Division of Health Care Finance and Policy Testimony
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Thank you for an opportunity to speak with you today regarding the important issue of resource allocation as it pertains to health financing reform policy initiatives currently being contemplated.

There are many important areas to discuss surrounding this topic, but I will restrict my comments to focus on just a few key areas concern:

First, I want to address the need for a robust Determination of Need process to ensure the availability of appropriate services and resources to address the actual health care needs of the communities served by the health care system in Massachusetts. This is the very essence of what it means to have care be accountable (i.e. are we accountable as a Commonwealth to provide the care people actually need where and when they need it). This issue is addressed in the Governor's payment reform legislation as "Resource Planning."

Secondly, I want to address the workforce development needs for registered nurses to ensure that Massachusetts residents receive the high quality and safe nursing care they require.

Finally, I will provide you with the bedside nurses' view of what deregulation and unbridled competition has done to the health care system in Massachusetts.

To my first point, any realistic attempt at finance reform must address in a meaningful way the need to appropriately allocate resources. The last fifteen years have brought the near complete removal of a meaningful Determination of Need process. One need only to tour the various hospital networks to see the effect of the lack of a robust Determination of Need process. The largest budget growth area of hospital expenditures has been capital budgets. Literally, hundreds of millions of health care dollars have been spent in the last decade on extensive building and technology expansion, supported by millions more in collateral advertising with no assessment of the actual need for these services by the communities these facilities and networks serve. The premise of deregulation, including the removal of the Determination of Need process, was driven by the belief that competition would spur efficiencies, cost reduction and enhanced quality. In reality, none of this occurred. Rather, the need to keep up with the competition has spurred institutions to mirror services already available at the same time that market leverage has allowed pricing to increase. More importantly, the

services that are expanded are not developed due to a review of need based on public health – rather they are expanded based on favorable reimbursement. Too many providers and networks focus on "cash cow" service and product lines, along with physician recruitment to support those product lines, while other, less profitable, programs and services are left stagnant to increasing needs or worse, reduced, or eliminated.

Witness the growth in competition for cancer treatment programs, cardiac surgery programs and out-patient surgery programs, while mental health beds and behavioral health services are slashed. It is unrealistic to adopt a market competition, business model of health policy, and then assign morality to motive. Health care today is fully a business, and therefore the desirable goal is profitability and growth. Without a robust Determination of Need process, health providers in a competition model are encouraged to use scarce resource dollars to "keep up with the Jones's" to compete and survive, and if that means abandoning less profitable services, then so be it.

By "robust," I mean the ability of a state agency to determine the relative need for various kinds of services, the ability to determine whether they can be developed and expanded, and where they should be placed to meet the actual health needs of a community. That means that in poorer communities hard hit by the recession, where unemployment is high and more people are likely to suffer from mental health problems, including substance abuse, we must ensure that there are appropriate and geographically accessible mental health and substance abuse treatment programs. This would also mean that we would not canniabalize and destroy our public health oriented networks, like Cambridge Health Alliance and Boston Medical Center, but support their growth and development to care for the populations the other networks have largely abandoned. Given the anemic budgeting of the Department of Public Health in this regard, this review would need to be done in conjunction with Division of Health Care Finance and Policy oversight. The Division's ability to analyze data in conjunction with the Department of Public Health provides a meaningful approach to assure that resource allocation occurs in a targeted manner, offering the most beneficial allocation of health dollars to meet the public's health needs.

The second topic I would like to briefly touch upon is workforce development – specifically with respect to registered nurses and nurse practitioners or advanced practice nurses. Given the aging demographics of the United States, the expected need for registered nurses grows sharply as the expected needs of the population with increasing age-related health issues grows sharply. Massachusetts enjoys one of the highest concentrations of registered nurses by population – yet the age of the current nursing population (average age is 49) poses a devastating problem.

The majority of Massachusetts' nurses are baby boomers and they are at or near retirement themselves. In previous years, the MNA has spent considerable effort highlighting what the literature has so clearly proven – that the relationship between registered nurses and patient outcomes in hospitals is inextricably linked. In hospitals today, the more patients the nurse is required to care for beyond four on a regular unit or beyond two in an intensive care setting results in a dramtically increased risk of injury or death. Without a regulatory standard in place, patients receive significantly varied levels of nursing care across the state, which results in dramatic variations in the quality of care delivered. The provider industry's opposition to the creation of such enforceable standards has vacillated between two key positions: either they cannot afford to hire more nurses, or they cannot find the nurses to hire. Neither argument has ever been based in reality or supported by any evidence, yet policy makers have been reluctant to challenge this faulty rationale. Given the current economy, this year the argument is cost, certainly not the ability to find nurses. Indeed, we have waiting lists of students seeking admission to our nursing schools, and we have hundreds of unemployed graduates waiting for an opportunity to enter the job market.

