New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Joint Assembly and Senate Budget Hearing:
Workforce Development
February 2, 2021

Testimony on behalf the New York State Nurses Association
Presented by Pat Kane, RN
NYSNA Executive Director

The New York State Nurses Association (NYSNA) represents more than 40,000 registered nurses across New York State for collective bargaining. We are the state's largest RN union and are on the forefront of the fight to expand health care to all New Yorkers, to protect the rights of nurses and other healthcare workers, and to maintain safe, high quality care.

NYSNA members were on the front lines of the fight against the COVID pandemic in hospitals, long-term care facilities and other care settings and are painfully aware of the broad health, social and economic impact of the pandemic on workers, patients and our communities.

1. **NYSNA rejects the implementation of austerity and demands revenue enhancements to address the pandemic and the fiscal crisis**

The Executive Budget reflects the ongoing fiscal crisis that was triggered by the COVID health crisis, and is primarily focused on closing an anticipated $15 billion state deficit and uncertainties about existing revenue streams and federal action to support state and local governments.

NYSNA continues to oppose austerity measures that will only worsen the health care and economic crisis and impede a full recovery. We strongly support revenue measures targeting wealthy individuals and business sectors, many of which saw their incomes and profits explode at the same time that essential workers and the broader population continue to endure health hazards and severe hardship.

To that end, we strongly urge the legislature to reject the budget cuts proposed in the FY22 Executive Budget and to increase revenues by targeting the ultra-wealthy and highly profitable business sectors, including Wall Street, banking and financial companies, and those businesses that experience dramatic increases in profits because of the pandemic.

The proposed cuts to health care, Medicaid and other vital health services will hurt working people, communities of color and the poor – the very communities that were hardest hit by the health and economic effects of the pandemic. We are particularly concerned about cuts to Medicaid and other vital health services that will severely impact our patients, reduce the quality and availability of need health

services, and result in layoffs of nurses and other healthcare workers in the midst of an ongoing pandemic.

2. Workforce provisions in the FY 2022 Executive Budget

In reviewing the Executive Budget, it is disappointing, though not surprising, that there are few proposals aimed at addressing the problems faced by health care workers, first responders, and essential workers.

NYSNA supports the following proposals:

- **Extension of paid leave benefits to require paid time off for COVID vaccination**: This measure would require employers to provide up to 4 hours of paid leave to any employee for receiving a COVID vaccination. The definition of employer is broad and includes public entities. The time cannot be charged to employee leave banks. (Education, Labor and Family Assistance, Article VII, Part W)
- **Expansion of unemployment benefits to more fully cover part-time work**: The proposal makes it easier for employees in part-time employment or full-time employees who have their work hours reduced to receive Unemployment Insurance payments. (Education, Labor and Family Assistance, Article VII, Part T)
- **Inclusion of renewable energy sector in prevailing wage requirement:** This proposal would include renewable energy projects in existing prevailing wage regulation. Given the threat of climate change and the vital role of renewable energy production in reducing carbon emissions, it is critical that jobs in this sector receive full wage protections to prevent abusive practices and exploitation. (Education, Labor and Family Assistance, Article VII, Part AA)
- **Support for domestic PPE production:** This proposal would direct state agencies purchase PPE supplies from American producers, unless such purchases are not feasible. NYSNA members strongly criticized the federal and state response to ongoing shortages of N95 respirators and other PPE vital to protecting the health of nurses, workers and the general public during the pandemic. Though we support the general directive to seek and support domestic PPE production, we feel this legislation does not go far enough. We would urge the legislature to consider enhanced local power to direct or support PPE production within NY and to provide enhanced powers to the state and local governments to manage the supply and distribution of PPE during a declared emergency. (Public Protection, Article VII, Part BB)
- **Public Health Corps initiative:** This proposal calls for the creation of a public health infrastructure to support COVID vaccination and provide enhanced emergency response capacity. Though we support this program, we note that it is contingent on the receipt of $15 billion in federal assistance. We also note that it aims only to recruit and train students in health fields to serve as a public health back-up workforce. This measure does not go far enough. The COVID crisis revealed significant weaknesses in state and local public health infrastructure, reflecting private providers increased focus on revenue generating services and neglect of basic public health programs and infrastructure (which produces little or no revenue). The state should provide significant funding to expand public health programs as an integral part of the total healthcare system.

NYSNA opposes the following proposal:

- **Decreased public employee retiree health benefits:** The Executive Budget makes several proposals to reduce retiree health benefits. The measures would reduce coverage for new state employees hired after October 2021, reduce subsidies for existing retirees and freeze the Medicare Part B cap for existing retirees. NYSNA strongly support universal health coverage for all NY

residents (including support for single-payer universal coverage as proposed in the NY Health Act). Reducing health coverage for retired state employees as an austerity measure is antithetical to the proposition that health care is a human right, not a fringe benefit. We should be expanding coverage, not reducing it. (Public Protection and Government Operations, Article VII, Parts CC, DD and EE)

3. What's not in the proposed FY2022 Executive Budget

The proposed Executive Budget fails to address a range of serious workforce issues that have arisen or been magnified by the effects of the COVID crisis.

