MASSACHUSETTS COLLEGE OF EMERGENCY PHYSICIANS

Mandated Nurse Staffing Ratios in Emergency Departments: Unworkable & Harmful to the Community

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The hospital Emergency Department (ED) never closes. It is open 24 hours a day, seven days a week, to help people in their time of need and is one of the most vital community services provided by a hospital to the communities it serves. No other resource exists to offer anyone in need of immediate treatment for acute pain, sudden injury, or life-threatening trauma. The ED is also the backbone of the healthcare system supporting primary care providers by handling overflow and providing after-hours cases, as well as performing complex diagnostic workups for patients needing immediate medical care.

This critical community resource will be at risk if Question 1 passes in November.

The Massachusetts Nurses Association (MNA), which represents fewer than 25% of Registered Nurses (RNs) in the state, has proposed in Question 1 restrictive, mandated registered nurse staffing ratios that would effectively limit the number of patients that can be treated in a hospital's ED based purely on the number of RNs on duty – a number determined without scientific evidence by the union. Other members of the ED care team that are critical to providing emergency services would ***not*** count towards meeting the ratios, including physicians, licensed practical nurses, licensed vocational nurses, certified nursing assistants, healthcare technicians, patient observers, nurse educators, registration clerks, security, and others; the proposed staffing mandates must be met by RNs *alone*. Exceptional patient care requires a team approach and this law would turn the clocks back on successful healthcare delivery reform efforts that have made Massachusetts a national model for high quality care. The staffing ratios would be mandated at all times, without exception, and would be identical for every hospital- whether it is a teaching or community hospital.

If Question 1 becomes law, and an RN in the ED cares for more patients than permitted by the mandated ratios, either due to an emergency situation, mass casualty event/disaster, or a rapid change in a patient's condition, and there are no other RNs to whom patients could be reassigned, the hospital would face *penalties of up to $25,000 per incident, per day* for appropriately taking care of ED patients.

If Question 1 passes, it will radically disrupt the way care is provided in the ED by:

- **Increasing wait times before a patient can be seen by a clinician;**
- **Potentially worsening patients' critical illnesses due to delayed access to emergency care;**
- **Prolonged wait times for inpatient beds when patients require admission from the ED since floor staffing ratios will dictate the number of beds available for new admissions. This will delay care for admitted patients and delay care for new ED patients who require evaluation; and**
- **Exacerbating the current crisis of ED boarding of admitted patients, when patients must wait in the ED until an inpatient bed is available.**

Outlined below are operational and clinical reasons why Question 1 is unworkable, dangerous, and would limit access to ED care for patients at hospitals while unnecessarily increasing healthcare costs.

Please join the many nurses and other medical professionals voting NO on Question 1 this November.

Mandated Ratios Will Hamper Access to Emergency Care

Question 1 mandates four different ***RN-to-patient ratios in an ED***:

- ***One RN to one patient ratio for intensive care patients;***
- ***One RN to two patients for urgent, unstable patients;***
- ***One RN to three patients for urgent, stable patients; and***
- ***One RN to five patients for non-urgent, stable patients.***

The proponents of Question 1 claim that mandated ratios are an attempt to improve patient care, but the proposal is misguided and will result in unintended consequences, such as decreased access to care and delays in treatment. Massachusetts clinicians use evidence-based best practices to determine care and treatment of patients in the ED, but Question 1 is an arbitrary determination of staffing that will harm patients in need of emergency care.

In the ED, patients' medical conditions change rapidly. If an RN's current patient assignment is already at one of the mandated limits listed above, s/he cannot be assigned another patient. If one of their patient's medical condition changes suddenly, the RN could quickly find themselves "out of ratio" and in violation of the law, unable to take on any additional patient assignments. **As a result, the proposed rigid RN staffing ratios will increase wait times throughout all EDs in Massachusetts.**

