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

Joint Assembly and Senate Legislative Hearing:
Hospitals and COVID-19
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Testimony on behalf the New York State Nurses Association
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Introduction
The COVID-19 emergency severely affected hospitals throughout the state, but New York City area hospitals were particularly hard hit.

The pandemic's surge took a particularly devastating toll on New Yorkers. At the peak in early to mid-April, more than 18,000 COVID patients were hospitalized on a daily basis state-wide, including than 5,000 being treated in ICUs. In New York City, the epicenter of the outbreak, the situation was even more dire – with hospitalizations averaging more than 12,000 daily at the peak, including more than 3,000 in ICUs.

To date, more than 422,000 have been diagnosed with COVID (including 229,000 in NY City), almost 90,000 have been hospitalized (56,000 in NY City), and more than 32,000 have died (more than 23,000 in NY City).

The ongoing pandemic has also triggered ripple effects in the broader economy and the health care system that threaten the health and welfare of New Yorkers on multiple fronts. The state unemployment rate is close to 20% (and higher in NY City); more than 1 million New Yorkers have lost or will soon lose their employer-sponsored health coverage; state and local budgets are facing massive shortfalls that threaten health care and other social services; Medicaid enrollments and the number of uninsured residents are rising; and hospital finances have been severely undermined by reduced revenues and higher costs in responding to the virus.

The pandemic has also brought into stark view the long-standing racial and socio-economic inequalities in our broader economy and health care system. Black and Latinx New Yorkers have suffered hospitalization and mortality rates that are more than double those of whites. This reflects historic inequalities in hospital funding, access to services, quality of care, distribution of wealth and income, social and economic determinants of health, and the prevalence of Black and Latinx workers in the lower paid "essential" workforce that continued to report to work throughout the worst of the crisis. These structural inequalities will only be reinforced in a second surge if they are not aggressively addressed now.

Though the pandemic is currently under some degree of control in NY State, the threat of a resurgence in the fall and winter is very real and indeed likely. The virus is spreading very rapidly in other parts of the country, and as cold weather forces people back indoors and schools and businesses are reopened, a COVID resurgence that also overlaps with the seasonal influenza is almost inevitable.

Given our members' direct experiences during the first COVID-19 surge and the likelihood of a second wave at the end of the year, it is imperative that we properly understand what happened in the spring and how the pandemic exacerbated existing weaknesses, structural trends and inequalities in our health care system. We have a responsibility to draw these lessons and take urgent action to fix these problems before we find ourselves facing a similar crisis in the fall and winter.

Based on the experience and analysis of the nurses who were on the frontlines of the fight against COVID, we believe that the following issues need to be urgently addressed:

1. Inadequate hospital staffing and the need for minimum staffing standards

During the height of the first phase of the crisis, hospitals were directed to increase their bed capacity by at least 50% and the state added tens of thousands of ventilators to accommodate increased ICU patients. As noted above, at the high point hospitalizations and ICU usage rates substantially exceeded pre-crisis system capacity (about 53,000 beds and 3,300 ICU beds), with the situation in NY City even more overstretched. The conversion of space and the procurement of beds and ventilators was accomplished relatively easily. What was not easy to accomplish, however, was to find adequately trained staff to provide care for the expanded admissions of COVID patients.

The staffing situation before the crisis was problematic, with nurses regularly reporting that they were too short-staffed to provide proper levels of patient care. The state, despite sustained demands from nurses and patient care advocates, had failed to implement minimum staffing ratios and other regulations to ensure safe patient care.

The lack of minimum staffing standards, equally enforced and applied to all hospitals, had two immediate effects that were amplified during the crisis and caused unnecessary suffering and higher mortality.

First, there was a general shortage of staff throughout the system, forcing nurses to scramble to provide care for large numbers of patients. For example, in a normal ICU there is little dispute that a nurse should have no more than 2 patients, and in some cases less than that. During the crisis, the number of ICU patients that nurses had to care for skyrocketed, with reports of nurses caring for six, eight and even more than 10 patients at a time. Similar patterns emerged in standard medical/surgical units and Emergency Rooms throughout the system.

Second, the crisis highlighted the staffing disparities within the system. Some hospitals (particularly the flagship hospitals within larger private systems as well as other profitable hospitals) were able to provide much better staffing during the crisis. Poorly resourced safety net hospitals, public hospitals and satellite community hospitals within large systems, on the other hand, had much poorer staffing to begin with and fared much worse. Reporting by the New York Times and numerous other sources has

shown that mortality rates in these understaffed and under-resourced hospitals was higher than in the "richer" hospitals.

If the state had implemented uniform minimum staffing requirements throughout the system, the disparities in outcomes resulting from unequal staffing patterns would have been avoided and fewer patients would have died. Improved staffing standards will lead to better care under normal circumstances and will improve the capacity of hospitals to respond to COVID and other public health emergencies. All patients, regardless of where they live their income level are entitled to quality care and the same chance of survival.

