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Testimony of Nancy Hagans, RN

On Behalf of National Nurses United
Before the
Senate Health, Education, Labor, and Pensions Committee
October 27, 2023

Hearing on "Overworked and Undervalued: Is the Severe Hospital Staffing Crisis Endangering the Well-Being of Patients and Nurses?"

Good morning and thank you, Chairman Sanders, Ranking Member Cassidy, and members of the committee, for giving me the opportunity to testify here today. My name is Nancy Hagans, and I am President of the New York State Nurses Association (NYSNA) and President of National Nurses United (NNU), the largest union and professional association of registered nurses (RNs) in the United States, representing nearly 225,000 nurses across the country.

The nursing workforce is in crisis. Years of industry neglect at the hands of our hospital employers, exacerbated by unsafe conditions during the ongoing pandemic, have left registered nurses feeling abandoned, morally distressed, and physically and emotionally exhausted.

I have worked for almost 30 years at Maimonides Medical Center in Brooklyn, New York. Over the course of my career, the staffing situation in our hospitals has gotten worse, and in recent years, it has become completely unbearable.

In my testimony today, I will be illustrating the impacts of understaffing on nurses and on patients, and the role that hospital management plays in perpetuating this crisis. Across the country, nurses have been taking collective action through their unions, both at the bargaining table and through legislative advocacy, to improve staffing levels in their hospitals. But RNs should not have to spend this amount of time and energy fighting for the scientifically proven, common sense solution to our staffing crisis. Congress must take action to establish mandatory minimum nurse-to-patient staffing ratios at all hospitals across the country.

I. Short-staffing of registered nurses in acute-care hospitals harms both nurses and their patients.

Every nurse in the United States has horror stories from being understaffed in their hospital units. When I began working on the surgical floor at Maimonides hospital, our staffing ratio was one nurse to eighteen patients - it was an impossible situation. To put this in context, the recommended safe ratio in a medical surgical unit is one nurse to four patients. We were caring for more than four times the number of patients than scientific evidence demonstrates is safe.

I moved to work in the ICU at my hospital, where I was caring for three critically ill patients at one time. The safe staffing ratio for the ICU is one nurse to two or fewer patients.

As President of the largest nurses' union in the country, I regularly hear from nurses across the country who are dealing with the same situation I was.

These short-staffing levels are dangerous for both patients and nurses.

As a nurse, when you're severely understaffed, you do not have the amount of time with each patient that you need to provide quality patient care. You can't give patients their medications on time; you can't turn them to prevent bedsores at regular intervals; you can't answer their calls promptly when needed because you have multiple other patients calling you at the same time. As a result, there are injuries, illnesses, and deaths that occur because a nurse is unable to give a patient the care they need.

I've been in situations where I know that if I had fewer patients, I might have been able to save a patient's life. It is the worst feeling you could imagine.

To do my job as a nurse well, I need to have enough time with my patients. Registered nurses have extensive education and clinical experience that enables us to provide safe, effective, and therapeutic patient care. These standards of nursing care can only be accomplished through continuous in-person assessments of a patient by a qualified licensed registered nurse. Every time an RN interacts with a patient, we perform skilled assessments and evaluations of the patient's overall condition. These assessments are fundamental to ensuring that the patient receives optimal care. Subtle changes in a patient, for example in skin tone, respiratory rate, demeanor, or affect, can provide critical information about their health and wellbeing. When RNs are understaffed, this information can be easily overlooked or misinterpreted by those without an RN's education and clinical experience.

Studies show that when RNs are forced to care for too many patients at one time, patients are at higher risk of preventable medical errors, avoidable complications, falls and injuries,[1] pressure ulcers,[2] increased length of hospital stay, higher numbers of hospital readmissions, and death.[3] Numerous studies have documented disparities in care in hospitals that serve communities of color.[4] Studies have also found that registered nurse staffing levels in hospitals that serve communities of color are often lower, contributing to these disparities in care.[5]

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[1] Kim J, Lee E, Jung Y, Kwon H, Lee S. Patient-level and organizational-level factors influencing in-hospital falls. J Adv Nurs. 2022 Nov;78(11):3641-3651. doi: 10.1111/jan.15254. Epub 2022 Apr 20. PMID: 35441709; PMCID: PMC9790490.

[2] Kim J, Lee JY, Lee E. Risk factors for newly acquired pressure ulcer and the impact of nurse staffing on pressure ulcer incidence. J Nurs Manag. 2022 Jul;30(5):O1-O9. doi: 10.1111/jonm.12928. Epub 2020 Feb 25. PMID: 31811735; PMCID: PMC9545092.

[3] Aiken, L., et al. "Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction." *Journal of the American Medical Association. 2002; 288(16): 1987-93, 1990.* (43 percent of RNs surveyed had high burnout scores, and a similar proportion were dissatisfied with their current job. Both burnout and job dissatisfaction are indicators of turnover.) Increased LOS, Mortality and Readmission: Dierkes, A. M., Aiken, L. H., Sloane, D. M., Cimiotti, J. P., Riman, K. A., & McHugh, M. D. (2022). Hospital nurse staffing and sepsis protocol compliance and outcomes among patients with sepsis in the USA: a multistate cross-sectional analysis. BMJ Open, 12(3), e056802. https://doi.org/10.1136/bmjopen-2021-056802

[4] Carthon, J. M. B., Brom, H., McHugh, M., Daus, M., French, R., Sloane, D. M., Berg, R., Merchant, R., & Aiken, L. H. (2022). Racial Disparities in Stroke Readmissions Reduced in Hospitals With Better Nurse Staffing. Nurs Res, 71(1), 33-42. https://doi.org/10.1097/nnr.0000000000000552

[5] Lake, E. T., Staiger, D., Edwards, E. M., Smith, J. G., & Rogowski, J. A. (2017). Nursing Care Disparities in Neonatal Intensive Care Units. *Health Serv Res*. https://doi.org/10.1111/1475-6773.12762.

In addition to the harm that short-staffing causes to our patients, it also harms nurses. The failure by hospital employers to staff appropriately and provide the needed resources make it impossible for registered nurses to meet their ethical and professional obligations to provide safe, effective, and therapeutic nursing care.[6] These conditions have led nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues, such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. Unsafe staffing levels leave nurses with the burden of having to decide who gets their care, and who doesn't. When your patient is harmed because you did not have the time to care for them, it is devastating.

When nurses are understaffed, we often do not have time to go to the bathroom, or to take a lunch or coffee break, because we have too many patients to care for at one time. We are literally running around for twelve hours, trying to provide the best care we can to far too many patients. It is exhausting and deeply stressful. Patient care suffers when nurses do not have adequate rest and meal breaks- it's dangerous for a nurse to be working when exhausted. As nurses, our state licenses hold us responsible for the nursing patient assignment. When we are working in unsafe staffing levels, we are constantly worried that our license is at risk because we cannot possibly do our jobs well enough.

Chronic short-staffing also increases the risks of workplace violence[7] and musculoskeletal injuries.[8] Workplace violence has become an epidemic in U.S. hospitals, with employees in health care and social service industries facing the highest rates of injuries caused by workplace violence of any industry. The delays in care caused by short-staffing can add increased stress and frustration for patients and families which can contribute to increased risk of violent incidents, while at the same time, nurses don't have enough staff to adequately respond to or help prevent violent incidents from occurring.[9] We're also at a higher risk of incurring musculoskeletal injuries because there may not be the staff needed to help with patient lifting, which often forces the RN to unsafely lift a patient by themselves.

II. The hospital industry intentionally implements short-staffing levels to reduce labor costs and increase profit margins.

At the heart of the horrific working conditions we experience are the hospital industry's intentional policies of short-staffing, a cost-cutting measure that has allowed hospital employers to save money on labor costs at the expense of quality patient care and nurse health and safety. The utter disregard for RNs health, safety, and lives by hospital employers became apparent early in the Covid-19 pandemic. It

[6] National Nurses United. 2020. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[7] Lipscomb J et al. 2004. "Health Care System Changes and Reported Musculoskeletal Disorders Among Registered Nurses." *Am J Public Health*. 94(8):1431-36. https://www. ncbi.nlm.nih.gov/pmc/articles/PMC1448467/.

[8] Lee S et al. 1999. "Work-related Assault Injuries Among Nurses." *Epidemiology*. 10(6):685-91. https://pubmed.ncbi.nlm.nih. gov/10535781/.

