

# BALLOT 2018

HOW MANDATED NURSE STAFFING RATIOS  
WILL HARM MASSACHUSETTS



COALITION TO  
**PROTECT**  
PATIENT SAFETY 

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## THE COALITION TO PROTECT PATIENT SAFETY

The Coalition to Protect Patient Safety was created to oppose the 2018 statewide ballot question that would impose nurse-to-patient ratios.

Leading healthcare organizations – representing nurses and hospitals throughout Massachusetts – are united in their opposition to government-mandated nurse staffing ratios that would override the decision making ability of healthcare professionals and cost more than \$880 million a year.

Coalition members include:

- The Massachusetts Health & Hospital Association
- The Organization of Nurse Leaders
- ANA Massachusetts (the local chapter of the American Nurses Association)
- Massachusetts Council of Community Hospitals
- Conference of Boston Teaching Hospitals

Other healthcare leaders, business groups, and those concerned about maintaining and improving the Massachusetts healthcare system are continuing to join the Coalition.

You can follow the Coalition to Protect Patient Safety:

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“Our patients will suffer. The additional costs will be passed on to them through higher premiums, deductibles and taxes. Care will be hindered by dramatically increased emergency room wait times and delays in other lifesaving care services. Even worse, it would force our hospitals to send patients to other hospitals or prevent us from admitting patients in crucial times of need.”

Diane Hanley, MS, RN-BC, EJD  
President, ANA Massachusetts, Associate Chief Nursing Officer  
Director, Professional Practice, Nursing Quality and Education, Boston Medical Center

## BALLOT 2018: HOW MANDATED NURSE STAFFING RATIOS WILL HARM MASSACHUSETTS HEALTHCARE

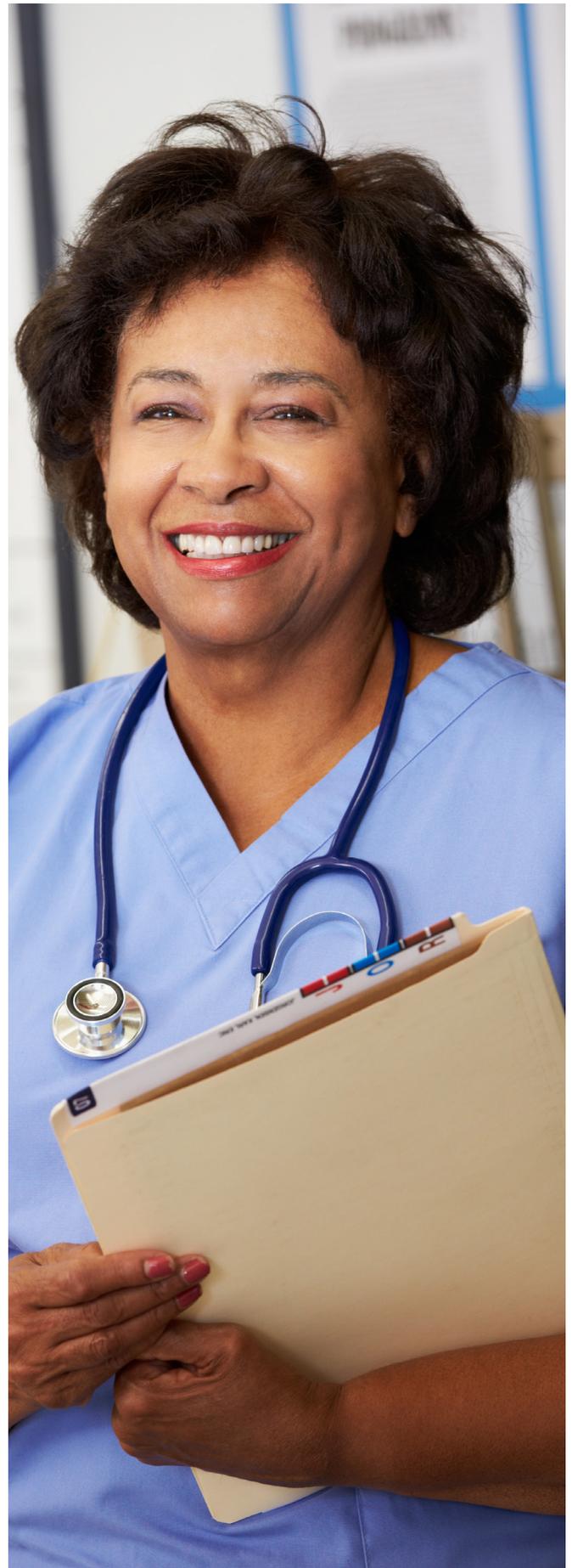
The Massachusetts Nurses Association (MNA), a union representing less than 25% of nurses in the state, is proposing a ballot question for the 2018 election that would impose government-mandated registered nurse staffing ratios on every hospital in Massachusetts. The Organization of Nurse Leaders and the American Nurses Association Massachusetts oppose this proposal.

These rigid ratios would have to be followed at all times, without exception, and would be identical for every hospital – large and small, rural and urban, teaching and community. **The proposal's impact on hospitals would be devastating: it would cost our system more than \$880 million a year. It would override the professional judgment of qualified healthcare professionals, threaten the quality and increase the cost of healthcare in Massachusetts.**

For voters, limiting the number of patients that nurses care for sounds reasonable – but the reality is far more complex. No existing scientific study has determined a “correct” nurse-to-patient ratio. Setting arbitrary, rigid ratios ignores the many variations in patient care, **including differences in nurses' education and experience, ever-changing patient conditions, the composition of the whole patient care team, and the varying technologies and physical attributes of different facilities.**

The MNA has waged this divisive and costly ratio battle in Massachusetts for nearly 20 years – and the Legislature has rejected it consistently.