Finally, we would note that the state was required to conduct a study of staffing patterns in hospitals and long-term care facilities and release it in December of 2019. It is our understanding that the DOH has committed to release the study this week. We call on the legislature to carefully analyze the study and other relevant data and to enact minimum staffing legislation to provide all patients with safe, quality care.

2. Implement minimum standards for shifting nurses to areas outside their areas of practice

During the height of the crisis, as hospitals scrambled to staff the increased number of beds, many non-critical services were reduced or entirely eliminated and those nurses were shifted to cover acute and intensive care COVID patients.

We received numerous reports of nurses with from labor & delivery, out-patient clinics, surgical suites, and other areas being abruptly transferred to staff acute care and intensive care units with little or no prior experience in these areas and inadequate or no training to fulfill these new roles.

This situation was particularly distressing to nurses as healthcare professionals who are committed and held to the standards of their profession and dedicated to providing the best possible level of care, notwithstanding that hospitals and nursing homes received broad immunity from civil liability during the state of emergency. The situation was made worse by the widespread staffing shortages and the influx of ill-prepared temporary "agency" staff who were often themselves not properly trained or experienced to help out with patient care on those critical care units.

The state must implement minimum standards and protocols to require that hospitals meet minimum training standards before they are allowed to transfer or shift nurses and other direct care staff care for patients in acute and critical care areas.

3. Failure to address the needs and consider the input of nurses and other front-line staff

In the response to the crisis, there was a consistent pattern of reliance on top-down directives (from the CDC, the State DOH, local health departments and hospital executives) that led to inconsistent or contradictory policies and protocols and failed to seek input and advice from the front-line nurses and other direct care staff who were responsible for implementing the direct response to the pandemic.

This pattern was expressed in numerous areas of hospital operations and led to significant confusion, undermined the health and morale of staff, impeded effective hospital operations and contributed to avoidable and unnecessary mortality among patients and staff.

Examples of these shortcomings included the following:

- Failure to effectively coordinate and direct patient care within the hospital system, including the proper distribution of PPE to protect staff;
- Infection control standards and protocols issued by the CDC, the State DOH and local health departments were constantly changed and watered down, without any scientific or clinical basis, and often driven by a systemic failure to produce and distribute adequate stocks of PPE;
- Implementation of policies to sterilize and reuse disposable PPE that lacked a scientific basis and exposed staff to infection by providing them with degraded or ineffective equipment;
- Refusal to consider the acquisition and distribution of reusable PPE such as PAPRs and Elastomeric masks in the face of acute shortages of disposable respirators;
- Failure to consider or implement engineering controls such as improved ventilation to protect staff and patients from infection;
- Constantly shifting criteria for isolation and quarantine of staff exposed to or infected by COVID, leading to staff being recalled to work while sick or still contagious;
- Widespread layoffs and furloughs of staff who could have contributed to COVID care in their hospitals or available to assist in other facilities;
- Failure of the State DOH and hospitals to implement an effective method for shifting staff to where there were shortages within the broader hospital system (NYSNA had to design and advocate for the activation of a "COVID Nurse Corps" to allow furloughed or laid off nurses to be deployed on a voluntary basis to other hospitals that were experiencing shortages);
- Failure to designate COVID as an occupational illness for nurses and other workers and to allow them to receive Workers Compensation disability or death benefits without employer or insurer interference when they contracted COVID;
- Ongoing lack of clarity and transparency during the reopening phase regarding the definition and meaning of the 90 day stockpile requirement (90 day PPE supplies under conventional infection control protocols is not the same as 90 days PPE supply under critical conservation standards).

These shortcomings need to be addressed before we face a resurgence of the pandemic. Infection control and PPE protocols needs to be scientifically based and uniformly applied throughout the hospital system.

Nurses and other direct care staff need to be included in the decision making process at the policy level and within their workplaces to effectively learn from our mistakes in the first wave and to avoid repeating those mistakes in any resurgence of the pandemic.

4. Racial and social inequalities in health outcomes and health care

The existence of racial and social inequalities in our health care system is long-standing and hardly a secret. Black and Latinx communities in New York have long suffered from lower life expectancy, higher infant and maternal mortality rates, and higher incidence of heart disease, diabetes and other chronic health conditions. People of color are more likely to be uninsured or to rely on Medicaid and other government health programs, to forego or be denied access to health care services due to discrimination, and more likely to live in unhealthy environmental conditions.

These historic inequalities were laid bare during the coronavirus pandemic, with startling results, according to data released by the City of New York (with similar patterns in other states and cities):

- The COVID hospitalization rate for Blacks was 711, for Latinx 685 and for whites only 320 per 100,000 population;
- The COVID mortality rate for Blacks was 246, for Latinx 261, and for whites only 123 per 100,000 population.