[9] Fernandes, C. et al. The Effect of an Education Program on Violence in the Emergency Department. *Annals of Emerg. Medicine*. 2002; 39(1):47-55. A 2002 study found that interactive, hands-on workplace violence recognition and intervention training can be effective in reducing violence incident rates and, importantly, that refresher trainings are needed to maintain those effects.

was clear then as it remains now that hospital employers will prioritize their profit margins over the health and safety of nurses and patients.

Labor is the largest cost in any hospital. To increase profit margins, hospital employers deliberately refuse to staff our nation's hospitals with enough nurses to provide quality patient care. Hospitals often refuse to hire nurses (even during a pandemic), call nurses off a shift after they've already come in to work, and knowingly ask for fewer nurses than necessary to care for patients. In NNU's most recent survey of more than 2,800 nurses from Sept. 22 through Nov. 28, 2022, 56.8 percent of hospital nurses reported that staffing has gotten slightly or much worse recently and nearly half of hospital nurses reported that their facility is using excessive overtime to staff units.

For several decades, the hospital industry has attempted to deskill the nursing profession by inappropriately pushing care to the lowest-cost and least-regulated setting, including displacing RNs with unlicensed or lower-licensed staff. Further, the industry has been replacing RN professional judgment with health information technology, automation, remote monitoring tools, and "acute-care hospital-at-home" programs where patients are forced to rely on family members or themselves to provide complex clinical care that they have no training or licensing to provide. The hospital industry's attempts to break down registered nursing practice into tasks (often called "routinization"), and shift the tasks to unlicensed and lower-licensed staff (i.e., deskilling) to reduce labor costs, undermines safe patient care.

III. The impacts of unsafe staffing levels are causing registered nurses to leave bedside nursing in acute-care hospitals, creating a national staffing crisis.

Hospital employers have been perpetuating the false narrative that there is a "shortage "of registered nurses in the United States. They claim that they cannot hire enough nurses to staff appropriately and safely. First and foremost, it is imperative that we clarify that there is not a national shortage of registered nurses in the U.S., and we can prove this by looking at national employment and licensure data.

According to statistics from the National Council of State Boards of Nursing and the U.S. Bureau of Labor Statistics, there were approximately 1.2 million licensed registered nurses who were not employed as RNs in 2022. The trend continues when you look at state specific data as well. Here in New Jersey, there are over 56,000 actively-licensed registered nurses who were not employed as RNs in 2022. In New York, more than 175,000 actively-licensed registered nurses are not currently working. In a 2022, NNU survey, more than half of nurses (55.5 percent) surveyed reported that they have considered leaving nursing.

We know that while the nursing workforce pipeline can and should be strengthened, in particular to diversify the nursing workforce and increase the number and diversity of preceptors and nursing school faculty, the key problem in our staffing crisis is not the number of graduating RNs. Every year,

the United States continues to graduate more new nurses out of nursing school than ever before.[10] Experts project that over the next decade, the national RN workforce will not only replace the expected 500,000 retiring RNs but expand the workforce by almost one million registered nurses.[11] At the same time, data from 2019 to 2022 shows that the entirety of growth in RN employment during that period has occurred outside of hospitals and instead into other settings like outpatient clinics and doctors' offices.[12]

As demonstrated by national data, we don't have a "nurse shortage," but we do have a staffing crisis in our hospitals, brought on by the lack of good nursing jobs where RNs are valued for their work, have strong health and safety protections, and are not required to care for more patients at any given time than is safe for optimal, therapeutic care.

Hospital employers can hire enough RNs to safely care for our patients, but for decades they have refused to do so. Instead, they continue to ask nurses to do more with less, putting our patients in danger. As a result, many nurses are leaving the hospital bedside.

IV. Mandatory minimum nurse-to-patient ratios will increase nurse retention and improve patient care.

There are decades of scientific evidence that demonstrates mandated minimum nurse-to-patient ratios save lives. California is the only state in the country that has an RN-to-patient ratios statute that covers every acute-care hospital unit and department. The fight to win legislation in California was a decade-long fight that was successful in 1999 because of an extensive grassroots campaign led by union nurses at the California Nurses Association, an NNU affiliate. Despite opposition from the hospital industry, the nurses in California won the ratios law, which established the gold-standard for mandatory minimum nurse staffing ratios, and regulations were implemented in 2004.

Now, nineteen years after implementing minimum nurse-to-patient ratios in California, a multitude of studies confirm the significant impact that mandatory, minimum staffing ratios have had on improving patient outcomes. A seminal study from 2010 compared California hospitals' post-implementation of the ratios law to hospitals in other states, including the state of New Jersey where this hearing is being held. The study found that if California's ratios in medical surgical units were implemented, New Jersey would have 13.9 percent fewer patient deaths.[13] A more recent study found that last year, patients in California hospitals received on average three more hours of nursing care than hospitalized patients in other states.[14] If the ratios mandate was implemented nationally, research estimates that thousands of

[10] National Council of State Boards of Nursing. 2009-20. "NCLEX Pass Rates." National Council of State Boards of Nursing. https://www.ncsbn.org/exams/exam-statistics-and-publications/nclex-pass-rates.page.
[11] Buerhaus, P. I., Staiger, D. O., Auerbach, D. I., Yates, M. C., & Donelan, K. (2022). Nurse Employment During The First Fifteen Months Of The COVID-19 Pandemic. *Health Affairs*, 41(1), 79-85. https://doi.org/10.1377/hlthaff.2021.01289.
[12] Ibid.
[13] Aiken L et al. 2010. "Implications of the California Nurse Staffing Mandate for Other States." *Health Services Research*. 45(4):204- 21. https://onlinelibrary.wiley.com/doi/10.1111/ j.1475-6773.2010.01114.x.
[14] Dierkes, A., Do, D., Morin, H., Rochman, M., Sloane, D.M., McHugh, M.D. (2021). The impact of California's staffing mandate and the economic recession on registered nurse staffing levels: A longitudinal analysis. Nursing Outlook, 70(2):219-227

lives would be saved each year. The California ratios mandate has proven to reduce costs for hospitals by improving nurse safety and job satisfaction,[15] reducing spending on temporary RNs,[16] overtime costs,[17] and staff turnover.[18] Nurses from other states flock to California because the working conditions are so much better than the rest of the country.

Nurses in other parts of the world are also taking up the fight for safe staffing ratios. The Center for Health Outcomes and Policy Research in Queensland, Australia conducted one of the most prominent studies on nurse-to-patient ratios legislation and it's impacts on health outcomes that was funded by the government of Queensland. Considered the "gold standard" in scientific literature regarding nurse staffing, the study evaluated health outcomes before and two years after the implementation of the state staffing ratios law. Published by The Lancet, the study found that mandated minimum RN-to-patient ratios prevented thousands of hospital deaths annually, and saved hospitals millions of dollars by reducing average length of stay and rates of readmissions within thirty days of leaving the hospital.[19]

Despite the abundance of evidence that shows the success of minimum nurse staffing ratios, most hospital employers continue to refuse to implement safe staffing levels. The hospital industry continues to use the same arguments against nurse staffing ratios that they used before the California ratios law was passed. However, these arguments are easily dispelled by the success of the California law.

Hospital employers often claim that ratios laws would force hospitals to close, and that nurse "shortages" would prevent hospitals from being able to meet ratio mandates. These criticisms proved false in the implementation of the ratios law in California. Just two years after the California law went into effect, California hospitals were in compliance with the ratios a super-majority of the time. The majority of safety-net hospitals, including rural hospitals with generally lower patient levels, were also in compliance.[20] Of the 69 hospitals defined as rural acute-care facilities in California by the Department of Health Services, only 16 applied for an exemption to the law in 2004, and just 11 exemptions were granted. [21] In the years since, these hospitals have been in compliance.

