

STATE COMMISSION ON PATIENT SAFETY
Michigan Department of Community Health
December 1, 2004

PREPARED BY:
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EXECUTIVE SUMMARY

This written testimony is being provided by General Teamsters Union Local 406 for the express purpose of identifying means to improve patient safety and providing recommendations for systematic improvements in the delivery of care. Teamsters Union Local 406 is in a unique position to provide comment on various areas addressing patient safety issues especially those arising in the context of a work stoppage by healthcare professionals at a hospital. The recommendations listed below serve as an attempt to identify means to improve patient safety and reduce medical errors in the context of a labor stoppage at a healthcare institution. This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. The recommendations outlined in the written submission include the following:

a. Recommendations for State actions in a pre-strike environment.

Prior to the commencement of a strike the following recommendations would mandate dialogue and communication for the purpose of informing the public of the issues in dispute.

! The State should mandate that a health care institution publish a plan of action to address issues related to public safety.

! The State should also create a framework to enable parties to a labor dispute in a health care setting to engage in a fact finding or binding arbitration hearing. For instance, the State could authorize the Michigan Employment Relations Commission (MERC) to hold public fact finding hearings or conduct binding arbitration.

b. Recommendations for State actions during a strike at a health care institution.

Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care:

! A system of frequent and random inspections should be mandated to monitor the level of care being provided at the institution. Random and frequent inspections are necessary to assure that quality care is being provided and that there is no “drop off” in the level of care as a result of a labor stoppage. A health care consumer should not have to “guess” whether a strike or the hospital’s reaction to the strike is impairing the ability of the institution to provide quality health care.

! In conjunction with the inspection scheme, the State should develop a framework to allow patients to be interviewed to assess the level of care being provided. Concerns regarding patient confidentiality could be addressed so that the patient interview process is useful while patient confidences are maintained.

! Staffing levels should be monitored and a patient/nursing ratio should be established at a level that provides an environment for the provision of quality and affordable health care. The patient/nursing staff ratio should also clearly limit the number of nursing staff that are provided by traveling nursing firms.

! Enact specific whistle blower type to protect health care employees who report problems with the provision of medical services. Again, patient confidentiality issues can be addressed so that both a patient’s confidentiality and an employee who reports a medical problem will be protected.

! Require that health care employees have an obligation to disclose patient safety issues. Such a mandatory reporting requirement can be patterned after the requirement that school employees report suspected child abuse.

! Require the health care institution to make timely disclosure of patient consumer information like infection, incident and medical error rates. Such information is essential not only to be able to monitor the provision of health care, but also to allow the public to make informed choices regarding health care services.

! Require the health care institution to make timely disclosure of financial reports that will reveal the financial status of institution.

! Exhibit greater oversight of a health care institution’s requests for loans, bond issuance, certificate of need filings, etc. during strike periods.

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I. Introduction

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Union Local 406 has become intimately familiar with the types of patient safety related concerns and problems that can become magnified in the context of a strike or other work stoppage. In representing the nurses who have been on strike at Northern Michigan Hospital since November 14, 2002, Teamsters Union Local 406 has been alerted to particular health care safety issues that arise in such situations.

In providing this paper, Teamsters Union Local 406's only interest is to advance and identify areas that can be improved so that patient safety issues are not comprised when a hospital or other health care entity is operating while its health care professionals are engaged in a strike. The written testimony is not being submitted to advance or advocate labor relations matters. That topic is a matter to be addressed in a different forum. Rather, the recommendations and suggestions raised in this paper serve as an attempt to identify means to improve patient safety and reduce medical errors in the context of a labor stoppage at a health care institution.

II. The Authority of the Executive and Legislative Branches to Address Patient Safety Issues.

This paper first identifies the authority vested in the Executive and Legislative Branches to enact legislation to protect public safety and to develop regulatory schemes to ensure that the legislation is effectively enforced. There can be no doubt that a primary purpose of the Michigan legislature and the Executive Office is to protect the health and public welfare of Michigan's citizens. The Governor is authorized and empowered to ensure that the hospitals licensed in the State provide the level of quality care necessary to secure the safety and welfare of the public. To the extent that public safety and/or patient care is threatened by substandard conditions present in a health care institution, the Governor has the authority and responsibility to take action to protect the people of this State. The Governor and State legislature's authority in this respect is derived from the Michigan Constitution of 1963, the Public Health Code, and applicable administrative rules.

The Michigan Constitution vests the executive power of the State of Michigan in the Governor. Article V, §1. The executive authority of the Governor invests the office with sufficiently broad power to confront periods of impending or actual public crisis. The Governor's executive authority is restated by Act 302 of 1945 which provides that:

It is hereby declared to be the legislative intent to invest the governor with sufficiently broad power of action in the exercise of the police power of the state to provide adequate control over persons and conditions during such periods of impending or actual public crisis or disaster. The provisions of this act shall be broadly construed to effectuate this purpose.