The racial disparities are even worse when factors such as income and geography are included. In largely white and affluent Battery Park City the mortality rate was 0/100,000 and in the Financial District 24/100,000. In Harlem/Washington Heights the mortality rate was 215/100,000 and in East New York 628/100,000. The largely Black and very low-income people of East New York thus died at *30 times the rate* of affluent residents of lower Manhattan.

The shocking mortality rates were worsened during the crisis because Black and Latinx patient are less likely to receive their care in well-resourced private hospital systems and more likely to be treated by under-funded and relatively poorly resourced public sector and private sector safety net hospitals.

The racial inequalities in our economic and health care system must be fully recognized and systemically addressed as the crisis that they are – this will require action to eliminate income and wealth inequality, equal funding for safety net hospitals and other care givers, and expansion of direct care and support services to target these vulnerable patients and communities.

5. Impose a moratorium on hospital closures and service reductions

The healthcare system in New York has been undergoing a sustained and intentional reduction in the number of hospitals and available in-patient beds. In New York City dozens of hospitals have closed in the last 20 years and rural hospitals are increasingly under threat of outright closure or substantial reductions in capacity and services.

These trends are partly the result of state policy to reduce direct and indirect government spending on hospitals, including reduced Medicaid reimbursement rates and an unequal allocation of government funding. This has enabled the creation of a two-tier system of haves and have nots.

They also reflect a restructuring of the hospital system to reduce the "brick and mortar" footprint, shift to outpatient and ambulatory services, and shed unprofitable "service lines" as hospital executives increasingly treat hospitals and health care as a market-oriented, revenue-generating, competitive business rather that social institutions meeting basic human needs.

This is reflected in pre-COVID efforts to shed services and beds in pursuit of higher revenues, a trend that has continued even in the midst of a public health emergency, including the following ongoing examples:

- The Montefiore system has been pushing to close the Mt. Vernon hospital, which serves a largely Black community, despite the opposition of the local community and its elected representatives;
- The NY Presbyterian system has been attempting to close its in-patient psychiatric unit at the Allen Pavilion in Northern Manhattan and to convert the space to a spinal surgical center;
- Numerous other hospitals around the state are temporarily or permanently seeking to close or reduce psychiatric/mental health, pediatrics, substance use and other in-patient units because they are poorly reimbursed and lose money.

These ongoing efforts have intensified during the pandemic as hospitals increasing use COVID as a rationale to "temporarily" close these services as a first step to permanently eliminating them.

The Greater New York Hospital Association (GNYHA) pretty openly admits that it is using the financial strains of the COVID crisis as a pretext to justify these already prevalent practices. Hospitals, says GNYHA, will have "to realign their costs" as part of "an extremely difficult process" that "may involve painful decisions for patients and communities because it will be particularly hard to preserve current service levels for clinical services that require cross-subsidization, such as obstetrics, mental health, addiction, and other services for which Medicaid is the principal funding source." Or in plain English, the hospitals want to dump the patients and services that don't generate profits.

In light of the ongoing pandemic, we call on the legislature to protect the public health by enacting a moratorium on outright closures and reductions of vital services. This will be an important first step to reversing the longstanding trend to treat health care as profit-making opportunity.

6. Increase reimbursement rates for underfunded safety net hospital and services

We have already noted that the COVID crisis has disproportionately affected historically underserved communities and particularly people of color.

The effects of the pandemic have also intensified long-standing inequalities and distortions in the funding of safety net hospitals. This historic structural problem is manifested in several ways.

First, we have a general inequality in hospital funding caused by structural distortions in reimbursement rates between Medicaid, Medicare and other government sponsored health care on the one hand, and private insurers on the other.

Medicaid, for example, is the primary source of funding for safety-net hospitals and it reimburses hospitals at rates that are substantially below costs (as low as 60% of costs for some services). Safety-net hospitals have high rates of Medicaid and uninsured patients and low rates of privately insured patients.

Private insurers, on the other hand, reimburse hospitals at rates that are greatly in excess of costs (ranging generally at about 150%-160% of costs, and in some cases much higher than than). The large private networks generally have low rates of Medicaid patients and high rates of privately insured patients.

Second, even within Medicaid and private insurance structures, many services are relatively under paid compared to others. For example, Medicaid reimbursement rates for in-patient mental health services are extremely low in comparison to reimbursement rates for surgical and other more complex procedures. The same pattern also applies to private insurer reimbursement rates.

Third, there are wide variations in reimbursement rates paid by private insurers. Large health systems, anchored by academic medical centers, are able to use their market share and other leverage to negotiate much higher rates for the same services than public or private safety net hospitals and independent community hospitals. This means that even when a safety-net hospital has privately insured patients, it often receives much less from the same insurer for the exact same services than a large private network hospital.