[15] Spetz J. 2008. "Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations." *Policy Polit Nurs Pract*. 9(1):15-21. https://pubmed.ncbi.nlm.nih.gov/18390479/.
[16] Schmit, J. "Nursing shortage drums up demand for happy nomads." *USA Today*. June 9, 2005. (Quoting Tenet Health System Chief Nursing Officer. Travel nurses cost hospitals at least 20 percent more than a nurse employee even when benefits are factored in. Full-time employees are paid at least 1.5 times their regular salary for overtime hours worked.)
[17] Ibid.
[18] Bland-Jones, Cheryl. "Revisiting Nurse Turnover Costs, Adjusting For Inflation." *Journal of Nursing Administration*. 2008; 38(1): 11-18, 12. (Finding that the total RN turnover costs for fiscal year 2017 were between $7,875,000 and $8,449,000, and estimating an RN annual turnover rate at 18.5 percent.) Aiken. 2010. supra, note 5 at 913. (Finding that California RNs, after the implementation of the mandated nurse-to-patient ratios, experienced burnout at significantly less rates than those in New Jersey and Pennsylvania. 20 percent California RNs reported being dissatisfied with their job, compared to 26 percent in New Jersey, and 29 percent in Pennsylvania. Both burnout and job dissatisfaction are precursors of voluntary turnover.)
[19] McHugh MD, Aiken LH, Sloane DM, Windsor C, Yates P. 2021. Nurse staffing and patient mortality, readmissions, and length of stay: a prospective study of the effects of nurse-to-patient ratio legislation in a panel of hospitals. The Lancet. May 11, 2021: https://doi.org/10.1016/S0140-6736(21)00768-6
[20] Aiken, L. H. (2010). The California nurse staffing mandate: implications for other states. LDI Issue Brief, 15(4), 904-921.
[21] Lauer, G. "Reaction To Nurse Staffing Rules Generally Favorable." *California Healthline.* October 25, 2004.

V. In the absence of federal regulation, Registered Nurses across the country are organizing collectively to win safe staffing ratios.

Across the country, registered nurses are sick and tired of being undervalued by our hospital employers. We want the best care for our patients, and to deliver that care, we need safe and healthy workplaces. So, we are organizing collectively to win safe staffing ratios.

That is why nearly 7,000 New York nurses with the New York State Nurses Association went on strike this past January. Nurses at Montefiore Bronx and Mount Sinai Hospital in Manhattan went on strike to win staffing ratios.

The strike came after a years-long legislative battle at the state level. In 2021, we passed laws that established a process for setting and enforcing staffing standards at every hospital and nursing home—no matter if the facility is public or private, union or non-union. This law laid the groundwork for us to more effectively fight for numerical staffing ratios in our contracts.

After extensive negotiations at the bargaining table about staffing ratios and enforcement, we ended up going on strike.

It takes a lot for nurses to decide to strike. If nurses are going on strike, then you know something is really wrong inside the hospital. We went on strike because it was our only option to fight for safe nurse-to-patient staffing ratios.

We went on strike for three days in New York City. We had incredible support not only from New Yorkers, but from people all over the country and the world. After three days on strike, we won historic contracts that include enforceable nurse-to-patient staffing ratios with expedited arbitration and potential financial penalties payable to nurses when employers fail to uphold contractual safe staffing standards. It was a significant win for nurses in New York and we're going to continue to use our contract negotiations to win safe patient ratios and strong staffing enforcement at other hospitals in New York.

We're not the only nurses taking strike action to make this happen. Nurses in Kansas, Texas, Minnesota, and many other states have been taking similar actions to win staffing ratios.

VI. Congress must pass federal legislation to establish mandatory minimum nurse-to-patient ratios in order to improve the staffing crisis.

Nurses should not have to go on strike to win common sense policy solutions that will improve patient care for everyone in our communities. We should be focusing on our patients and on health care. But the greed of our employers and the negligence of our elected officials has left us with no other choice.

Instead, Congress must step up and take action to give nurses and patients basic protections. We strongly urge this Committee to swiftly pass S.1113, the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2023 sponsored by Senator Sherrod Brown. The bill would establish

mandatory minimum staffing ratios based on the successful ratios that have been implemented in California. It would require hospitals to develop annual safe staffing plans that meet the bill's minimum staffing ratios, and it would require hospitals to provide additional staffing based on individual patient care needs. Hospitals would be required to post notices on minimum ratios and maintain records on RN staffing. The bill provides whistleblower protections for nurses who speak out against assignments that are unsafe for the patient or the nurse, and it authorizes the Secretary of Health and Human Services to enforce the minimum RN staffing ratios through administrative complaints and civil penalties.

On behalf of the 225,000 registered nurses represented by National Nurses United, I strongly urge the committee to work to improve patient care, protect our nurses, and solve the nurse staffing crisis in this country, by implementing safe staffing nurse-to-patient ratios in every hospital in this country.

ATTACHMENTS

1. National Nurses United, Letter of Support of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, H.R. 2530
2. National Nurses United, Proposed Congressional Actions to End the Industry-Created Nurse Staffing Crisis
3. National Nurses United, Written Testimony to Senate Health, Education, Labor, and Pensions Committee in advance of hearing titled, "Examining Health Care Workforce Shortages: Where Do We Go from Here?"
4. National Nurses United, Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis. Available at https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_StaffingCrisis_ProtectingOurFrontLine_Report_FINAL.pdf
5. National Nurses United, RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals. Available at https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/NNU_Ratios_White_Paper.pdf
6. National Nurses United, Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity. Available at https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf

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March 23, 2023

Dear Member of Congress,

On behalf of the nearly 225,000 nurses represented by National Nurses United, we write today to ask you to become an original cosponsor of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act. The legislation will be introduced on March 30, 2023, by Senator Sherrod Brown and Congresswoman Jan Schakowsky. This critical bill would establish federally mandated nurse-to-patient ratios in acute care hospitals across the country, drastically improving patient care and working conditions for registered nurses.

The nursing workforce is in crisis. Years of industry neglect at the hands of our hospital employers, exacerbated by unsafe conditions during the ongoing pandemic, have left registered nurses feeling abandoned, distressed, and physically exhausted. As a result of these horrific working conditions, many nurses have chosen to leave bedside nursing in recent years, exacerbating the staffing crisis we find ourselves in now.

At the heart of the horrific working conditions we experience is the hospital industry's intentional policies of short-staffing, a cost-cutting measure that has allowed hospital employers to save money on labor costs at the expense of quality patient care and nurse health and safety. Hospital employers deliberately refuse to staff our nation's hospitals with enough nurses to provide quality patient care. As a result, nurses are consistently required to care for more patients than is safe, compromising patient care and negatively impacting patient outcomes.

Studies show that when RNs are forced to care for too many patients at one time, patients are at higher risk of preventable medical errors, avoidable complications, falls and injuries,[1] pressure ulcers,[2] increased length of hospital stay, higher numbers of hospital readmissions, and death.[3] Numerous studies have documented disparities in care in hospitals that serve communities of color.[4] Studies have also found that registered nurse staffing levels in hospitals that serve communities of color are often lower, contributing to these disparities in care.[5] Setting a single

[1] Kim J, Lee E, Jung Y, Kwon H, Lee S. Patient-level and organizational-level factors influencing in-hospital falls. *J Adv Nurs*. 2022 Nov;78(11):3641-3651. doi: 10.1111/jan.15254. Epub 2022 Apr 20. PMID: 35441709; PMCID: PMC9790490.
[2] Kim J, Lee JY, Lee E. Risk factors for newly acquired pressure ulcer and the impact of nurse staffing on pressure ulcer incidence. *J Nurs Manag*. 2022 Jul;30(5):O1-O9. doi: 10.1111/jonm.12928. Epub 2020 Feb 25. PMID: 31811735; PMCID: PMC9545092.
[3] Increased LOS, Mortality and Readmission: Dierkes, A. M., Aiken, L. H., Sloane, D. M., Cimiotti, J. P., Riman, K. A., & McHugh, M. D. (2022). Hospital nurse staffing and sepsis protocol compliance and outcomes among patients with sepsis in the USA: a multistate cross-sectional analysis. *BMJ Open*, 12(3), e056802. https://doi.org/10.1136/bmjopen-2021-056802.
[4] Carthon, J. M. B., Brom, H., McHugh, M., Daus, M., French, R., Sloane, D. M., Berg, R., Merchant, R., & Aiken, L. H. (2022). Racial Disparities in Stroke Readmissions Reduced in Hospitals With Better Nurse Staffing. *Nurs Res*, 71(1), 33-42. https://doi.org/10.1097/nnr.0000000000000552.
[5] Lake, E. T., Staiger, D., Edwards, E. M., Smith, J. G., & Rogowski, J. A. (2017). Nursing Care Disparities in Neonatal Intensive Care Units. *Health Serv Res*. https://doi.org/10.1111/1475-6773.12762.

standard of nursing care across hospitals will improve outcomes for patients of color including reduced readmission rates, increased satisfaction, and better obstetrical outcomes.[6]

The failure by hospital employers to staff appropriately and provide the needed resources make it impossible for registered nurses to meet their ethical and professional obligations to provide safe, effective, and therapeutic nursing care.[7] These conditions have led nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. As a result, many nurses are leaving the hospital bedside.[8]

This legislation would protect patients and improve healthcare outcomes by setting specific limits on the numbers of patients an RN may care for at one time in U.S. hospitals. The bill is modeled on the RN safe staffing ratios law in California that has been shown to save patient lives, improve quality of care, reduce nurse job dissatisfaction, and retain and bring back experienced nurses to the bedside.