In California, the only state with a nurse staffing mandate, studies show that ED wait times *increased* following the implementation of mandated ratios, despite fewer people seeking care.[1] Physicians from the University of California, Davis Department of Emergency Medicine specifically list eliminating mandated ratios as a method to reduce crowding in the ED. They state, *"… **enforcement of this fixed ratio has been harmful rather than helpful to ED patients**. In the past, during periods of extreme crowding, ED patients might have been 'doubled up' in some treatment areas to provide the safest environment for monitoring. Now, with a rigid 4:1 patient: RN ratio, patients are placed in hallways with no direct nursing observation during periods of crowding. Indeed, some patients who are very ill must remain in the waiting room*."[2]

Question 1 also proposes arbitrary and strict ratios in other medical and psychiatric units throughout hospitals, which would restrict the flow of admitted patients from the ED to inpatient units. In some cases, ED patients may need to be redirected to another facility farther away. Researchers warn that staffing mandates, *"likely affect ED patient flow by restricting staffed hospital beds for admitted patients,*" so that patients in the ED determined to need inpatient care must wait for an inpatient bed to become available, resulting in **backups and boarding in the ED**; consequences which research shows is harmful to patients.[3]

Further, quality outcomes for ED services collected by the Centers for Medicare and Medicaid Services show that for the majority of ED-related measures, Massachusetts, which currently does not have mandated RN-to-patient ratios, scores ***better*** than California, which *has* had mandated ratios for 14 years.[4]

Massachusetts	Emergency Department Measure	California
Better	Time from ED Arrival to Inpatient Unit for Admitted Patients	Worse
Better	Time from Decision to Admit to Departure to Inpatient Unit	Worse
Better	Percentage of Patients Presenting with Stroke Symptoms who Receive Brain Scan Results Within 45 Minutes of Arrival	Worse
Better	Arrival to Pain Management for Bone Fracture	Worse
Same	Percentage of Patients Who Left without Being Seen	Same

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare Database

Question 1 removes flexibility for nurses to exercise their best professional judgement. Question 1 would preclude the ED from taking patients when there is a local emergency situation (such as a multi-car accident or other unexpected surge of patients in need of care). Flexibility is key in the ED; emergency nurses and doctors must be able to change the numbers of staff and how many patients are simultaneously treated to ensure all patients receive the care that they need. **With the opioid epidemic impacting every community in Massachusetts, and patients, including children, often waiting in EDs for days for psychiatric care, we cannot afford a rigid, mandate that will increase wait times with no evidence that it will improve patient care.**

Impracticality of Mandated Staffing Ratios in Emergency Departments

1. **Hospitals would be forced to redirect resources to watch staffing numbers instead of providing patient care.**

Patients' conditions in an ED can change very quickly, with little warning. In order to maintain compliance with the mandated RN ratios, hospitals would need to constantly assess staffing assignments and reassign available RNs based purely on unproven, arbitrary mandates, **regardless of whether there are other members of the ED team (including but not limited to: physicians, licensed practical nurses, licensed vocational nurses, certified nursing assistants, healthcare techs, patient observers, nurse educators, registration clerks, security, and others) who are capable and available to help**. Instead of providing care based on clinical judgment, patients' medical needs, and the skills, experience, and availability of the entire care team, hospitals would be forced to constantly scramble RN patient assignments to try to prevent the RNs from exceeding the mandated ratios. To ensure that hospitals have the resources to hire more RNs, many of the ED team positions would have to be eliminated, which would result in RNs performing medical services below their expertise that will further delay evaluation and treatment for other ED patients.

In a California study,[5] researchers found that *1 out of every 13 ED patients were cared for by nurses considered "out of ratio," meaning that they were caring for more than the allotted maximum number of patients imposed by the California law*. The researchers described several common scenarios that would cause "out of ratio" care, including a patient's condition rapidly deteriorating and requiring 1:1 care, surges in patient volume, and staff shortages if nurses call in sick or fail to report to work. To put this into perspective for Massachusetts, in 2017 there were 3,139,980 ED visits across all hospitals, with an average of 8,603 visits per day across the commonwealth. For small, community hospitals, this averages out to about 129 visits per day, and for larger teaching hospitals, 217 visits per day.[6] If 1 of 13 patients in Massachusetts EDs were treated by RNs "out of ratio," this could amount to penalties of $248,076 *daily*

for community hospitals and $417,307 for teaching hospitals. In total, all hospitals could theoretically be forced to pay penalties *of up to **$6 billion annually** just for violations in EDs, which may force hospitals to close other services or the ED itself.*[7] Even if hospitals only received penalties of half or a quarter of this amount, it would be crippling and force them to make difficult decisions that would hurt patients.