In 2014, the nurses' union succeeded in gathering enough signatures to place a similar mandated ratio question on the November 2014 statewide ballot. However, in June of 2014, a legislative alternative was adopted, establishing staffing standards for hospital Intensive Care Units only. **Under the law passed in July 2014, registered nurse patient assignments in ICUs were set at a standard of 1:1 or 1:2, depending on the stability of a given patient as determined by an acuity tool and nurses in the unit,**



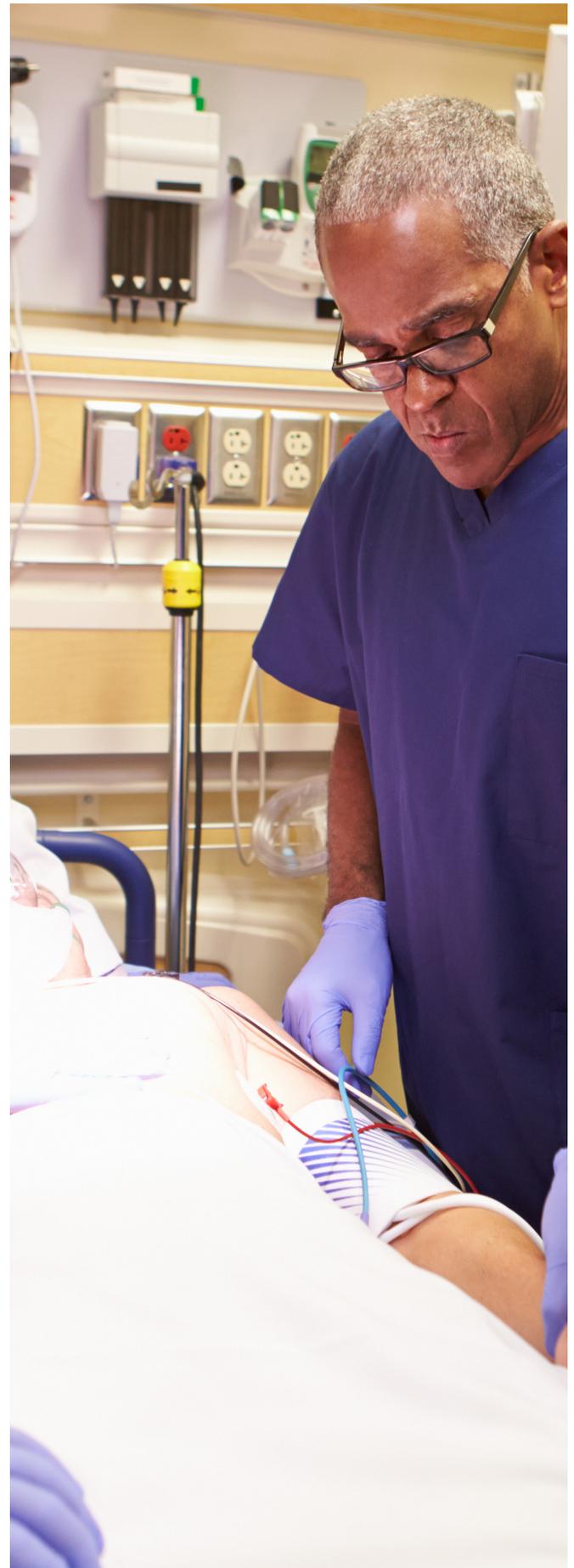
including the nurse manager.

As part of the ICU agreement, the union agreed to withdraw its ballot question which would have imposed nurse-to-patient ratios at all times across all hospital units.

Now, in 2018, the MNA is moving once again toward placing its rigid and costly question on the November statewide ballot. Again, this law would apply to all Massachusetts hospitals, in all units, at all times.

Although the healthcare system has changed dramatically in recent years, some fundamental truths remain:

- Staffing decisions need to be flexible in nature and made by healthcare experts at the bedside, not through the ballot box.
- Massachusetts hospitals have renowned reputations for high-quality care and patient satisfaction; allowing the government to second guess the professional judgement of talented and dedicated doctors, nurses, and healthcare professionals will disrupt and endanger care delivery.
- The \$880-million-per-year cost of rigid staffing ratios will drive up the cost of healthcare for families across Massachusetts; the high cost of this mandate could require hospitals to cut services to meet increased labor costs and force some financially vulnerable community hospitals to close completely.
- The staffing mandate will likely result in increased wait times in Emergency Rooms, ICUs, and other hospital units.



## THE CALIFORNIA EXPERIENCE: NOT A TEMPLATE FOR MASSACHUSETTS

In 2004, California became the first and only state to implement minimum nurse staffing ratios in acute care hospitals. Similar laws have been proposed in numerous other states since, but have been rejected in every one. Since then, studies have examined the effect of government-mandated nurse staffing ratios on patient safety, quality of care, and hospital financial performance.

### QUALITY & PATIENT SAFETY

To date, findings have shown that in California ratios have increased hospital costs with little to no benefits to patient care quality and safety.

A 2013 systematic review<sup>1</sup> of research literature focusing on how mandated staffing ratios affected patient outcomes and satisfaction in California found the following:

- Although nurse-to-patient ratios and RN hours per patient day increased, this did not have a statistically significant impact on any of the patient outcomes.
- In interviews with 12 hospital leaders from 23 California hospitals, researchers report that participants did not feel that patient satisfaction had improved since the implementation of the ratios.
- The findings from the majority of these studies do not support the assumption that increases in nurse staffing would lead to better quality of care, improvements in patient safety, or increased patient satisfaction.

**The bottom-line conclusion is that even though the California ratio law is less restrictive than what the MNA is proposing, it has wreaked havoc with California hospital finances and has not improved quality of care for patients.**

- The initial phase of the California law set a 1-to-6 nurse-to-patient ratio for Medical /Surgical floors. After a transition period, the ratio was set at 1-to-5 where it is now.
- The MNA is proposing a 1-to-4 ratio, at all times, for Medical/Surgical units, with no transition period.