California is the only state in the country that has an RN-to-patient ratios statute, and studies confirm the significant impact such mandatory, minimum staffing ratios have had on improved patient outcomes.[9] Research estimates that if the ratios mandate were implemented nationally thousands of lives would be saved each year.[10] The California ratios mandate has proven to reduce costs for hospitals by improving nurse safety and job satisfaction,[11] reducing spending on temporary RNs,[12] overtime costs,[13] and staff turnover.[14]

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[6] Brooks-Carthon, J. M., Kutney-Lee, A., Sloane, D. M., Cimiotti, J. P., & Aiken, L. H. (2011). Quality of Care and Patient Satisfaction in Hospitals With High Concentrations of Black Patient. *Journal of Nursing Scholarship*, 43(3), 301-310. https://doi.org/10.1111/J.1547-5069.2011.01403.X.

[7] National Nurses United. 2020. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[8] Even health care management consulting companies like McKinsey and staffing agencies like ShiftMed have released surveys showing that between 29 percent and 66 percent of nurses report they are inclined to leave the profession.
Berlin G et al. February 17,2022. "Surveyed nurses consider leaving direct patient care at elevated rates." *McKinsey & Company.* https://www.mckinsey.com/industries/healthcare/our-insights/surveyed-nurses-consider-leaving-direct-patient-care-atelevated-rates.
ShiftMed. September 22, 2022. "Staffing Shortages Push Nurses to the Brink, With Nearly Two-Thirds Considering a Departure from the Profession in Next Two Years." Available at: https://www.shiftmed.com/press-releases/shiftmeds-annualstate-of-nursing-survey-2022/.

[9] Lasater, K. B., Aiken, L. H., Sloane, D. M., French, R., Martin, B., Reneau, K., Alexander, M., & McHugh, M. D. (2020). Chronic hospital nurse understaffing meets COVID-19: an observational study. *BMJ quality & safety*, bmjqs-2020-011512. https://doi.org/10.1136/bmjqs-2020-011512.

[10] Aiken, L. H., Sloane, D. M., Cimiotti, J. P., Clarke, S. P., Flynn, L., Seago, J. A., Spetz, J., & Smith, H. L. (2010). Implications of the California nurse staffing mandate for other states. *Health Serv Res*, 45(4), 904-921. https://doi.org/10.1111/j.1475-6773.2010.01114.x.

[11] Spetz J. 2008. "Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations." *Policy Polit Nurs Pract*. 9(1):15-21. https://pubmed.ncbi.nlm.nih.gov/18390479/.

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[13] Ibid.

[14] Bland-Jones, Cheryl. "Revisiting Nurse Turnover Costs, Adjusting For Inflation." *Journal of Nursing Administration.* 2008; 38(1): 11-18, 12. (Finding that the total RN turnover costs for fiscal year 2017 were between $7,875,000 and $8,449,000, and estimating an RN annual turnover rate at 18.5 percent.)

The Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act would:

- Require hospitals to meet the mandated minimum RN staffing ratios, and to provide for additional staffing based on individual patient acuity and needs. The ratios in the bill are:
    - 1 nurse : 1 patient in trauma emergency units
    - 1 nurse : 1 patient in operating room units
    - 1 nurse : 2 patients in critical care units
    - 1 nurse : 3 patients in emergency room units, pediatrics units, stepdown units, telemetry units, antepartum units, and combined labor, delivery, and postpartum units.
    - 1 nurse : 4 patients in medical-surgical units, intermediate care nursery units, acute care psychiatric units, and other specialty care units
    - 1 nurse : 5 patients in rehabilitation units and skilled nursing units
    - 1 nurse : 6 patients in postpartum units and well-baby nursery units.
- Require hospitals to post notices on minimum ratios and maintain records on staffing.
- Provide strong whistleblower protections for nurses who speak out against assignments that are unsafe for the patient or nurse.
- Require that all nursing personnel have adequate training and demonstrated skill competence to perform their assigned patient care tasks, restrict the inclusion of nurse administrators and supervisors in the ratios calculations, and require that additional staffing above the minimum ratios is based on individual nursing plans and acuity level.
- Require that in acuity adjustable units, the highest patient acuity level in the unit will determine the applied ratio.
- Prohibit the substitution of direct patient care and RN professional judgment with video monitors or other technology
- Allow the Secretary of HHS to promulgate regulations requiring additional staffing of RNs and other patient care staff.
- Require that staffing plans are a subject of collective bargaining.
- Allow a longer implementation timeline for rural acute care hospitals to ensure compliance.

This legislation is of high priority for registered nurses across the country, and we hope you will join us in supporting it. If you have any questions, please do not hesitate to contact our Legislative Advocate, Julia Santos at jsantos@nationalnursesunited.org. To co-sponsor the bill, please contact Suzanne Luther in Senator Brown's office (Suzanne_Luther@brown.senate.gov), or Gidget Benitez in Congresswoman Schakowsky's office (Gidget.Benitez@mail.house.gov) before March 30th, 2023.

Thank you for your attention to this important issue.

Sincerely,

Aiken. 2010. supra, note 5 at 913. (Finding that California RNs, after the implementation of the mandated nurse-to-patient ratios, experienced burnout at significantly less rates than those in New Jersey and Pennsylvania. 20 percent California RNs reported being dissatisfied with their job, compared to 26 percent in New Jersey, and 29 percent in Pennsylvania. Both burnout and job dissatisfaction are precursors of voluntary turnover.)

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National Nurses United

Proposed Congressional Actions to End the Industry-Created Nurse Staffing Crisis

National Nurses United (NNU) is the largest union and professional association of registered nurses (RNs) in the United States, representing nearly 225,000 nurses across the country. Our members are dedicated to protecting and advancing the interests of direct-care nurses, patients, and communities across the United States.

Over the course of the Covid-19 pandemic, the nation's attention has focused on the dire conditions under which nurses have been forced to work. Dangerous working conditions have put our nursing workforce at constant risk of injury, illness, and death, and have led many licensed registered nurses to leave bedside nursing entirely. **The staffing crisis we are experiencing now is the result of years of industry neglect and intentional policies of short-staffing and cost-cutting measures enacted by hospital employers.**

Nurses have consistently experienced dangerous working conditions including:

- Intentional low RN staffing levels imposed by hospital managers.
- Inadequate occupational health and safety protections.
- Insufficient stock of critical medical supplies and personal protective equipment (PPE).
- Increasing levels of violence in the workplace.

It's important to note that while the Covid crisis has exacerbated these challenges, nurses have been facing these issues in their hospital workplaces for *decades*.

As Congress looks to address the nurse staffing crisis, it is critical to resolve the root problems that are leading thousands of registered nurses to leave the bedside. **First and foremost, it is imperative that we clarify there is not a national shortage of trained and licensed RNs in the United States.** According to statistics from the National Council of State Boards of Nursing and the U.S. Bureau of Labor Statistics, there were approximately one million licensed registered nurses who were not employed as RNs in 2021. While we do not yet have updated BLS data on RN employment since 2021, the National Council of State Boards of Nursing data shows sustained increases in the number of nurse licenses nationally since 2021, suggesting that the nurse education and licensing pipeline is strong.

We don't have a "nurse shortage," but we do have a staffing crisis in our hospitals, brought on by the lack of good nursing jobs where RNs are valued for their work, have strong health and safety protections, and are not required to care for more patients at any given time than is safe for optimal, therapeutic care.