For over two decades, I have watched various health reform initiatives come and go. In each scenario, and regardless of the specific reform adopted, the industry moves to cut costs in preparation for expected revenue losses. The target of those cuts is inevitably nurses, but this strategy doesn't make sense from the point of view of quality care. The only reason you stay in a hospital is for nursing care. If your procedure or treatment did not require the 24/7 expertise of a registered nurse, you would be discharged. Today, the only patients staying in the hospital are those that have underlying health issues, making treatment in a more expedited fashion unsafe. Yet even as the patients have far more complex health issues than the patients of a decade ago, the nurse-patient load is the same as it was or heavier than it was ten years ago. With each change, nurses are asked to do more with less, at an ever increasing speed, with no let up in sight. Recently a number of hospitals have once again begun engaging in a dangerous game of speculation with patient care delivery – suggesting that nurses can take greater loads and non-nurses can begin to do some of the "tasks" of registered nurses. This de-skilling was an avenue of cost reduction attempted by the industry in the mid-90's and it was a devastating failure. Not only did it reduce the quality of care, it drove nurses form the bedside as they were put in untenable situations. So here we are, twenty years later, and once again, without enforceable staffing standards in place, we see institutions retreating to failed tactics, all in the name of cost containment. These realities, if not abated, given the demographics of both the current nursing workforce and the citizens they care for, will lead to the worst nursing shortage we have ever seen. The adoption of staffing standards would protect the public interest and allow the state to predict the number of nurses needed to avoid this looming shortage. Without action, we can expect

the nursing enrollment to decrease and nurses to leave the bedside due to poor working conditions at a time when many nurses will be retiring. This will all happen at the very time we will need the highest concentration of nurses.

As we look at the resource allocation of bedside RN's, we also need to look at the need to expand advanced practice nurses/nurse practitioners) due to the growing need for providers of primary care. Nurse Practioners have proven to be excellent providers of primary care and have been utilized effectively, particularly in areas of the country where physician access was limited or non-existent. Access to primary care can be greatly improved by assuring greater numbers of nurse practitioners as the population's needs increase. We suffer a similar problem in the area of acute mental health care, where the shortage of psychiatrists has resulted in the closure of a number of psychiatric beds. Here again, the utilization of Psychiatric Clinical Nurse Specialists could help alleviate this crisis.

Lastly, I would like to make some generic comments about health reform. It is difficult to argue success or failure when few can agree on what the goal is that we are measuring and when the goals themselves are valued from completely different perspectives.

What I can describe are the results of reform to date:

- Significant cost reduction has not occurred.
- Quality has not been enhanced.
- Most concerning, however, is that the role of clinicians in the assessment of actual public health needs seems ever diminishing.
- Reimbursement, not clinical assessment, is determining how and what care is delivered.
- Reimbursement is built on competition, yet best clinical practice requires the promotion of collaboration among providers.

To this latest point, let's look at a patient admitted to the emergency department today in need of a medical intensive care bed. If the hospital does not have a bed available, they are not incentivized to see whether the hospital two blocks away does have an immediate bed for that patient. Policies currently in place discourage providers from conferring and sharing resources for the benefit of the patient. And while ACO's are a model discussed – collaboration only within that ACO will be encouraged. MDs will become employees and thus have even less of an ability to exercise their clinical judgment to care for their patients. In the worst scenario, the greatest profit will be derived from the least amount of care provided.

The health financing reform contemplated is being called “global”, but it is not. It’s an expanded capitation arrangement. While the change will likely have some desirable effects – and likely some negative. Certainly deregulation in the 90’s was to bring about reductions in cost while improving quality – neither of which occurred. Yet a desired outcome was achieved by deregulation, namely, the reduction of the then assessed Massachusetts’ “over-bedded” status. Indeed, deregulation closed 30 hospitals. In today’s contemplated market reform, global payment via ACO’s, are spurring further consolidation of hospitals into network systems at a rate not seen since initial deregulation. For profits are now substantial portions of our health safety net. These two issues alone raise the potential for further market leverage on pricing as well as raise issues of stability of the health care safety net should for profits choose to exit.

In this round of health financing reform, I unfortunately do not believe that the health financing reform envisioned will have the desired effect of encouraging collaboration across competitors, nor will it encourage clinical collaboration that puts the patient first regardless of payer, nor will it enhance the clinical judgment capabilities of professionals whose licenses dictate they advocate for the well being of their patients.

Indeed a true global budget could have this effect – if it was implemented in conjunction with robust regulatory oversight of the need for services and the allocation of resources, with an assurance that patients will receive an appropriate standard of care throughout the entire system.

Thank you for the opportunity to participate and share our comments on this important discussion.