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“This ballot question is basically, for me, somebody else telling me how to do my job effectively. As a nurse, I’ve gotten experience, I’ve worked my way up, I have learned how to manage patients and how to manage staffing, and now the state of Massachusetts is asking the voters to tell me how to do my job and how to best care for patients. And I think that’s a scary thought.”

Lauren Healey, R.N., BS, BSN, Emerson Hospital

<sup>1</sup> Serratt, T. (2013). California's nurse-to-patient ratios, Part 1: 8 years later, what do we know about nurse-level outcome? *Journal of Nursing Administration*, 43(9), 475-480.

## HOSPITAL FINANCES

The majority of studies that measured the financial impact of imposing mandated nurse staffing ratios in all units of a hospital showed increased costs for California hospitals, which one would expect with an increased demand for RNs across the state.

- A 2013<sup>1</sup> article explored the findings of 10 studies associated with the financial implications of California's nurse-to-patient ratios. After the ratios had been implemented for 8 years, this study concluded that ratios increased the cost of providing care, and forced hospitals to cut non-nurse staff, programs and services. Additionally, wages increased by more than 7-9%, contributing to significant increases in labor costs for California hospitals.
- Research<sup>2</sup> has shown that staffing ratios disproportionately affect safety-net hospitals that are generally already more financially constrained.

## MASSACHUSETTS VS. CALIFORNIA HOSPITALS

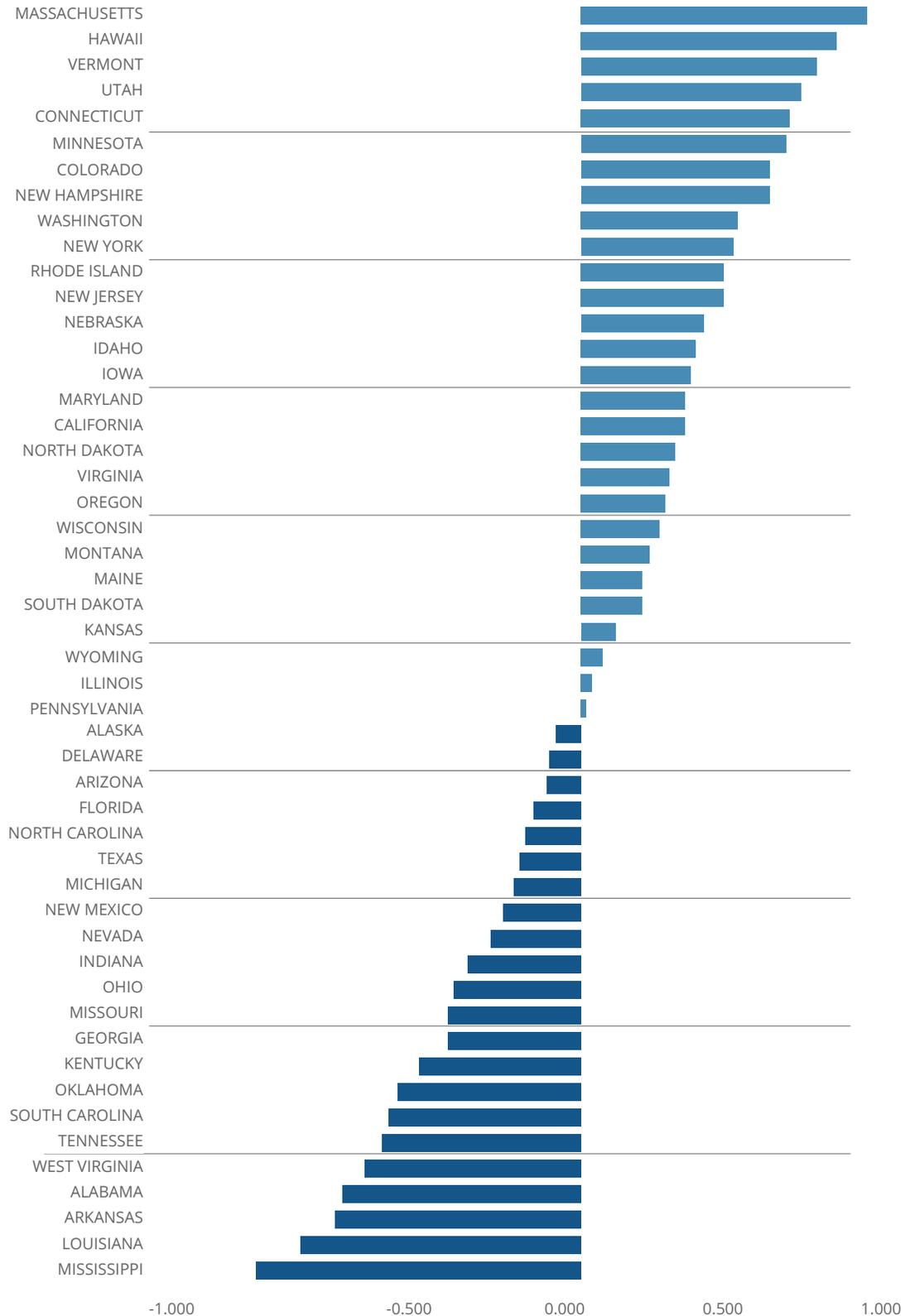
Massachusetts hospitals already have among the best quality outcomes in the nation. The latest evidence-based, nursing-sensitive measures reported through the Centers for Medicare and Medicaid Services' Hospital Compare website shows that Massachusetts scores the same as or higher than California hospitals in hospital quality as well as patient satisfaction. That is, although California hospitals have operated under stringent and costly ratios for more than 13 years, the measures show that the care California hospitals provide is no better – and sometimes worse – than the care patients receive in Massachusetts hospitals.