The hospital industry is using the false narrative of a "nursing shortage" to propose interventions that will reduce labor costs and maximize revenue without regard for health care workers or safe patient care. For several decades, the hospital industry has attempted to deskill the nursing profession by inappropriately pushing care to the lowest-cost and least-regulated setting, including displacing RNs with unlicensed or lower-licensed staff. The industry has been replacing RN professional judgment with health information technology, automation, remote monitoring tools, and "acute-care hospital-at-home" programs where patients are forced to rely on family members or themselves to provide complex clinical care that they have no training or licensing to provide. Hospital employers are also keen to focus Congressional action on bolstering the nursing workforce pipeline and other proposals that allow them to avoid responsibility for improving working conditions for nurses to stay at the bedside.

TABLE 1. **Data from the National Council of State Boards of Nursing, which reports the total number of licensed registered nurses, and the Bureau of Labor Statistics, which reports the total number of employed registered nurses, can be compared to estimate the number of actively licensed RNs who are not employed as RNs.**

Total Number of Registered Nurses, 2021*	**4,316,687**
Registered Nurses Total Employment, May 2021	**3,333,920**
Estimated Number of Actively Licensed RNs who are NOT Employed as RNs, 2021	**982,767**
Adjusted Total Number of Registered Nurses, 2021*	**4,419,167**
Adjusted Estimated Number of Actively Licensed RNs who are NOT employed as RNs, 2021*	**1,085,247**

**The National Council of State Boards of Nursing did not include reporting from Michigan in 2021, and therefore, their estimation of the total number of RNs is lower than the national total. The BLS data does include data from Michigan, in which they reported 102,480 employed RNs. Given this disparity, the first estimated number of actively licensed RNs who were not employed as RNs in 2021 is a conservative estimate. To allow for a more accurate comparison, we have added the Michigan BLS data to the total number of Registered Nurses in the adjusted estimation. This adjusted estimation does NOT account for licensed RNs who were not working as RNs in the state of Michigan.*

TABLE 2. **Recent data on the numbers of active RN licenses from the National Council of State Boards of Nursing shows a steady growth in licensed RNs in recent years, including a particularly large increase in licenses issued in 2023 thus far.**

Number of RN Licenses, 2021	**5,066,932**
Number of RN Licenses, 2022	**5,328,873**
Number of RN Licenses, as of 3/16/2023	**5,523,906**

We know that while the nursing workforce pipeline can and should be strengthened, in particular to diversify the nursing workforce and increase the number and diversity of preceptors and nursing school faculty, the key problem in our staffing crisis is not the number of graduating RNs. Every year, the United States continues to graduate more new nurses out of nursing school than ever before.[1] Experts project that over the next decade, the national RN workforce will not only replace the expected 500,000 retiring RNs but expand the workforce by almost one million registered nurses.[2] At the same time, data from 2019 to 2022 shows that the entirety of growth in RN employment during that period has occurred outside of hospitals and instead into other settings like outpatient clinics and doctors' offices.[3] This data confirms that graduating more nurses from nursing schools on its own will not solve the staffing crisis in American hospitals. We need to increase retention of nurses working in acute-care hospitals by treating them with the respect that nurses deserve and improving their working conditions.

NNU supports Congressional efforts to adequately fund and strengthen the RN workforce pipeline; however, these efforts must be paired with actions to revitalize the current workforce by increasing nurse retention and bringing licensed nurses who have left the hospital bedside back to work. **Focusing exclusively on nurse recruitment without simultaneously solving the problems of nurse retention will not fix the staffing crisis in American hospitals**.

For more details on the hospital nurse staffing crisis, please review our report titled, **Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis**.

National Nurses United Urges the 118th Congress to Support the Following Proposals »

Prioritizing Retention of Bedside Nurses

» Federally mandate minimum nurse-to-patient staffing ratios, through passage of the **Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act**. Currently, there are no federal mandates regulating the number of patients a registered nurse can care for at one time in U.S. hospitals. To reduce labor costs and increase profits, the hospital industry deliberately refuses to staff our nation's hospitals with enough nurses to care for patients safely and optimally. As a result, RNs are consistently required to care for more patients than is safe, compromising patient care and negatively impacting patient outcomes, subsequently pushing nurses to leave the bedside. Further, unsafe staffing levels put RNs' licenses at risk when they care for more patients at any given time than is safe.

  › Studies show that when RNs are forced to care for too many patients at one time, patients are at higher risk of preventable medical errors, avoidable complications, falls and injuries,[4] pressure ulcers,[5] increased length of hospital stay, higher numbers of hospital readmissions, and death.[6]

  › Numerous studies have documented disparities in care in hospitals that serve communities of color.[7] Studies have also found that registered nurse staffing levels in hospitals that serve communities of color are often lower, contributing to these disparities in care.[8] Setting a single standard of nursing care across hospitals will improve outcomes for patients of color including reduced readmission rates, increased satisfaction, and better obstetrical outcomes.[9]

  › The failure by hospital employers to staff appropriately and provide the needed resources make it impossible for nurses to meet their ethical and professional obligations as RNs to provide safe, effective, and therapeutic nursing care.[10] These conditions have led nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. As a result, many nurses are leaving the hospital bedside.[11]

  › **California is the only state in the country that has an RN-to-patient ratios statute, and studies confirm the significant impact such mandatory, minimum staffing ratios have had on improved patient outcomes.**[12] Research estimates that if the ratios mandate were implemented nationally thousands of lives would be saved each year.[13] The California ratios mandate has proven to reduce costs for hospitals by improving nurse safety and job satisfaction,[14] reducing spending on temporary RNs,[15] overtime costs,[16] and staff turnover.[17]

» Pass the **Workplace Violence Prevention for Health Care and Social Service Workers Act**, which would mandate that OSHA issue a Workplace Violence Prevention Standard for health care and social service workplaces. Health care and social service workers experience the highest rate of workplace violence of any profession in the United States[18] Nurses report being punched, kicked, bitten, beaten, choked, and assaulted on the job — and some have faced stabbings and shootings. The Covid-19 pandemic has exacerbated the hazard of workplace violence, with nurses reporting an increase of violent incidents on the job since the beginning of the pandemic.[19] This bill would require employers to develop unit-specific and facility-specific prevention plans rather than one-size-fits-all plans, and actively involve employees in developing, implementing, and reviewing the plan, and provide robust training programs for employees.[20] **Congress can improve retention rates of registered nurses by making hospitals safe places to work.**

» **Ensure that hospitals protect nurses and other workers from the hazards posed by emerging infectious diseases, including Covid-19, by mandating that OSHA issue final permanent standards that enforce protections for health care workers.** During the pandemic, hospital employers showed their utter disregard for nurses' health and safety by failing to implement proper infection control practices and failing to provide appropriate PPE. Moreover, the industry's misdeeds extend beyond mere negligence; it actively opposed measures that would protect nurses from exposure to Covid-19 or compensate them if they contract the virus. These occupational health and safety standards would provide nurses and other health care workers with enforceable tools to ensure hospitals are protecting them from workplace hazards. Congress should pass legislation to mandate that the Occupational Safety and Health Administration (OSHA) issue the following standards:

  › A final permanent Covid-19 Health Care Standard to enforce Covid protections for health care workers.

- A final permanent standard on infectious diseases, that includes protections against all aerosol-transmissible diseases.

» Strengthen and protect the right of nurses and other health care workers to organize unions and bargain collectively, including:

- Passing the **Richard L. Trumka Protecting the Right to Organize (PRO) Act**, which would enact critical improvements to current labor law in order to protect the right for workers to organize a union and bargain collectively. The right to form a union provides workers with the power necessary to address issues in their workplace and bargain collectively for improvements that benefit both recruitment and retention. The dire need for this legislation, which has bipartisan support, has been made even clearer during this pandemic. Due to employer neglect, nurses have been forced to struggle together for the most basic safety protections at their hospitals and clinics. Union organizing has led to improvements in infectious disease protocols, staffing levels, workplace violence prevention programs, and safe patient handling programs, all of which directly improve patient care.
- Passing the **VA Employee Fairness Act**, which repeals restrictions on collective bargaining for VA clinicians, including RNs. For registered nurses, union advocacy and representation allow us to focus on what we do best: caring for our patients. Without full collective bargaining rights, nurses' ability to speak out on behalf of patients is hindered, and we are constrained from advocating for the highest quality of safe patient care that our veterans deserve. This bill, which has bipartisan support, brings the rights of Title 38 employees in the VA in line with other VA workers, as well as clinicians in Department of Defense hospitals, and in private sector facilities. Passing this bill is a critical step towards improving both the recruitment and retention of the VA's most valuable resource — those who care for our nation's heroes — and, in the process, improving patient care in the VA.