It thus comes as no surprise that safety net hospitals experience recurring financial difficulties. They have more Medicaid and uninsured patients, they provide more low-paid mental health and other kinds of services, and even when they provide care to privately insured patients that don't make enough to break even.

It also comes as no surprise that the large hospital systems are openly admitting that they will seek to close or reduce services that provide care to Medicaid and uninsured patients and make the "painful" decision to stop providing mental health, obstetrics and other poorly reimbursed services.

This two-tiered system results in less money for staffing, for PPE, for equipment and supplies, for capital improvements and maintenance, and inequality in the quality of care and patient outcomes. It is unconscionable to allow such pronounced inequalities to continue to exist in a modern society.

To address these inequalities, we need to (a) increase Medicaid reimbursement rates to safety-net hospitals, particularly those defined as Enhanced Safety Net Hospitals under state law; (b) equalize the reimbursement rates for mental health and other poorly paid services that are increasingly provided by safety-nets; and (c) regulate the reimbursement mechanisms of the private insurers to equalize the distribution of funding within the hospitals system.

These goals will require the reestablishment of a system of direct reimbursement rate setting by the state that applies to Medicaid and private insurers or a transition to a single payer model that will distribute funding equally based on patient and community needs.

7. Target distribution of DSH/ICP funding to safety-net hospitals

The federal government provides New York with approximately $1.8 billion in Medicaid Disproportionate Share Hospital (DSH) funding. This pool of money requires an equal share of local funding, creating a total pool of about $3.7 billion that is supposed to be targeted to safety net hospitals that provide a disproportionate share of Medicaid and uninsured patient care. The idea is that this funding makes up for the losses that result from poor Medicaid reimbursement rates.

Of this amount, $1.1 billion is distributed through the Indigent Care Pool (ICP). The ICP in New York has been structured in a manner that improperly distributes money broadly to almost every hospital in the state. This funding thus provides substantial amounts to hospitals that neither deserve nor need the additional support.

Some hospitals receive ICP funds even though they provide very few services to Medicaid patients. In addition, many large network hospitals that routinely generate very high net revenues (profits) because they have high rates of privately insured patients continue to receive ICP payments that they do not need. For example, NY Presbyterian received more than $60 million in 2018, even though it generated profits of more $300 million that year. Similarly, Mount Sinai and NYU Langone each received more than $50 million while also generating large annual profits.

The distribution of ICP funds to profitable hospitals that have lower rates of Medicaid and uninsured patients, higher numbers of privately insured patients and large operating surpluses depletes the amount of funding available for safety-net hospitals that truly need the money to maintain services and continue to operate.

Accordingly, the formulas for the distribution of ICP funding should be restructured and those funds should be target exclusively to safety net hospitals, and particularly to hospitals that meet the statutory definition of Enhanced Safety Net Hospitals under PHL Section 2807-c(34).

8. Enhanced coordination and oversight of hospital services and resources

During the height of the COVID crisis it was apparent that the hospital system was operating in a fragmented and competitive manner that hindered the ability of the state to respond effectively to the public health threat.

This fragmented approach was the culmination of decades of state policy that emphasized a competitive market-based approach in the hospital system, with large networks increasingly consolidating market share and competing with each other and with public or independent hospitals for patients, profitable services and new revenue streams.

This model was particularly unsuited to responding to a widespread health emergency that threatened to overwhelm the health care infrastructure and made the human toll of the pandemic worse than it should have been.

The lack of coordination, combined with the previously discussed inequalities in the availability and distribution of funding and health care resources was evident throughout the worst of the crisis:

- Wide variations in the distribution of COVID patient loads, with some hospitals being inundated an others relatively untaxed;
- Inefficiencies in the availability and distribution of PPE, equipment, medications and other resources, leaving hospitals to compete with each other for what supplies existed in tight markets and at exorbitant cost – a competition that disadvantaged poorer safety net hospitals;
- Unequal distribution of nursing and other direct care staff;
- Unfair or inequitable competition for resources, placing safety net hospitals at a disadvantage;
- Inequalities in outcomes and the quality of care directly resulting from the above factors, particularly affecting patients from communities of color and poorer areas.

The state recognized the vulnerabilities that resulted from the lack of central coordination and oversight. To address the problem, informal mechanisms were established to attempt to instill some degree of order on a disorderly system, but these efforts were ineffective at best.

This lack of coordination and oversight is a long-standing problem and the result of conscious policy choices that have been pursued over many decades. The pandemic exposed the weaknesses of the broader hospital system.

The state and local governments must create a unified hospital system (and health care network) that is subject to more democratic control, coordinates the provision of services based on local community needs, and distributes funding and resources equally in pursuit of the public interest and not the private interest of individual hospital systems.