The budget is thus most notable not for what is proposed, but rather for what is missing.

NYSNA supports the inclusion of the following vital provisions in the FY22 budget legislation or, in the alternative, as priority stand-alone legislation:

(a) Implement minimum safe staffing standards in hospitals and nursing homes – Enact the Safe Staffing for Quality Care Act (A108/S1168)

NYSNA and other patient care advocates have long noted that the hospital and nursing home industry r remain chronically understaffed.

Nurses and other caregivers routinely are assigned more patients than they can properly care for, resulting in staff burn-out and turnover, and directly impacting the quality of patient care and patient outcomes. In addition, the lack of minimal uniform staffing standards results in wide variations in staffing levels and the quality of patient care based on geography, race, socio-economic standing and the source of insurance coverage.

Even before the onset of the COVID pandemic, the lack of minimum staffing standards created a two-tiered healthcare system in which communities of color, working people, immigrants and the uninsured received lower quality of care and fewer health care services.

The COVID pandemic has worsened these systemic inequalities. The lack of minimum staffing standards, equally enforced and applied to all hospitals and nursing, had several immediate effects when the pandemic hit New York. First, there was a general shortage of staff throughout the system, forcing nurses to scramble to provide care for even larger numbers of patients. Second, the crisis highlighted staffing disparities between hospitals and nursing homes – some facilities had better staffing before and during the crisis than others. These disparities impacted mortality rates during the crisis, as has been widely reported in the press and academic research.

The issues that NYSNA and others have been raising were directly implicated in the toll of deaths in New York nursing homes in a report issued by the State Attorney General on January 28th.

The report found that at least 6,645 nursing home residents died of COVID between March and November, accounting for about 25% of all deaths statewide during that time period. The AG report notes at the outset that the death toll in nursing homes was undercounted by the state DOH.

The more important and damning finding in the AG's report is that high mortality rates in nursing homes are largely attributable to a chronic pattern of inadequate staffing levels in nursing homes that was worsened by the onset of the pandemic. Current state law gives operators wide latitude to determine the number of RNs, LPNs and Aides they use to provide resident care. This has resulted extreme variations in the level of staffing and patient care from facility to facility. The arrival of COVID exposed these vulnerabilities and made them worse.

The central finding and core recommendation of the AG's report is that poor staffing was a major factor in the high death toll in nursing homes and that New York must enact enforceable, minimum staffing ratios or hours of care per resident. If we had required nursing home operators to provide mandatory levels of RN, LPN and Aide staffing, thousands of lives would have been saved.

Among the key findings of the AG report are the following:

- **Direct correlation of poor staffing and higher mortality rates in nursing homes, as evidenced by the differences in staffing levels and mortality**

CMS Staffing Rating	5 Star	4 Star	3 Star	2 Star	1 Star
Mortality Rate	4.94%	5.12%	5.56%	6.92%	7.13%
Excess Mortality Rate	-------	+4%	+13%	+40%	+44%

If state law had required all nursing homes to meet the staffing levels of "5 Star" CMS-rated facilities, the 6,645 deaths in nursing homes would have been reduced to 5,094 - 23.34% fewer deaths or 1,551 lives saved.

When the authors of the AG's report weighted the mortality data by staffing levels and geography, the difference between the best staffed and lower ranked facilities was even more pronounced: Weighted mortality rates for residents of facilities receiving the top "5 Star" staffing rating were less than half the mortality rates of the rest of the facilities, meaning that If all facilities were staffed at the "5 Star" standard, 3,300 fewer nursing home residents would have lost their lives between March and November.

- **Poor staffing and ineffective infection control measures increased risks of resident harm**
Many nursing homes failed to prepare and implement infection control protocols to protect residents from exposure to COVID.

The AG's report identifies the following infection control factors that contributed to high mortality rates: failure to isolate patients with COVID; improper or inadequate sterilization of equipment and surfaces; continued communal dining and other less labor intense patient care practices; failure to screen or test direct care staff for COVID; pressuring or mandating exposed or sick staff to report to work; failure to train direct care staff on proper infection control measures; and failure to provide personal protective equipment (PPE) to protect staff from COVID exposure. Understaffed facilities did not have the ability to devote extra time to implementing heightened COVID infection control measures.

The proper implementation of infection control measures is directly or indirectly attributed by the report to a lack of direct care staff, particularly of RNs, who are responsible for creating and implementing patient care plans. Infection control in the closed space of a nursing home is a labor intensive process. Insufficient staffing undermined efforts to protect residents and contributed to the high death.