» Increase funding for OSHA enforcement programs and OSHA hiring of health care sector inspectors. As of Jan. 20, 2021, federal OSHA had received 12,831 complaints from workers since the beginning of the pandemic and reported opening a mere 357 inspections in response to complaints across all sectors (2.8 percent). Under the Biden administration, inspections in response to complaints have risen dramatically, nearly five-fold to 13 percent,[21] but this response rate is still unacceptably low. Congress should require OSHA to improve enforcement activities in the health care sector where enforcement historically has been lacking, including through inspector training and programs to hire inspectors with particular experience in health care settings.

REDLINES — NNU OPPOSES PROPOSALS TO »

» **Move care that should take place in acute-care facilities to other settings, including:**

  › Congress should not make permanent the temporary "flexibilities" given to the hospital industry during the pandemic. Programs like the Acute Hospital Care at Home (AHCaH) endanger patients requiring acute hospital-level care by allowing hospitals to treat them in their homes, where patients no longer have access to the mandated 24-hour nursing care and immediate availability of a registered nurse to treat worsening conditions. Additionally, AHCaH allows emergency responses in the home to be delayed up to 30 minutes. Finally, patients at home lack the full complement of resources available in a hospital setting to respond to unexpected complications or deterioration of patients' health status. These types of programs allow hospitals to shift care to inappropriate patient care settings rather than increasing acute inpatient capacity by investing in staffing and infrastructure.

  › Congress should not move in-person nursing care to tele-nursing and lower the standards of acute-care nursing practice. The standard of providing safe, effective and therapeutic nursing care is fundamental to patient care. These standards of nursing care can only be accomplished through continuous in-person assessments of a patient done by a qualified licensed registered nurse. RN-patient interactions involve a skilled evaluation of the patient's condition, and in these assessments, RNs must use their sense of sight, smell and touch to effectively care for their patient, which is impossible to do remotely. During the Covid-19 pandemic, the hospital industry successfully lobbied Congress to expand temporary flexibilities to telehealth programs, opening the door to proposals that would fundamentally alter the standards of nursing care. A nurse is unable to provide a high standard of nursing care over a video screen or on the phone. Without in-person nursing assessments, patient care is put at risk.

  › Congress should not weaken state licensing requirements and labor protections for RNs. Congress should oppose any effort to allow interstate nursing practice or establish a federal Nurse Licensure Compact, which is an interstate agreement that provides licensing reciprocity for registered nurses (RNs) and licensed vocational nurses (LVNs). Compact agreements also allow the practice of nursing across state lines using telehealth technology. Further, it allows major health care companies to outsource the provision of certain health care services to states where providers are less regulated and lower paid. Compact licensure allows for the outsourcing of jobs out of states with strong nurse union membership and enhancing profit for health care companies at the expense of patient care.

» **Infringe upon RNs' scope of practice.** Nursing practice is fundamentally holistic in nature. Registered nurses have extensive education and clinical experience that enables them to provide safe, therapeutic patient care. Attempts to break down registered nursing practice into tasks (often called "routinization"), and shift the tasks to unlicensed and lower-licensed staff (i.e. deskilling) to reduce labor costs, undermines safe patient care. As stated above, even the simplest RN-patient interactions involve skilled assessment and evaluation of the patient's overall condition. Subtle changes in a patient's skin tone, respiratory rate, demeanor, and affect provide critical information about their health and wellbeing that can be easily overlooked or misinterpreted by those without an RN's education and clinical experience.

  › Another term that the industry uses to disguise infringing upon RNs' scope of practice is "team nursing" or "team-based care" models, where RNs spend less time at the bedside where they can get to know a particular patient's needs and use their professional judgment to ensure that the patient's needs are met. Instead, they spend more time on paperwork and monitoring the work of other staff, leaving RNs demoralized and alienated.

  › Additionally, as Congress considers funding for community health workers, NNU strongly urges the inclusion of a narrow and precise definition of community health workers, so that there are no infringements on scope of practice and quality patient care can be protected.

- **Increase legal punitive measures on patients and family members who commit violence against nurses and other health care workers.** Elevating the crime of committing violence against nurses to a felony charge does not address the issues that allow the violence to occur in the first place. Hospital employers must be held responsible for preventing violence in the workplace by requiring them to develop and implement a workplace violence prevention plan tailored to specific workplaces and worker populations, with employee involvement in all steps of the plan.
- **Increase the number of immigrant nurses brought into the United States without additional labor protections.** Recruiters and employers have long used abusive and deceptive practices to force immigrant nurses to work in unfair or unsafe working conditions. We must ensure that employers cannot use coercive contracts and other abusive practices to prevent immigrant nurses from full exercise of their labor rights, including the right to organize unions.

Strengthening and Supporting the RN Workforce Pipeline

» Create a long-term, dedicated funding stream for tuition-free nursing programs at public community colleges. Tuition-free nursing programs, particularly if coupled with stipends to cover living expenses, diminish the financial and time constraints that are the most common barriers to higher education. With sufficient in-person (not simulated) pre-licensure clinical training, nurses with associate degrees in nursing (ADNs) can be ready for entry-level nursing positions **in two years**. All new RNs, regardless of the type of degree they have, then need to be paired with preceptors to make the transition to professional practice.

  › Congress should give funding priority to public community colleges located in health professional shortage areas (HPSAs) and medically underserved areas and populations (MUAs/MUPs). Linking community colleges with local pre-licensure clinical training and post-licensure job placement in public hospitals and critical shortage facilities increases the likelihood that RNs working in these areas will be culturally competent and share values that reflect the communities in which they work. Many HPSAs and MUAs/MUPs have higher percentages of underrepresented Black, Indigenous, People of Color (BIPOC) community members; locating nursing programs in these areas would tend to serve a more racially and ethnically diverse student population. In turn, increasing tuition-free access to nursing programs could lead to greater RN diversity and improve racial, ethnic, and other disparities in health care access, leading to greater health equity.

  › In recent years, there has been a focused effort on the part of the federal government and academic institutions to increase the numbers of advanced practice registered nurses (APRNs). While the United States has experienced dramatic growth in the number of APRNs in recent years, we now need to increase the number of licensed RNs working in acute-care hospitals. The number of nurse practitioners (NPs), the largest occupation among APRNs, increased by 109 percent between 2010 and 2017, while the number of RNs who were not APRNs grew only 22 percent during this same time period.[22] In 2023, according to the National Center for Workforce Analysis, the supply of nurse practitioners, nurse anesthetists, and nurse midwives are all currently over 100 percent adequacy in meeting demand and are predicted to rise to 173 percent, 137 percent, and 118 percent of adequacy, respectively, by 2030.[23]

» Support programs that build a culturally competent and diverse pipeline of nurses into bedside care, including increasing funding for and improving the Nursing Workforce Diversity Program (NWDP). It's well documented that patient-provider racial, ethnic, and linguistic concordance improves communication, trust, and health care quality, which is why it is concerning that numerous racial and ethnic groups are underrepresented in the RN workforce, particularly Latinx and Black RNs but also Asian, American Indian, and Alaskan Native RNs. Additionally, studies show that Black, Hispanic/Latinx, and Native American health care providers are more likely to practice in underserved communities.[24] Similarly, students from rural areas are more likely to practice in rural communities.[25] Congress should:

  › Adopt the President's budget request for an additional $32 million to support nursing education programs, including increasing the number of nurse faculty and clinical preceptors.

  › Significantly increase NWDP funding for Fiscal Year 2023.

  › Amend 42 U.S.C. § 296m to include National Nurses United in the list of organizations in Section (b). As the country's largest union and professional association of direct care registered nurses, we are well suited to provide the voice of labor in the nursing workforce diversity discussion.

  › Require the Health Resources and Services Administration (HRSA) to allocate sufficient funding for research to gather data to better identify racial and ethnic minorities that are underrepresented among registered nurses. This research should include collecting and disaggregating workforce and patient data for Asian, Asian American, and Pacific Islanders and for gender-oppressed and gender non-conforming people.