- Massachusetts scores equal to or better than California in ALL 11 HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) measure categories and receives scores equal to or better than the national average in 9 of 11 (82%) measure categories.
- Massachusetts scores equal to or better than California on all 6 mortality prevention measures and equal to or better than the national average on 5 of 6 mortality measures.
- Hospital readmissions: Massachusetts scores comparable to both California and the national average on 4 of the 8 readmissions measures (50%).
- Patient Safety Indicators (PSIs): Massachusetts scores equal to or better than both California and the National Average on 10 of the 11 patient safety indicators (91%).

<sup>2</sup> Conway, P. H., Tamara Konetzka, R., Zhu, J., Volpp, K. G., & Sochalski, J. (2008). Nurse staffing ratios: trends and policy implications for hospitalists and the safety net. *Journal of Hospital Medicine*, 3(3), 193-199.

## 2017 SCORES SORTED BY RANK

In December 2017, the United Health Foundation released its annual ranking of America's Health Rankings, naming Massachusetts as the healthiest state and ranking California at #17.



\*Weighted standard deviation relative to US value. A score of 0.000 is equal to the US value.

## THE BALLOT QUESTION

Last November and December, MNA collected and local municipal clerks certified the required amount of signatures to qualify for placement on the 2018 ballot.

The MNA's proposed ballot question – "Initiative Petition for a Law Relative to Patient Safety and Hospital Transparency" – would mandate the "maximum number of patients assigned **at all times** to a registered nurse." Facilities must implement the patient assignments "without diminishing the staffing levels of its health care workforce." The definition of healthcare workforce included in the question extends to maintenance and clerical workers.

The mandated nurse-to-patient ratios would be set as follows:

- In all units with medical, surgical and telemetry patients: 1 to 4.
- In all units with observational/outpatient treatment patients: 1 to 4.
- In all units with step-down/intermediate care patients: 1 to 3
- In all units with post anesthesia care (PACU) patients: 1 to 1 (for patients under anesthesia) and 1 to 2 (post anesthesia)
- In all units with operating room (OR) patients: 1 to 1 (under anesthesia) and 1 to 2 (post anesthesia)
- In the Emergency Department:
  - Critical care or intensive care patients: 1 to 1
  - non-stable patients (defined as needing care within 15 to 60 minutes): 1 to 2
  - Urgent stable patients (defined as a patient needing "prompt" care, but who can wait up to 3 hours if necessary) : 1 to 3
  - Non-urgent stable patients (the patient has a condition that needs attention, "but time is not a critical factor."): 1 to 5
- In all units with pediatric patients: 1 to 4
- In all units with psychiatric patients: 1 to 5
- In all units with rehabilitation patients: 1 to 6
- In all units with maternal child care patients: a sliding scale based on a variety of factors.
- In any unit not otherwise listed, the maximum patient assignment is 1 to 4.

Hospitals must develop a patient acuity tool for each of the above units "to determine if the maximum number of patients that may be assigned to a registered nurse(s) should be lower than the patient assignment limits" detailed above. (At no time can the number of patients assigned be higher than the arbitrary ratios in the ballot question.)

Hospitals in violation of the ratios at any time can be fined up to \$25,000 per incident, per day. The Massachusetts Health Policy Commission (HPC) could conduct inspections and, if violations of patient assignment limits are found, the HPC would report violations to the Attorney General's Office, which would seek penalties through Superior Court action.

*To view the complete text of the MNA's ballot question visit here:*

<http://www.mass.gov/ago/docs/government/2017-petitions/17-07.pdf>

## BALLOT QUESTION TIMELINE

Petitioners seeking to place a question on the state ballot follow a series of steps that are governed by a strict timeline. The MNA in 2017 met the deadline for submitting the required number of signatures (64,750) and placed the question before the Secretary of the Commonwealth, who certified the question in December.



The petition was filed with the Massachusetts House of Representatives for consideration.



Deadline for legislative action on the petition. (If both the House and Senate approves the initiative without amendment and the Governor signs it or it passes over his veto by a two-thirds vote of both houses, it becomes a law. In a rarely used procedure, after rejecting the proposed initiative, the General Court may formulate a legislative proposal of its own, to be grouped on the ballot with the initiative measure as an alternate choice.) If the final legislative action is not satisfactory to the sponsors of the question, they may move forward with gathering the additional signatures to put it on the ballot.



Deadline to submit additional signatures to local clerks and registrars for certification.



Deadline to file with the Secretary of the Commonwealth additional signatures (10,792) to put the petition on the November ballot in the event the Legislature fails to enact the measure.



State Election Day.



If the restrictive ratio question passes, the law takes effect.



“Mandating the nurse levels at every hospital is like having the same speed limit for all vehicles on all roads at all times. We need flexibility, not rigidity in staffing.”

Tim Quigley, DNP, MBA, R.N., Chief Nursing Officer, South Shore Health System

## UNFUNDED MANDATE OF THE BALLOT QUESTION – ALMOST \$900 MILLION ANNUALLY

While the healthcare system as a whole embraces the concept of highly individualized patient care throughout the entire continuum, the **nursing union's ballot question treats nurses and patients as numbers within a ratio**. Another number – the unfunded cost of the rigid ratio scheme – is equally troubling.

To determine the cost of mandated government ratios as described in the ballot question, MHA employed a sophisticated formula that takes into account:

- Current staffing levels and registered nurse wages;
- Benefit costs;
- Shift differentials;
- Meal-time coverage;
- Non-productive time;
- Census variation;
- Paid holidays;
- Overtime percentages; and
- Estimates for wage inflation.

**MHA has determined that the aggregate statewide cost of implementing the ballot question in the first year would be at least \$881 million, without any promise of improved care.**

**The total cost to hospitals after year one would be \$835 million annually.**

(The statewide aggregate cost of implementing an acuity tool is estimated to be \$53 million in the first year only.)