M.C.L. §10.32. The Michigan legislature is empowered to enact legislation and to engage in policy making pursuant to the Michigan Constitution, Article IV, §1.

The Michigan legislature has recognized the import of protecting the health and welfare of individuals receiving care and services from a health care provider. The legislature has enacted an entire Code designed to ensure that health care providers act in a manner to ensure patient safety by requiring that such institutions comply with obligations under the Public Health Code and administrative rules promulgated under the Code. MCL §333.20101 et seq.; R. 325.1001 et seq.

Pursuant to the executive police powers bestowed upon the executive office, the Executive Branch possesses the authority and responsibility to ensure that health care institutions comply with their obligations under the Public Health Code and the related regulations to provide an adequate standard of patient care. See e.g., M.C.L. §333.20101 et seq. Part of this legislative scheme mandates that health care institutions providing services to Michigan residents must be licensed and certified by the State. Such institutions must comply with requirements set forth in the Health Code and the rules promulgated pursuant to the Code -- deficiencies which seriously affect the health, safety and welfare of individuals receiving care or services justify the revocation of a license. The licensing scheme was specifically enacted to:

“Protect the health, safety, and welfare of individuals receiving care and services in or from a health facility or agency. [and to] [a]ssure the medical accountability for reimbursed care provided by a certified health facility . . .”

M.C.L. §333.20131.

In addition to basic licensing requirements, the Legislature has promulgated certification requirements. In particular, the State Code contains provisions detailing requirements that hospitals must adhere to in order to maintain, expand and establish health care facilities. (Hospital Finance Authority Act of 1969).

The Michigan Legislature and Executive Branches therefore have the authority and responsibility to make certain that public safety in the health care field is appropriately addressed in legislation and that the legislation is enforced through an effective regulatory scheme.

III. The Potential Threat to Public Safety and Patient Care that Can Arise in the Context of a Labor Stoppage at a Health Care Institution.

This section of the paper seeks to identify the particular and serious issues that can develop in a community where a health care institution is subject to a strike by its health care professionals. The operation of a health care institution in the face of a work stoppage can present particular and serious threats to the public safety and to the delivery of quality patient care.

a. Operating with qualified professionals

A health care institution must take steps when faced with a staff labor stoppage to ensure

that it is able to provide quality health care coverage for its patients. The use of traveling nurses by a health care institution to replace striking nurses can result in adverse effects on patient safety and quality of care. The pervasive use of traveling nurses, and the lack of any effective legislative or regulatory framework monitoring their use, is a troubling development.

The retention of traveling nurses from employment agencies and the problems inherent in such a situation were well documented in the Blue Ribbon Panel Report to the Governor which detailed the impact of the labor dispute at the Northern Michigan Hospital.¹ September 2003 Blue Ribbon Panel Report to Governor (“Report”). The Report noted that NMH replaced many of the striking nurses with “traveling” nurses employed by traveling-nurse employment agencies. Report at 16. NMH’s Form 990, filed with the Internal Revenue Service, discloses that the hospital paid \$13,311,309 to the U.S. Nursing Corp. – a provider of traveling nurses based in Denver, Colorado in the year 2003 alone. In the Form 990 2002 disclosure, NMH paid this same firm \$5,038,034 even though the nurses had only been on strike approximately six weeks in 2002. These financial outlays constitute incredible sums for an institution that reported total revenue of only \$140 million in 2003. As the Blue Ribbon Commission reported, “the decision by NMH to hire temporary nurses, first through the U.S. Nursing Corporation and more recently through several Midwest organizations has had costly implications to NMH’s already uncertain fiscal position.” Report at 22.

Moreover, the significant expenses for the traveling nurses did not assure that the quality of health care would be maintained at the hospital.

In fact, the Blue Ribbon Commission reported that the quality of health care suffered during the strike and the Report specifically cited the use of traveling nurses as a potential problem to the delivery of quality patient care:

What is known, however, about utilization of traveling nurses is that too often they do not have time to become sufficiently oriented to new environments. Since hospitals are each unique, the lack of adequate orientation time is problematic. Traveling nurses do not know where to locate or how to use essential equipment; are not conversant with specific protocols; and, are unfamiliar with routines of individual physicians. The Panel heard a number of complaints that were related to lack of timeliness to respond that were directly related to inadequate orientation of traveling nurses. A corollary to the increases in traveling nurses appeared to be a reduction in the numbers of RN staff. Several studies document that inadequate RN staffing increase outcomes that are particularly sensitive to nursing, i.e., urinary tract infection, pneumonia and shock. Report at 15.