2. **To provide the care they feel is best for the patient, nurses at the bedside would be forced to violate federal laws, resulting in possible loss of license or ability to care for patients with Medicare coverage.**

The federal Emergency Medical Treatment and Active Labor Act (referred to as "EMTALA") requires Medicare-participating hospitals with dedicated EDs to screen, treat, and stabilize patients with emergency medical conditions coming to a hospital in a non-discriminatory manner regardless of their ability to pay, insurance status, national origin, race, creed or color. The federal government implemented EMTALA to ensure that emergency care is provided to any patient who believes that they have an emergency medical condition, so they are not prevented from accessing care. Non-compliance with EMTALA can result in steep penalties, including hospital fines up to $50,000 per violation and/or physician fines up to $50,000 per violation, including on-call physicians.[8]

If Question1 passes and a critical patient arrives at a hospital where all RNs are at the maximum limit of the MNA's strict RN-to-patient ratios, and unable to accept additional patients, the ED would be forced to choose whether to break a federal law, EMTALA, by sending the patient to another hospital without treating them or break a state law, by exceeding the limits on patient assignments. To remain in compliance with both the federal and state laws, the patient would be forced to travel to another hospital or remain and wait longer- for either an additional RN to arrive in the ED or for another patient to be discharged- during which the patient's medical condition might worsen. ***Question 1 would create an unacceptable and unnecessary dilemma, which begs the question: what is <u>really</u> better for patient care?***

Increased Cost and Unmet Demand for ED Nurses Will Weaken the System

If the ballot proposal were to become law, it would require a ***dramatic increase in the RN workforce in Massachusetts EDs in less than 2 months or 37 business days.*** Recruiting ED RNs is difficult because there is a small pool of qualified RNs from which to hire. EDs currently have the second highest RN vacancy rate of all hospital unit types in Massachusetts and nearly 40% of hospitals in Massachusetts report that it takes them more than 60 days to hire an ED RN.[9] In the ED, RNs care for patients in the emergency phase of their illness or injury in a dynamic, fast-paced, stressful environment and ED RNs are typically expected to have a specific skill set and level of experience.

Research has shown that adverse events, including medication errors, are associated with inexperienced nurses and may risk patient safety.[10] However if the ballot question passes, hospitals may be forced to hire less experienced RNs, including new or recent graduates or those from other non-hospital settings, most of whom would require longer orientation as well as education and close mentoring from peer RNs.

Moreover, *if* hospitals were able to hire the additional ED RNs needed to comply with the mandate, the estimated statewide cost would be ***$162 million annually,*** assuming current wage levels.[11] Not only

would the mandate require hospitals to scramble to fill an artificially-created need for additional ED RNs, the increase in hospital costs would increase health care costs for the state and for the general public through increases in insurance premiums and/or **force reductions in services and programs** in other areas of the hospital**, such as community benefit programs that provide mental health, substance use disorder, and child/adolescent preventative services**.

Research also identified that the effect of the nurse staffing mandate in California resulted in ***nurse wage growth as much as 7.8-9%*** higher than other areas in the same time period, which would substantially add to the $162 million in annual cost estimate.[12] RN wage inflation in California ***disproportionately affected hospitals with lower operating margins, such as safety-net and community hospitals*** that often provide care for more vulnerable populations. This caused some hospitals to make trade-offs between nurse staffing and other patient safety and quality programs and services. It also made it more difficult for these safety-net and community hospitals to retain nursing staff lured away to other higher-paying hospitals.[13] The effects would likely be replicated here if MNA's ballot proposal passes.

Massachusetts hospitals and healthcare professionals know how to manage patient care. Vote NO on Question 1 and let our nurses and doctors do their job without government interference.

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