“If there is a question about appropriate staffing in a particular hospital, then it should be addressed by its nurses in the context of each hospital’s caregiving team, its patient mix, and its technological resources. Not all patients, not all nurses, and not all hospitals are alike – and there shouldn’t be a statewide law that treats them as identical.”

Patricia M. Noga, PhD, R.N., FAAN

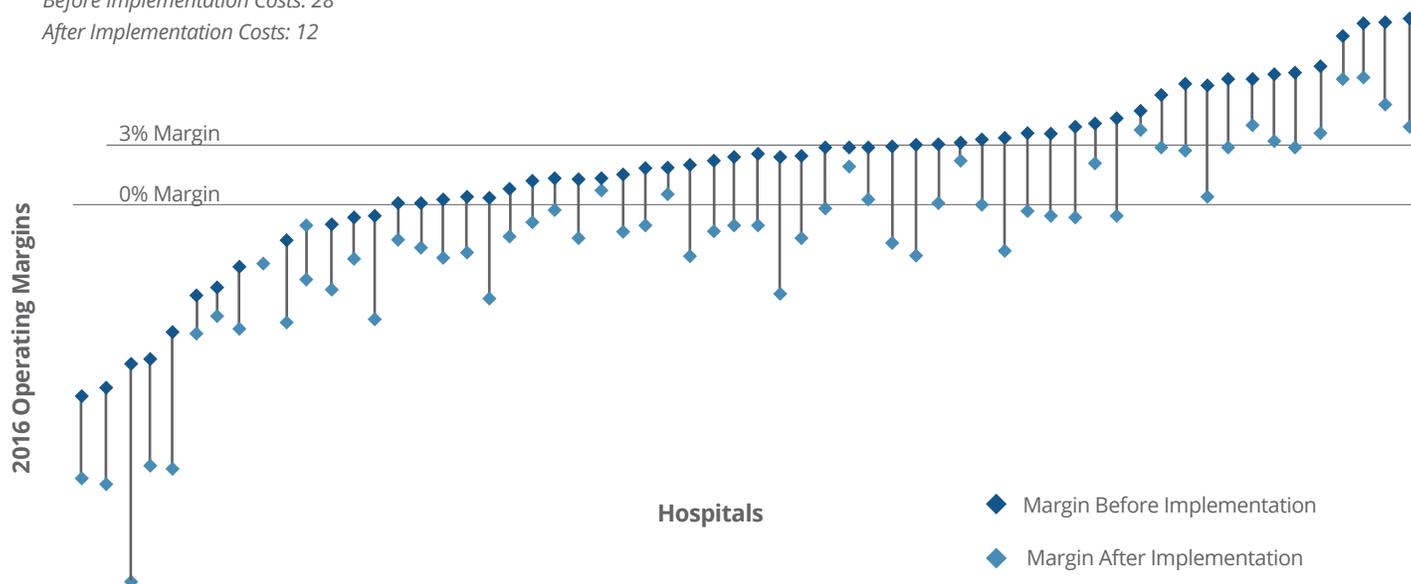
Vice President, Clinical Affairs, Massachusetts Health & Hospital Association

## EFFECT OF BALLOT QUESTION IMPLEMENTATION COSTS ON HOSPITAL OPERATING MARGIN

Number of Hospitals with >3% margin

Before Implementation Costs: 28

After Implementation Costs: 12



Note: Each pair of light and dark blue diamond markers represents the same hospital's operating margin with and without implementation costs

As shown in the above chart, 14 Massachusetts hospitals in FY16 had negative operating margins. If the ratio ballot question had been in effect at the time, an additional 25 hospitals shown by the light blue diamonds would have had negative operating margins – and some of those may have been forced to close or to severely cut back services. An industry rule of thumb is that hospitals must maintain an operating margin of at least 3% to be considered financially healthy. The ratio ballot question would drive many hospitals below the 3% margin threshold.

**Many Massachusetts families are already struggling to pay for healthcare. This proposal will drive costs up even more.**

- Higher costs will be felt across our state's healthcare system. The additional costs will ultimately be passed on to families and local businesses in the form of higher insurance premiums, co-pays, deductibles, and taxes.

**Absorbing the additional cost to hospitals will adversely affect services.**

- The high cost of this unfunded mandate will require hospitals to **cut vital community health programs and services** – including resources to battle the opioid crisis – in order to meet increased staffing costs.
- **Emergency room wait times will increase dramatically as will delays in other life-saving services.**
- Some financially vulnerable **community hospitals will be forced to close** completely.
- This one-size-fits-all government mandate would require **small rural and suburban hospitals to staff at the same level as Boston teaching hospitals** that have up to 1,000 beds and that treat more complex patients.

## THE RESEARCH: NO STUDIES SUPPORT SPECIFIC RATIOS

The nursing union promoting the at-all-times, government-mandated, nurse-ratio ballot question lists 63 research studies on its website that the union says supports its ratio claim. **BUT NOT ONE OF THOSE 63 STUDIES ADVOCATES FOR A SPECIFIC NURSE-TO-PATIENT RATIO APPLICABLE TO ALL HOSPITALS AT ALL TIMES.** That's because such an agreed-upon, specific ratio does not exist. While some studies show that nurses caring for fewer patients correlate with some better outcomes, **FEW STUDIES SUGGEST THAT INCREASING NURSE STAFFING ALONE RESULTS IN BETTER CARE.**

What studies DO show is that educating nurses, empowering nurses, providing nurses with the latest technology, support, and good working environments – among other factors – work independently of nurse staffing levels to affect quality of care and patient outcomes.