- **The prevalence of for-profit operators contributed to poor staffing and infection control**
  More than 65% of the nursing homes in New York are operated by for-profit owners, 31% by non-profit companies, and 5% by the government. The AG's report notes that the drive to maximize revenues and enrich the operators of these for-profit facilities played a key role in the high mortality of residents.

  The report notes that the lowest staffing levels and the highest mortality rates were concentrated in the for-profit nursing home group, which comprised more than 81% of the worst staffed "1 Star" and "2 Star" facilities. Conversely, non-profit and government facilities made up 88% of the top ranked "5 Star" staffed nursing homes.

  According to CMS data, for-profit operators received 79% of verified citations for safety violations. Government-run nursing homes provided a total average of 4.40 hours of direct nursing care per patient day (HPPD) and non-profits provided 4.14 hours. For-profits, in comparison, provided only 3.45 hours per day – 20% lower than non-profits and 30% lower than government-run facilities.

- **Safe staffing also saves lives in hospitals**
  The AG's report on nursing homes does not address the impact of staffing levels in hospitals and COVID mortality rates. There is, however, ample evidence that lower staffing in hospitals also contributed to COVID higher mortality, including of nursing home residents who were transferred to hospitals.

  A recent study in peer-reviewed BMJ Quality & Safety documented poor staffing ratios in New York City and State hospitals even before the COVID pandemic. (http://bit.ly/BMJStaffing).

  The New York Times reported that the better staffed and resourced flag-ship hospitals of large NY City area systems had lower mortality rates than their less resourced and understaffed hospitals in the outer boroughs.

  The Wall Street Journal recently reported on the impact on mortality rates in hospitals using "lean" staffing plans that rely on supplemental temporary staff to respond to surges in demand.

  The weakness of these cost-cutting staffing models is a central finding of the AG's report, and it applies equally to our hospital system. All nursing home residents and hospital patients should be protected by minimum staffing standards that apply to uniformly to all facilities.

- **Enact mandatory minimum staffing ratios in NY nursing homes and hospitals**
  One of the core recommendations of the AG's report is to enact minimum caregiver to resident

staffing ratios in our nursing homes.

The legislature should immediately enact the "Safe Staffing for Quality Care Act" (A108/S1168). This legislation will require minimum RN, LPN and Aide staffing hours for nursing home residents and minimum nurse-to-patient ratios in our hospitals. Passing safe staffing legislation will save lives and address the devastating shortcomings in our health care system identified by the Attorney General.

(b) Address the ongoing PPE problem

During the height of the crisis, nurses and other health care workers experienced widespread and severe shortages of personal protective equipment (PPE), including disposable N95 respirators, protective gowns and face shields. The shortages also led to regular downgrading of infection control protocols that were driven by the need to conserve PPE rather than evidence-based scientific best practices.

The situation with N95 respirators was particularly acute in our hospitals and nursing homes, with nurses being required to reuse these disposable products for up to a week and other staff being denied respirators entirely, notwithstanding increasing evidence that the virus is airborne and lingers for hours suspended in the air.

The PPE situation has eased somewhat, but remains a serious concern and ongoing conservation of PPE continues to plagues nurses and other staff in hospitals and nursing homes.

We believe that the following measures need to be implemented to address this situation and prepare for the next round:

- Coordinate and control the production, acquisition, stockpiling and distribution of PPE supplies for health care workers and essential workers in all industries and sectors. The availability of PPE cannot be contingent on an employer's financial resources or personal connections. Shortages of PPE are unconscionable and threaten the public health;
- Respirators, masks, gowns, face shields, coveralls, head coverings, booties, gloves and any other necessary PPE will be available on all units, for all workers coming into contact with patients, and replaced after each patient care session with a confirmed or suspected COVID patient, or when the PPE is soiled, damaged or contaminated;
- To protect against supply chain disruptions, hospitals and nursing homes are currently required to maintain a sufficient onsite PPE stockpile for 90 days of operation, but the regulations issued by DOH still leave unclear whether PPE stockpiles are to be measured using "conventional capacity" guidelines (as opposed to "contingency capacity" or "crisis capacity" guidelines that restrict the use of PPE);
- Require transparency about the actual levels of PPE on hand, at the hospital level and statewide, with regularly published, up-to-date information about the numbers of each type of PPE stockpiled;
- Increase the use of reusable rather than disposable respirators. Hospitals should be required (and receive funding if necessary) to purchase reusable elastomeric respirators and Powered Air Purifying Respirators (PAPRs) to reduce supply chain pressures and enhance capacity for future surges;
- Prohibit the sterilization and re-use of disposable single-use PPE (cleaning or sterilizing disposable PPE degrades the equipment and reduces its effectiveness);
- Ensure that all hospital staff (including ancillary or support workers) have access to full PPE and are all properly fit tested and trained in proper donning and doffing;

(c) Protect Nurses and other essential workers who are exposed to or become ill from COVID

Throughout the course of the pandemic, nurses, other health care workers and "essential" workers were required to report to work while many other workers are able to work remotely to avoid exposure to COVID. As a result, large numbers of these workers were exposed to or fell ill with COVID.