The use of traveling nurses at NMH has coincided with an increase in infection rates and other occurrences. Although NMH has claimed that there has not been an increase of occurrences since it has retained substantial numbers of traveling nurses during the strike, the facts that have revealed otherwise. The May 21, 2003 minutes of NMH’s Infection Control

¹ A full copy of the Report and any materials referenced herein can be provided upon request.

Committee report significant increases in urinary tract infections, viral acquired pneumonia and bodily substance incidents rates for ICU patients in the first quarter of 2003. The BSI rate is reported as “the highest that NMH has experienced.” Inspection Control Committee Minutes.

Moreover, NMH had not corrected the deficiencies by the spring of 2004 when the CMS Department of Health & Human Services determined that NMH was not in compliance with patient rights, physical environment, and infection control. The CMS found that “the deficiencies are significant and limit [NMH’s] capacity to render adequate care and ensure the health and safety of [its] patients.” April 12, 2004 CMS Correspondence.

It is reasonable to conclude that the increase in infection rates and occurrences is related to the large reliance upon the traveling nurses that have been employed during the strike.

b. Maintaining fiscal responsibility

The State should enact legislation or develop a regulatory scheme to provide that even during labor disputes, a hospital is obligated to remain fiscally responsible to assure that it is able to continue to operate for the benefit of the public. Fiscal irresponsibility by a public institution like a hospital can create devastating consequences for a local community.

The Blue Ribbon Committee recognized that “a primary responsibility of the Board and officers of NMH is to protect the assets of the institution through fiscal policies.” Report at 20. Unfortunately, even the Blue Ribbon Commission appointed by the Governor was unable to fully assess the fiscal position of the hospital as a result of the strike. The Blue Ribbon Commission, authorized by the Governor to determine “how the on-going labor dispute at NMH has impacted the delivery of adequate, safe and affordable health care services” noted its frustration in not being able to assess the fiscal status of the hospital -- and NMH’s unwillingness to provide forthcoming data -- with actual figures and documents.

The Blue Ribbon Panel specifically cited as criticism the “*NMH administration for failing to meet with the community to inform the community of the full implications of the strike, particularly the fiscal implication*” and that “*to date, NMH has not provided specific information either to the Panel or to community members who have requested it.*” Report at 19, 22.

An appropriate legislative and/or regulatory scheme should be devised so that this responsibility is adhered to even in turbulent times like a labor dispute. The NMH Certificate of Need and Form 990 filings demonstrate the adverse impact that fiscal irresponsibility can have on a hospital’s finances and corresponding ability to provide health care services to the community.

In 2001, the year before the strike at NMH, the hospital reported a \$2.1 million dollar gain in operating income. In 2002, where the nurses were on strike for only six weeks of the entire year, the hospital reported an operating income gain of \$105,000. By 2003, NMH reported an operating loss of \$11.2 million and has acknowledged that it will have another loss

reported for 2004. The cost of the labor dispute has had an adverse effect on NMH's ability to provide the quality care to residents of Northern Michigan. Certificate of Need 04-0255.

In addition to reporting losses, the NMH occupancy rates have declined even though the population in the region has grown during the strike. For instance, occupancy rates in 2003 were only 59.5% while rates in 2002 were 62.2%. Certificate of Need 04-0255 at 92. The Blue Ribbon Panel reported that it received testimony from numerous individuals stating that "former patients at NMH were seeking services from hospitals in surrounding communities" and that the NMH CEO "acknowledged that NMH has reduced its operation bed count from 213 as reported by state agencies in 2001 to 180 in July 2003, a 15% decrease in a growing health care market." Report at 21.

The State process for approving Certificates of Need (CON) must be monitored more closely in strike situations so that hospitals are not able to "finance" a labor stoppage by obtaining alternate financing. The ease at which a health care institution can apply for and obtain alternate financing for operating and capital expenditures, without added scrutiny by the State during a labor strike, makes it strategically possible for a health care institution to prolong a labor dispute.

NMH filed an amended CON in May 2003 which was later approved by the State. The background behind the amended CON filing provides an example of the type of financing approval that can have an undesired impact of delaying resolution of a labor dispute. In August 2002, before the strike commenced, the State approved NMH's initial CON which was granted on the premise that the NMH capital improvement project would be financed by approximately \$16 million raised through donations. However, in May 2003, 6 months after the strike commenced, NMH filed an amended CON seeking to secure alternative financing through a bank qualified loan of \$10 million dollars begging the question as to what became of the funds cited in the original CON. The amended request for alternative financing, filed so soon after the initial CON and after substantial costs were incurred as a result of the strike, certainly raise questions about the fiscal accountability of the NMH administrators and trustees (not to mention questions about the accuracy of the original CON filing and/or about the funds NMH claimed would be raised to fund the capital project). The State has an interest in demanding that health care institutions are fiscally responsible and do not have the opportunity to "finance" and prolong a labor dispute by obtaining alternate financing for capital and operating expenses.

c. Fully disclosing infection, incident and other medical errors

The lack of a legislative and/or regulatory scheme mandating public disclosure of infection, incident and error rates at health care institutions is a problem that is magnified in the context of a labor dispute. As noted above, the utilization of traveling nurses has become more prevalent in the health care market. The retention of traveling nurses to replace striking nurses often becomes a health institution's reflexive response at the onset of a labor dispute. Unfortunately, such a response can have an adverse effect upon the delivery of quality health care, as noted above.