## THE MNA CHERRY PICKS DATA/CONCLUSIONS

Ratio proponents' most frequently referenced paper (5,300-plus cites) is the 2002 *JAMA* article "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction" by Linda Aiken, et. al. The article used Pennsylvania hospital and nurse data only and determined RN workloads by merely asking nurses how many patients they cared for during their last shift. Using the study's narrow data set, researchers concluded that each additional patient a nurse cared for increased the risk (by 7%) of the patient dying within 30 days of admission. The MNA uses the study to argue: Impose ratios, limit mortality. **Here's what the authors actually say:**

*"Our results do not directly indicate how many nurses are needed to care for patients or whether there is some maximum ratio of patients per nurse above which hospitals should not venture."*

Or take 2016's "Better Nurse Staffing and Nurse Work Environments Associated With Increased Survival of In-Hospital Cardiac Arrest Patients," in *Med Care*, by Matthew McHugh, et. al. The MNA claims the article shows heart attack patients in hospitals "are more likely to survive in those facilities where nurses have safe patient assignments and higher RN staffing levels." **But the article does not say that at all.** It says:

*"Our results add to a growing body of research literature suggesting that improving hospital work environments may hold promise for reducing preventable deaths ... Improving nurse staffing, however, may be difficult for some hospitals because of costs ... This suggests that adding more nurses without considering the work environment may be a poor investment ... There may be other confounding variables not accounted for that might otherwise have influenced our findings."*

On its website, the nursing union distorts nearly every study it cites, cherry picking favorable quotes, but ignoring the fact that **NO STUDY SUGGESTS IMPOSING A SPECIFIC RATIO ACROSS ALL HOSPITALS AT ALL TIMES.**

## WHAT THE STUDIES DO SAY ABOUT IMPROVING CARE

Scientific research – and resultant hospital practices – over the past two decades outline a non-ratio path to improving the nursing profession and patient care.

### NURSING EDUCATION

Several studies have shown that nurses with higher levels of education (B.S. or higher) are linked to significantly lower mortality and failure-to-rescue rates, and shorter hospital lengths of stay. **The QUALITY of nurses is more important than the QUANTITY of nurses.**

*“The documented effect of BSNs on lower mortality in this study is at least the fifth major study to confirm this association.”*

--Aiken, L. H., et.al.; The effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments (Medical Care, 2011; 49(12), 1047-1053)

Acknowledging the effect of nursing education on patient outcomes, the Institute of Medicine calls for **increasing the proportion of RNs with a bachelor’s degree** to 80% by 2020. (*The Future of Nursing: Leading Change, Advancing Health; IOM, 2011*)

### WORK ENVIRONMENT

Nurse-physician relations, nurse involvement in decision-making, and physical work environment all contribute to nurses’ ratings of quality care, according to studies.

*“We have found in prior research that the relationship between staffing and outcomes can depend on having a good work environment. This suggests that adding more nurses without considering the work environment may be a poor investment.”*

--M. McHugh, et. al Better Nurse Staffing and Nurse Work Environments Associated With Increased Survival of In-Hospital Cardiac Arrest Patients (Medical Care 2016;54: 74–80)



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“The idea of applying ratios is absurd, counterproductive, and backward thinking. I believe some people think there is an ‘optimal ratio,’ an idea that has no merit whatsoever. Ratios are a bankrupt idea, and their widespread implementation could slowly bankrupt the profession... I would not want to be associated with a profession that allowed itself to be dummed down to the point where it self-inflicted onto the profession the very notion it abhors: ‘a nurse is a nurse is a nurse.’”

Peter Buerhaus, Ph.D., RN, FAAN  
Professor, College of Nursing; and  
Director, Center for Interdisciplinary  
Health Workforce Studies, Montana State  
University, as quoted in *A Provocative  
Conversation with Peter Buerhaus* (Nursing  
Economics, July-Aug. 2011; 29(4), 169)



## TEAMWORK AND COLLABORATION

Several studies have assessed **the role of the whole medical team** in relation to better patient outcomes for mortality and infections. The studies indicate that staffing assessments should take into account the whole care team as opposed to being mandated by an arbitrary number.

*“Units with favorable perception of nurse-physician collaboration were associated with lower rates of both [Central-line Associated Bloodstream Infection and Ventilator Assisted Pneumonia (CLABSI and VAP)] ... [U]nits with a higher proportion of certified nurses were associated with lower incidences of both CLABSI and VAP ... Our findings support existing research that links nurse-physician collaboration and patient outcomes.”*

- Boev, C., & Xia, Y.; Nurse-Physician Collaboration and Hospital-Acquired Infections in Critical Care (Critical Care Nurse 2015; 35(2), 66-72)

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 Economics, July-Aug. 2011; 29(4), 169)

## FORCED RATIOS IN ICUs: REDUCING FLEXIBILITY, HARMING ACCESS

The 2014 legislative alternative on Intensive Care Unit (ICU) staffing set a nurse-to-patient ratio of 1:1 or 1:2 only. Before the ICU law, Massachusetts hospitals already maintained 1:1 or 1:2 ratios for patients needing ICU-level care – but they did so with the flexibility that nursing care requires.

In the three-plus years since its passage, the 2014 ICU mandate has in many ways adversely affected patient care. By removing flexibility and nurse autonomy in care decisions, the ICU law has caused backups in emergency departments, delayed transfers of patients into and out of ICUs, and has even resulted in the temporary separation of newborns from their mothers. The Massachusetts Health & Hospital Association surveyed hospitals on their experiences with the ICU mandate. Excerpts from their responses follow.