Among nurses and direct care workers in hospitals and nursing homes, infection rates were very high and many were forced to self-isolate due to exposure or to miss work because they fell ill. In addition, the spread of the virus among facility staff directly contributed to and worsened the toll on hospital

patients and nursing home residents.

Nurses and other essential workers were also left unprotected if their exposure resulted in illness, disability or death. Under current law, COVID 19 is not classified as an occupational disease for purposes of getting health care, disability and death benefits under the Workers' Compensation Law. This means that these workers were discouraged for applying for benefits, and in many cases employers and insurers challenged their claims, forcing workers to prove that they contracted COVID at work to win their cases.

Given the critical role played by health workers and other essential workers during the crisis, it is unacceptable that these workers should not receive the supports and assistance that they earned with their sacrifice for the common good. Thanking them for their service is not enough.

Accordingly, NYSNA supports the following measures to recognize the sacrifices of nurses and other essential workers and provide them with fair support or compensation if they become ill:

- **Pass the New York Hero Act (S1034/A2681) to require mandatory infection control protocols and standards applicable to all private sector work settings**

  This legislation would require the DOL and the DOH to jointly develop minimum infection control protocols tailored to specific industries/work settings to protect workers and the public from airborne disease transmission. The lack of minimum, consistent infection control standards has been a critical problem in hospitals, nursing homes and in various essential industries. The state must act now to protect workers and the general public from airborne disease transmission. This bill should be included in the state budget or immediately passed as stand-alone legislation. The legislature should also consider expanding the applicability to include public sector work settings, which are currently covered by a less stringent framework passed in 2020.

- **Make the COVID accidental death benefit permanent for public employees (Chapter 89 of the Laws of 2020)**

  Chapter 89 modified various pension programs applicable to state and local public employees to include any employee death attributable to COVID after March 0f 2020 in the accidental line-of-duty death benefit. This allows the worker's survivors to receive death benefits permitted under the pension laws.

  The provision included a December 31, 2020 sunset. The Governor has extended the applicability by Executive Order to February 26, 2021.

  The legislature should permanently extend the applicability of the program in statute. The families of state and local government employees who die of exposure to COVID should be permanently protected.

- **Define COVID-19 as an occupational illness for nurses and other essential workers under the Workers Compensation Law (S1241 (Ramos))**

  We have noted that employers and insurers have sought to prevent employees who became ill from COVID from filing claims for Workers Compensation benefits or challenged claims by forcing employees to establish that the illness was contracted at work. In the absence of clear

mandatory workplace protections for nurses and other workers, and given the near impossibility of proving that a viral infection was contracted in a particular moment or place, the existing statutory framework is inadequate.

Existing Workers Compensation provisions include certain diseases as occupational illnesses that do not require the employee to prove that the disease was contracted at work. Instead, there is a rebuttable presumption that specified diseases are endemic to given occupations and work settings.

For health care workers and workers in private and public sector "essential" titles who worked and continue to work in settings that expose them to COVID, the Workers Compensation system should provide similar presumptions that COVID was contracted at work.

Accordingly, the legislature should include the provisions of S1241 in the state budget or enact the measure as stand-alone legislation.

- **Authorize early retirement incentives for state and local government workers**
  We have noted that the state faces a $15 billion deficit this year. Local governments face similar fiscal crises – NY City, for example, faces its own $9.5 billion deficit. Though we expect the new Democratic majority in the Senate to approve substantial state and local government aid, it remains unclear whether this will be enough to address the huge state and local budget gaps.

  If state or local governments are forced to reduce their workforces to address budget gaps (something NYSNA strongly opposes and calls for revenue enhancements target to the rich and profitable businesses), in most cases it will result in the layoff of younger and more recently hired workers. Because these newer, less senior workers tend to be paid less and to have lower pension costs, the state and localities will be forced to resort to more layoffs of nurses, teachers, firefighters, police officers and other vital providers of needed services to meet savings targets.

  If state and local governments were authorized to offer early retirement incentives to encourage older workers to voluntarily resign, higher savings could be generated and fewer workers would need to be laid off to meet budget targets.

  Under current law, the legislature must modify existing pension laws to authorize local governments to offer retirement incentives (in the form of extra years of service and/or vesting credits.

  Accordingly, we urge the legislature to grant authority to the state and local governments to craft voluntary early retirement incentives under existing pension laws. This will ease fiscal burdens and minimize the extent of any workforce reductions.