» Significantly increase funding for and improve the Nurse Corps Scholarship (NCSP) and Loan Repayment (NCLRP) Programs. While we applaud the one-time $200 million funding boost for these programs in the American Rescue Plan Act, these programs remain underfunded. The NCSP and NCLRP are highly competitive with far more

applicants for awards than available funding. The high number of nurses who apply for NCSP and NCLRP support but are turned down due to lack of funding demonstrates that RNs, NPs, and APRNs are ready to fulfill unmet needs in critical shortage facilities and schools of nursing but may need federal support because of their student debt obligations. Congress should:

- Increase NCSP and NCLRP funding to levels that ensure that all eligible applicants applying to the scholarship or loan repayment programs are fully funded, until all those residing in the United States have equitable access to high-quality care across the full range of health care services. Funding levels should be sufficient to meet the ongoing need for health care professionals.
- Congress should improve the programs by requiring HRSA to:
  - Increase NCLRP funding for faculty teaching positions. Funding for faculty teaching positions has been minimal historically and accounted for less than 10 percent of the NCLRP fiscal year 2023 budget.[26] Additionally, HRSA should prioritize placing NCLRP applicants in faculty positions in schools that have at least 50 percent of students from a disadvantaged background, followed by prioritizing the placement of applicants by absolute applicant debt levels rather than debt-to-salary ratio.
  - Use HPSA critical shortage facility scores and absolute debt levels — rather than a debt-to-salary ratio — in defining funding preference tiers in the NCLRP, as using the debt-to-salary ratio creates an incentive for paying lower wages. Moreover, HRSA should treat NCLRP loan repayment as nontaxable; and include in NCLRP loan forgiveness all loans that a nurse obtained for training in vocational or practical nursing for coursework required to become an RN, as well as loans that have been consolidated/refinanced with ineligible non-qualifying debt or loans of another individual if the eligible qualifying debt can be disaggregated from the ineligible non-qualifying debt.
  - Prioritize NCLRP awards by HPSA scores, followed by prioritization based on an applicant's absolute debt levels rather than a debt-to-salary ratio in awarding loan repayment funds.
  - Simplify and ease the ways in which applicants to the NCSP can adjust the expected family contribution based on their actual financial circumstances, including based on their independent status, if they are not dependents on another's income tax filings, have supported themselves in the prior year, or based on other relevant circumstances.
  - Increase NCSP funding, particularly for ADN students, as well as devoting some Tier 1 funding to part-time students to enable those with child or elder care responsibilities to attend school.
  - Substantially increase funding for NCSP "career pathway" awards which received only $2 million of the $89 million in funding in the fiscal year 2021 budget. This program provides scholarships to unlicensed assistive personnel (e.g., certified nursing assistants and home health aides) as well as licensed practical/vocational nurses so that they can become registered nurses.

- Address institutional and industry bias towards bachelor's degree of nursing (BSNs) versus associate degree of nursing (ADNs).
  - At the hospital level, the industry should be required to adjust practices that have limited the ability for nurses from underrepresented communities to find work. Most notably, many hospitals refuse to hire nurses with ADNs, choosing to prioritize hiring of nurses with four-year BSNs. Nurses with ADN and BSN degrees typically must fulfill the same education and clinical experience requirements, with the exception of courses primarily geared toward research, teaching, and management, and they must pass the same licensing examination. By choosing to prioritize BSN nurses, hospitals are restricting diversity in the workforce. A BSN requires a larger time and financial commitment, and statistics on RN graduates show that nurses from underrepresented communities, and specifically communities of color, are more likely to graduate with an ADN. It is important to note that hospitals' refusal to hire nurses with ADNs is happening while the hospital industry is attempting to delegate nursing work to lesser licensed and unlicensed personnel and family members.

- In addition to increasing the funding for the NCSP and NCLRP, Congress must reverse the bias these programs have shown towards APRNs and BSNs. It is important that the NCSP and NCLRP adequately fund ADN students.

» Create and adequately fund "career laddering" education, clinical placement, and training opportunities to support unlicensed support staff (e.g., certified nursing assistants and home health aides) or licensed practical/ vocational nurses in becoming registered nurses. As stated above, Congress should require HRSA to substantially increase funding for NCSP "career pathway" awards. Additionally, Congress should require the Center for Medicare and Medicaid Services (CMS) to create a payment add-on to support a career ladder for CNAs and LPNs/LVNs in acute-care hospitals to become RNs.

» Cancel educational debt for nurses. Nurses who work at the bedside providing direct patient care to members of their community put themselves at risk of exposure to infectious disease, including deadly viruses such as SARS-CoV-2. For the risk that nurses bear to illness, injury, and death from their work at the bedside and for their services to their patients and communities, Congress should take legislative action to cancel any educational debt of nurses.

REDLINES — NNU OPPOSES PROPOSALS TO »

» **Expand nurse apprenticeship programs**. We have witnessed numerous programs over the years that have exploited student nurses' labor, undermined licensure and scope of practice, and left nurses vulnerable. The industry seeks to exploit student nurses as a cheap labor force with little regard to their actual education. There is no uniform definition within the health care industry of what constitutes an "apprenticeship." Nurse apprentices do not have the same level of accountability as a licensed nurse. The licensed registered nurse is legally accountable for all care that is delegated to an apprentice nurse even though they may not have the staffing resources to appropriately direct, evaluate, and observe a nurse apprentice. This puts registered nurses' licenses in jeopardy. **Congress should ensure nursing students are afforded the opportunity to learn in the clinical environment with dedicated clinical preceptors who do not have a patient care assignment as part of their pre-licensure program**. Student nurses already are able to work in health care facilities as certified nursing assistants, patient care assistants, and other capacities that familiarize them with patient care environments that do not pose a risk to patient safety or rely upon unsafe delegation models.

» **Infringe upon RNs' scope of practice, including incorporating "team-based care" training models in nursing school curriculum**. As stated above, NNU is firmly opposed to proposals that aim to break apart nursing care, which is an inherently holistic practice, into discrete tasks that can be parceled out to unlicensed and lower-licensed staff, thus reducing labor costs while endangering patients. We also oppose modifying nursing school curriculum to advocate for this type of nursing care.

» **Push nursing students' education towards more simulated training rather than in-person clinical training and incorporate training in tele-nursing into their curriculum**. Recent studies show that the academic and clinical preparedness of nursing students is declining.[27] In recent years, experienced nurses have seen a trend in which student nurses, who enter their hospitals for their clinical rotations, are less prepared than in previous years, have had less experience with patients in real-life situations versus simulation labs, and are less supported by their instructors. While in-person clinical training needed to adjust following the onset of the Covid-19 pandemic, it is critical that Congress take action to better equip and expand in-person clinical training programs, not weaken education requirements by encouraging simulation trainings while compromising patient care.

» **Prioritize and expand enrollment in baccalaureate nursing programs, including Accelerated Nursing Programs**. There are many financial barriers to becoming a nurse imposed by the exorbitant expense of private programs and the lack of admission slots in public nursing programs. These barriers, added to other systemic issues, result in the underrepresentation of numerous racial and ethnic groups in the RN workforce. NNU strongly urges Congress to prioritize funding and expanding tuition-free nursing programs at public community colleges and address the industry bias towards BSNs rather than ADNs.

» **Give large sums of money to private institutions and hospitals without requirements to address harmful working conditions and access to care issues**. Funding for educational institutions and hospitals must be targeted to those most in need, rural and underserved communities, and must be conditioned to expand bedside RN capacity, improve working conditions for registered nurses, and prevent closures of acute-care units or critical access hospitals.

ENDNOTES

1 National Council of State Boards of Nursing. 2009-20. "NCLEX Pass Rates." National Council of State Boards of Nursing. https://www.ncsbn.org/exams/exam-statistics-and-publications/nclex-pass-rates.page.

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National Nurses United
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February 15, 2023

Senator Bernard Sanders, Chairman
Senator Bill Cassidy, Ranking Member
Committee on Health, Education, Labor and Pensions
U.S. Senate
428 Senate Dirksen Office Building
Washington D.C. 20510

Dear Chairman Sanders, Ranking Member Cassidy, and Members of the Committee,

National Nurses United is the largest union and professional association of registered nurses (RNs) in the United States, representing nearly 225,000 nurses across the country. Our members have been on the frontlines of the Covid-19 response for three years and are dealing first-hand with the repercussions of the nurse staffing crisis that the health care industry is facing today. We write to you today in advance of your hearing titled, "Examining Health Care Workforce Shortages: Where Do We Go from Here?" to provide you with frontline worker insights into the working conditions that have created this staffing crisis, and to discuss the important solutions needed to address this crisis and ensure a robust health care workforce in the future.