### NEONATAL ICUs: SEPARATING FAMILIES IN THE INTEREST OF RATIOS

Perhaps the most pernicious result of the 2014 ICU mandated ratio law is its effect on Neonatal Intensive Care Units (NICUs). If twins need different levels of care, NICU teams previously kept the newborns side by side in the NICU, providing emotional and physical support for both twins and their parents. **Now the ICU law often has required some NICUs to separate twins.**

*“We often have to split siblings now in the NICU if one is quite ill and needs the Level 3 bed while the healthier siblings needs a Level 2 bed. If we are busy, then we split up the siblings and the parents have to go back and forth. Previously we kept the family together as that is the best thing to do for the family and patients.”*

*“In the NICU, we’re constrained to standardize assignments instead of using nursing judgment to meet patient and family needs. We’ve had to turn away high-risk mothers and babies due to the staffing law – some of whom were primary patients of our own high risk [Maternal-Fetal Medicine] obstetrician, others were patients of referring private MDs, straining those relationships but more importantly restricting access of patients who require expert care.”*

### EMERGENCY DEPARTMENT (ED) BOARDING

Before the 2014 law, an RN treating an ICU patient who had recovered enough to leave the ICU – but who was awaiting transfer to another unit – could accept a new ICU patient from the ED. Now that ICU RN can never have more than two patients under his or her care – even if one is merely awaiting transfer. This causes **backups in the ED.**

*“Prolonged length of stay in ED due to lack of ICU beds can range from 4-8 hours.”*

*“We have experienced wait times increasing to greater than 120 minutes ... and have seen an increase in transfers out of our ED/hospital to other ICU/hospitals.”*

*“Patients are being held in the ED longer than previously while we await arrival of an ICU RN to meet the ratios. In the past, the patient would have been absorbed by current ICU staff while additional help was redeployed, sought, or drove in from home.”*

*“We are now transferring patients to other community hospitals as far away as Springfield and often out of state to R.I.”*

## TRANSFERS FROM ONE UNIT TO ANOTHER

If a hospital's Med-Surg beds are full, can that hospital temporarily place a Med-Surg patient in an ICU bed? Under the 2014 ICU law, even if a Med-Surg patient needs minimal care for a limited time, his/her presence in the ICU could bump the unit past the ratio and violate the law.

*"We had more liberty before. We could hold patients needing lower level of care or accept a new patient knowing a lower acuity patient is leaving in a few hours ... It has impacted throughput. The law did not improve care, it just delayed it and had negative effects."*

*"Prior to the legislation, on rare occasions, we would board [Med/Surg] patients in the ICU. Now we may still do this but would need to staff these patients to the ICU ratio of 1:2 despite the acuity and needs of the patients – hence, it's an approximately twice as expensive staffing model."*

*"We encounter patients that are ready to be transferred or floor-ready patients that still require the same nurse-to-patient ratio for an ICU. There are times that a transfer to a med/surg floor needs to happen first before we can take an ICU patient, which delays the whole process."*

## IMPACT ON AUTONOMY AND FLEXIBILITY OF THE CARE TEAM

**Nursing is all about teamwork, critical thinking, and empowerment** – all with the goal of providing excellent care to patients. The by-the-number concept of mandated ratios adversely affects RN autonomy.

*"[The law] created a distraction as it moved conversations and focus away from patient-centered care and professionalism ... [I]t has created a lack of flexibility to determine level of care based on acuity rather than location."*

*"Front-line nurses in the ICU setting are highly skilled and have been empowered to impact staffing decisions based on their clinical assessments and judgment. Some feel that using an automated system takes away from their autonomy as a professional nurse."*

## THE CLOSURE OF ICU BEDS

As further evidence of the ICU staffing law's negative effect, Massachusetts hospitals have to date lost a combined total of 11% of Neonatal Intensive Care Unit beds across the state since implementation of the law. The law has negatively affected the commonwealth's vulnerable infant population by altering patient care practices, forcing the unnecessary division of siblings and families, and increasing the rate of infants being transferred to other hospitals across the state.



## RATIOS WILL ERODE CARE & COMPROMISE PROVIDERS

In an interconnected healthcare system, imposing unfunded government-mandated ratios on hospitals will seriously weaken the system as a whole. Here's how.

### WORKFORCE

- Based on the MHA and Organization of Nurse Leaders 2016 Survey of Hospital Nurse Staffing, the state is currently facing a RN vacancy rate of 5.3% – or 1,200 RNs.
- Additionally, more than half of RNs in Massachusetts are over the age of 50 and nearing retirement.

### HARMING THE FIGHT AGAINST SUBSTANCE USE DISORDER

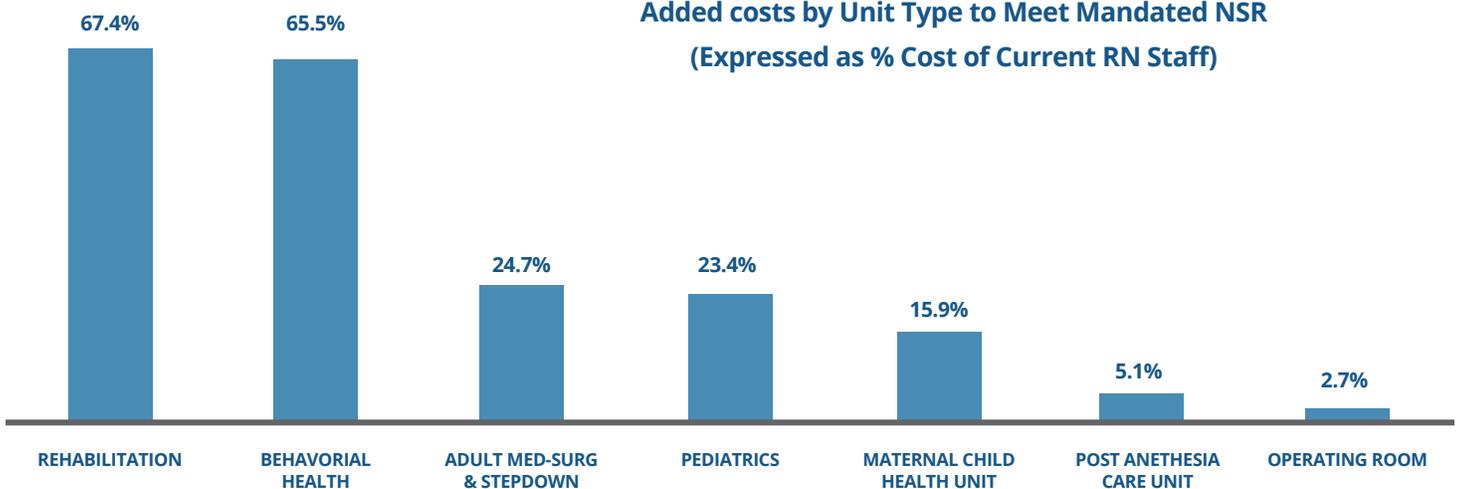
As hospital units are forced to staff up to the arbitrary levels in the ballot question, the resource drain will adversely affect other units.

