.

"If this is such a great idea, why aren't more states doing it?"

The research is clear, and the results are clear where a minimum patient safety standard has been implemented. The only reason it hasn't been done in more states is because hospitals have dumped millions of dollars into campaigns against it and have fought tooth and nail to avoid a basic, common-sense safety regulation. **It's time we listened to nurses, not hospital CEOs, and to potential patients: In a recent national Harris Poll, 90% of the public favor minimum nurse staffing standards in hospitals.**

90%

of the public favor minimum nurse staffing standards in hospitals.

"Now is not the time. We're just coming out of the pandemic. This is not the time to ask hospitals to take on something like this. We can't find nurses, and we're paying an arm and a leg for agency. If you force us to get even more agency, we'll go under."

We hear you, and we have to make sure our hospitals are successful. But part of that is making sure there are basic safety standards in place, and that hospitals can meet them. If our hospitals can't do that, we are failing the people of Pennsylvania.

"Hospitals and their CEOs oppose ratios."

Not all of them. In fact, the CEO of the most highly rated hospital in the state strongly supports ratios. Kevin Mahoney has written opinion pieces and spoken publicly about the need for minimum standards to relieve nurse burnout, improve care for patients, and create better work environments to attract and retain frontline caregivers.

"We should not be afraid to follow the evidence toward new approaches when the status quo is broken. Without ratios, we're going to get into a perpetual downward spiral and nurses will continue to exit the business."

— KEVIN B. MAHONEY
CEO, University of Pennsylvania Health System

From his July 9, 2023 op-ed published in *Penn Live*: "Opposition to the Patient Safety Act has frequently hinged on whether hospitals could comply, especially as the entire industry is under significant financial strain. These concerns are valid and well-meaning, and efforts to apply safe staffing standards statewide should be coupled with initiatives to strengthen Pennsylvania's nursing workforce and ensure the long-term sustainability of hospital care in our communities. We should not be afraid to follow the evidence toward new approaches when the status quo is broken."

Mahoney has stated that without ratios nurses will continue to feel burnout from caring for too many patients during a shift—ultimately resulting in quality of patient care suffering. "Without ratios, we're going to get into a perpetual downward spiral and nurses will continue to exit the business." (February 7, 2024 *Business Journal*)

"This is a Democratic bill to help unions."

This bill is supported almost universally by bedside nurses across the state, regardless of party or union membership. The only nurses who oppose it are those who are in management or part of hospital administration. This bill has nothing to do with politics and everything to do with patient safety and public health.

House Bill 106 was introduced by a Republican member of the PA House of Representatives, and was Co-Primed by another Republican. It had 14 Republican Co-Sponsors from across the commonwealth. These GOP members represent union and non-union hospitals in rural, suburban, and urban settings. HB106 ultimately passed the House on 6/28/2023 with an overwhelming, bipartisan majority: 119–84. It received "Yes" votes from 19 Republicans from regions across the commonwealth.

House Bill 106 is supported by PA State Nurses Association (PSNA), which represents nurses who are not in unions, as well as the American Nurses Association (ANA).

Although nurses who are in unions also almost universally support this bill, the bill could actually hamper new organizing. The number one reason nurses form unions inside their hospitals is due to the unsafe staffing. This bill is likely to actually *hurt* nurse organizing efforts as it would take away a driving force for unionization.

The Pennsylvania Chamber of Business and Industry says "Nurse staffing ratios could also increase healthcare costs for Pennsylvania patients and employers by as much as $2 billion"—citing estimated costs in Massachusetts and New York.

This is a scare tactic, and completely misleading. According to the evidence, the costs of hiring additional nurses to meet the ratios will be largely, if not completely, offset by cost savings from reduced length of stay, reduced readmissions, reductions in medical errors, hospital acquired infections, and a host of other negative events that increase costs for hospitals, in addition to savings from reductions in nurse turnover.

However, the Chamber includes none of these estimated cost savings in its analysis.

Insurance companies will also see savings from reduced readmissions and less costly patient stays due to the reduction of negative events. There is no evidence that health insurance rates in CA rose as a result of their ratios and no reason to think insurance rates would rise in PA as a result of mandated staffing standards.

The public won't suffer the costs of improved staffing. To the contrary, the public will benefit in having better health outcomes. Dr. Aiken calls the cost numbers thrown around by the Chamber a "scare tactic," pure and simple.

"What about the Emergency Medical Treatment and Labor Act (EMTALA)? Won't hospitals be forced to violate ratios and face fines?"

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergent medical condition.

The screening and treatment do not need to be done by a nurse who has an assignment, and typically they are not—usually, a doctor, triage nurse (who typically has no assigned patients), or other medical personnel do the assessment and screening. This may be done upon entry, while in the waiting room, or upon being placed in a bed and assigned to a nurse. It is only when a patient is assigned a bed and a nurse that the patient counts as part of that nurse's maximum number of assigned patients.

Patients must be seen, but they sometimes have to wait, and sometimes get transferred, and sometimes are seen by a doctor, not a nurse. This is the ordinary course of operations in an ER, and in no way does a limit on the number of assigned patients to a nurse interfere with this.