First and foremost, it is imperative that we clarify there is not a national shortage of trained and licensed RNs in the United States. According to statistics from the National Council of State Boards of Nursing and the U.S. Bureau of Labor Statistics, there are at least 1.3 million actively licensed registered nurses who are not currently employed as RNs. We don't have a "nurse shortage," but **we do have a staffing crisis, brought on by the lack of good nursing jobs where RNs are valued for their work, have strong health and safety protections, and are not required to care for more patients at any given time than is safe for optimal, therapeutic care.**

Throughout the Covid-19 pandemic, nurses have been dealing with dangerous working conditions, including intentional low RN staffing levels, inadequate health and safety protections, insufficient stock of critical medical supplies and PPE, and increasing levels of violence in the workplace. While the Covid crisis has exacerbated these challenges, nurses have been facing these issues in their hospital workplaces for decades. **The staffing crisis we are experiencing now is the result of years of industry neglect and intentional policies of short-staffing and cost-cutting measures enacted by hospital employers.**

The hospital industry is using the false narrative of a "nursing shortage" to propose interventions that will reduce labor costs and maximize revenue without regard for health care workers or patient care. For several decades, the hospital industry has attempted to deskill the nursing profession by inappropriately pushing care to the lowest-cost and least-regulated setting, including substituting nursing care provided by licensed RNs for unlicensed, or lower-licensed, care to reduce labor costs. The attack on nursing practice and patient advocacy also includes displacing RNs and RN professional judgment with health information technology, automation, remote monitoring

tools and, ultimately, abandoning the patient by leaving complex clinical care to be provided in the home by family or even by the patient alone. Additionally, the industry has lobbied for bringing in more immigrant nurses into the U.S. to solve the staffing crisis. We know that recruiters and employers have long used abusive and deceptive practices to force immigrant nurses to work in unfair or unsafe working conditions, which is why we must ensure that all immigrant nurses are guaranteed the strongest labor protections, including the right to organize.

Hospital industry mistreatment and neglect of RNs and other health care workers has led many health care workers to leave their respective facilities in order to protect their health, wellbeing, and licenses. The hospital industry's own actions have created the staffing crisis in health care.

To that point, the first step to address this staffing crisis is to revitalize the workforce by increasing nurse retention and bringing licensed nurses who have left the bedside back to work. To do this, it is critical that the federal government implement policies that will require the hospital industry to provide safe and healthy workplaces.

Nurses are leaving the bedside because their employers refuse to staff their units appropriately and fail to supply the resources necessary to provide safe, therapeutic patient care. Many hospitals have chosen to adopt policies that result in high patient caseloads that compromise the health and safety of both nurses and patients. Moreover, hospital employers have failed to implement programs to protect nurses from infectious diseases, prevent violence, and enable safe patient handling so nurses can avoid workplace musculoskeletal injuries.

Hospital employers have created a vicious cycle of deteriorating workplace conditions that has exacerbated the staffing crisis. Although working conditions have been deteriorating for decades, the problems intensified during the pandemic. Hospital employers showed their utter disregard for nurses' health and safety by failing to implement proper infection control practices and failing to provide appropriate PPE. Nurses working on the pandemic's front lines have been experiencing severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion.

To bring nurses back to the bedside and increase nurse retention, NNU recommends the following solutions:

- Congress must mandate minimum nurse-to-patient staffing ratios, through passage of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, sponsored by Senator Sherrod Brown and Congresswoman Jan Schakowsky.
- The Occupational Safety and Health Administration (OSHA) must issue a final permanent Covid-19 Health Care Standard to enforce Covid protections for health care workers. Further, OSHA should issue an Infectious Diseases standard, so that workplace protections will be enforced during future infectious disease outbreaks.
- Congress must pass the Workplace Violence Prevention for Health Care and Social Service Workers Act, sponsored by Congressman Joe Courtney and passed in the House of Representatives, and introduced by Senator Tammy Baldwin in the 117th Congress. The bill would mandate that OSHA issue a Workplace Violence Prevention Standard for health care and social service workplaces.
- The federal government must do everything in its power to restore and protect the right of nurses and other health care workers to organize and bargain collectively, including passing the VA Employee Fairness Act and the PRO Act which both passed the House of Representatives in the 117th Congress.

While there is not a national nursing shortage in the United States, there is a lack of racial, ethnic, cultural, linguistic, and socioeconomic diversity within the current nursing workforce. This challenge has resulted from a lack of investment in nursing education, job placement, and hospital industry practices that have restricted the pipeline of nurses from socioeconomically diverse and underserved communities.[1] The federal government should take measures to recruit nurses from underserved communities, and to ensure that hospital industry practices support a diverse nursing pipeline.

Diversity in the health care workforce facilitates health care access and health care quality, necessary elements of health equity. Patient-provider racial, ethnic, and linguistic concordance improves communication, trust, and health care quality. Black, Indigenous, and People of Color communities, along with rural communities, often have fewer health care professionals practicing locally and even fewer who are culturally and linguistically competent. Studies show that Black, Hispanic/Latinx, and Native American health care providers are more likely to practice in underserved communities.[2] Similarly, students from rural areas are more likely to practice in rural communities.[3]

To increase diversity within the nursing workforce, investments must be made to support education and job placement for nurses from underrepresented communities. This should include the following investments:

- Long-term funding for tuition free nursing programs at community colleges;
- Increased funding for the Nursing Workforce Diversity Program;
- Increased funding for Nurse Corps scholarship and loan repayment programs.

At the hospital level, the industry needs to adjust practices that have limited the ability for nurses from underrepresented communities to find work. Most notably, some hospitals refuse to hire nurses with an associate degree in nursing (ADN), choosing to prioritize hiring of nurses with four-year bachelor's degrees of nursing (BSNs). Nurses with ADN and BSN degrees typically must fulfill the same education and clinical experience requirements, with the exception of courses primarily geared toward research, teaching, and management, and they must pass the same licensing examination. By choosing to prioritize BSN nurses, hospitals are restricting diversity in the workforce. A BSN requires a larger time and financial commitment, and statistics on RN graduates show that nurses from underrepresented communities, and specifically communities of color, are more likely to graduate with an ADN. It is important to note that hospitals refusing to hire nurses with ADNs is happening while the hospital industry is attempting to delegate nursing work to lesser licensed and unlicensed personnel and family members.

As the committee explores approaches to addressing the current health care staffing crisis, it is crucial to protect RNs' scope of practice. We urge you to focus on providing the resources needed to

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[1] There was a big one-time bump of $200 million in workforce funding in the FY 2021 COVID-19 Supplemental funding.

[2] Pittman P et al. 2021. Health Workforce for Health Equity. Medical care, 59(Suppl 5), S405–S408. https://doi.org/10.1097/MLR.0000000000001609. Citing Goodfellow A et al. Predictors of primary care physician practice location in underserved urban or rural areas in the United States: a systematic literature review. Acad Med. 2016;91:1313–1321 and Mertz E et al. Underrepresented minority dentists: quantifying their numbers and characterizing the communities they serve. Health Aff. 2016;35:2190–2199

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educate more RNs in two-year nursing programs, which enable nurses to enter practice in two years rather than four, rather than on "upskilling" other workers. Nursing practice is fundamentally holistic in nature. Registered nurses have extensive education and clinical experience that enables them to provide safe, therapeutic patient care. Attempts to break down registered nursing practice into tasks, and shifting the tasks to unlicensed workers, undermines safe patient care. Even the simplest RN-patient interactions involve skilled assessment and evaluation of the patient's overall condition. Subtle changes in a patient's skin tone, respiratory rate, demeanor, and affect provide critical information to their health and wellbeing that can be easily overlooked or misinterpreted by those without an RN's education and clinical experience.

Attached to this letter is NNU's report, "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-Created Unsafe Staffing Crisis," which contains more detailed information on the hospital industry practices that have created the nurse staffing crisis we are experiencing right now, and NNU's proposed solutions to increase nurse retention and diversity.

We look forward to working with your committee to protect the workplace health and safety of nurses, improve staffing levels and nurse retention, and build a sustainable nursing workforce well into the future.

Sincerely,

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