The added cost by unit type to meet mandated nurse staffing ratios shows that **rehabilitation units** and **behavioral health units** will be the most affected, with costs increasing 67.4% and 65.5%, respectively.

Imposing new, non-beneficial financial and staffing burdens on behavioral health units at a time when they are overburdened with a worsening opioid crisis would likely result in the **closure of units – not their expansion.**

### RN DEFICIT BY UNIT TYPE

Added costs by Unit Type to Meet Mandated NSR  
(Expressed as % Cost of Current RN Staff)



## RATIOS WILL REVERSE REFORM PROGRESS AND CAUSE DELIVERY SYSTEM DISASTER

With an astronomical and unfunded price tag, no promise of improved care, lack of scientific data to support the union's arbitrary staffing levels, loss of bedside control for nursing staff, and a downstream of other unintended consequences – including loss of services and hospital closures – **government-mandated ratios in the current healthcare environment will spell disaster for our state's healthcare delivery system.**

Massachusetts hospitals have been steadily making progress since 2006 under the commonwealth's innovative reform models to transform the system with effective and efficient patient-centered care. Now Massachusetts hospitals provide some of the highest quality care in the nation.

On the federal level, **the slow but steady dismantling of the Affordable Care Act** is of equal concern to Massachusetts, whose reform efforts are based in part on federal matching revenue. Additionally, the sweeping tax package that Congress passed at the end of 2017 led many to speculate that the increase to the federal deficit as a result of the tax cut will eventually result in federal spending cuts – to Medicare and Medicaid – in the near future.

At a time when there is a broadly supported effort to become efficient in order to make healthcare affordable, government mandated ratios for staffing will only frustrate and reverse efforts to improve care and efficiency. Imposing unfunded costs for an unproven mandate that won't improve care turns back the clock back on more than a decade of progress and will harm patients, caregivers, and local communities.

**The healthcare community must be the frontline voice within the public debate leading up to the November 2018 election to articulate the realities and dangers staffing ratios will have on our state's healthcare delivery system.**

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“I became a nurse to help people, regardless of the circumstances. Patients and nurses are not numbers. The assignment of nurses to patients is a thoughtful and ever-evolving process. This law would go against the fundamental mission of the nursing profession, limiting the care we can provide even if we are able to. No law should prevent nurses from providing care to patients who desperately need it.”

Karen Conley, DNP, R.N., NEA-BC  
Former Chief Nursing Officer, Newton Wellesley Hospital



*Editorial: Nurses speaking out  
January 20, 2018*

Massachusetts nurses do not speak with one voice. And now one of their large professional organizations has come out against an incredibly ill-advised ballot question that calls on voters to micromanage hospital staffing.

The militant Massachusetts Nurses Association, which represents at most a quarter of registered nurses in the state, has long pushed first for the Legislature to do the job of micromanaging hospital staffing. Failing that, they now support a similar effort on the November ballot.

Yes, they want voters to weigh in on the nurse-patient ratios for, say, maternity units or post-surgical care units or the emergency room. You name it, the MNA thinks it should have the last word on how many nurses should be employed in a variety of settings.

But this week the Massachusetts chapter of the American Nurses Association, a professional organization rather than a union like the MNA, has officially come out in opposition to the ballot question.

The Massachusetts Nurses Association will always talk a good game about how critical mandated staffing ratios are to patient safety. Now at least the larger and more credible affiliate of the American Nurses Association will be there to set the record straight.

## The Republican.

*Editorial: Ballot no way to settle hospital staffing  
Aug 9, 2017*

The Massachusetts Nurses Association has proposed settling a dispute over hospital staffing levels by ballot referendum ... Admirable as the goal appears, a referendum vote would be a bad way to resolve an important question, and would set a dangerous labor precedent to boot.

By reducing complicated issues to brief summaries on the ballot, government by referendum is inherently flawed and useful only in certain cases – and not as a panacea for labor stalemates ... Let's be blunt. Massachusetts voters do not know what constitutes proper staffing levels at hospitals. They do not work in the field nor operate the facilities.

This vote would be decided by emotion and splashiest forms of campaigning, not the facts or realities faced by Massachusetts staff and administrators ... The average voter will make decisions based on emotion or the catchiest TV spot, not factual knowledge. That would be true whether the Nurses Association wins the ballot vote or not.





*State nurses rail against bill requiring minimum nurse-to-patient ratios*

*February 7, 2018*

The New Jersey State Nurses Association, a trade group that represents roughly 125,000 registered nurses in the state, is arguing against a new bill that would require medical care facilities and hospitals to establish minimum nurse-to-patient ratios.

Judith Schmidt, NJSNA's CEO, argues the new bill could decrease the quality of care for patients ... She added "ratios are rigid and dictate a set number of staff, which is not the best model for optimal patient care, which constantly changes. We need to give the nurses at the bedside the authority and the accountability for staffing their units as needed" ... "This bill does not address some of the key issues that occur with staffing, such as the constantly changing needs of patients ... Staffing is not about a specific number, but the appropriate mix of how sick the patients are, which dictates how much care they need, plus the level of experience of the nurse."