The public, especially in situations involving labor disputes, should have full access to information relating to quality care issues. In particular, the public should be able to access information that details infection and incident rates and medical errors committed at health care institutions. The public should be granted access to information so that an individual can make an informed choice when seeking health care services.

During the strike at NMH, the administration has made public relations claims that it has been business as usual at the hospital. These claims have been belied by a number of factors including:

- 1) the report from the Blue Ribbon Panel which “heard disturbing examples of questionable health care practices during the strike from both former patients and licensed health professionals, both strikers and non-strikers”; Report at 6.
- 2) by the May 21, 2003 minutes from NMH’s own Infection Control Committee which reported significant increases in infection rates during the strike, and
- 3) by the CMS Department of Health & Human Services which determined that NMH was not in compliance with patient rights, physical environment, and infection control as noted in the April 12, 2004 correspondence from the agency.

The public should be provided information relating to infection, incident and error reports like those noted above to assure that individuals are able to make informed choices and not have to rely upon the comments generated by an institution’s public relations department.

IV. Recommendations for Systemic Improvements in the Delivery of Care.

This section of the paper provides recommendations to address the problems identified above which impede the delivery of quality and affordable health care – especially during a period of labor strife.

The State should enact legislation and/or administrative regulations to protect the delivery of health care for the public during work stoppages. Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike.

a. Recommendations for State actions in a pre-strike environment.

Prior to the commencement of a strike the following recommendations would mandate dialogue and communication for the purpose of informing the public of the issues in dispute.

! The State should mandate that a health care institution publish a plan of action to address issues related to public safety. Such a plan of action should include crucial public health information detailing how the institution plans to operate in the face of the strike and advising of the public of the issues in dispute.

! The State should also create a framework to enable parties to a labor dispute in a health care setting to engage in a fact finding or binding arbitration hearing. For instance, the State could authorize the Michigan Employment Relations Commission (MERC) to hold public fact finding hearings or conduct binding arbitration. Although the process would be voluntary for the parties engaged in the dispute, both sides would hopefully be responsible enough to recognize the benefits of disclosing to the public the labor issues in contention. A fact finding or arbitration hearing process would shed light on matters that generated the labor dispute and would permit public scrutiny of the issues. Such scrutiny would allow the public to weigh in on the relative positions of the parties and would perhaps serve as an effective mechanism to pressure the parties to resolve the dispute. Certainly the public has a vital interest in seeing that healthcare labor disputes are resolved as expeditiously and fairly as possible.

b. Recommendations for State actions during a strike at a health care institution.

Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are appropriate to assure the continued provision of quality and affordable health care:

! A system of frequent and random inspections should be mandated to monitor the level of care being provided at the institution. Random and frequent inspections are necessary to assure that quality care is being provided and that there is no “drop off” in the level of care as a result of a labor stoppage. A health care consumer should not have to “guess” whether a strike or the hospital’s reaction to the strike is impairing the ability of the institution to provide quality health care.

! In conjunction with the inspection scheme, the State should develop a framework to allow patients to be interviewed to assess the level of care being provided. Concerns regarding patient confidentiality could be addressed so that the patient interview process is useful while patient confidences are maintained.

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! Enact specific whistle blower type to protect health care employees who report problems with the provision of medical services. Again, patient confidentiality issues can be addressed so that both a patient’s confidentiality and an employee who reports a medical

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! Require the health care institution to make timely disclosure of financial reports that will reveal the financial status of institution. Although private non-profit institutions like NMH are required to file Form 990s with the IRS, the information contained in the Form 990s is outdated by the time it is released to the public. For instance, the financial information relating to the costs and expenses incurred by NMH in 2004 as a result of the strike are not required to be disclosed through Form 990 filings until fall 2005.

! Exhibit greater oversight of a health care institution's requests for loans, bond issuance, certificate of need filings, etc. during strike periods. The State has an obligation to oversee the health care institutions operating in Michigan and making certain that the health care institution is not being fiscally irresponsible simply to "defeat" a strike. Moreover, a hospital or other health care institution should not be permitted to "finance" a strike (effectively prolonging resolution of the dispute) by seeking and obtaining loans from financial institutions under the guise of securing funding for capital projects.

V. Conclusion

The State of Michigan has an interest in seeing that healthcare institutions provide quality and affordable healthcare for the citizens of the State. This interest is heightened when a labor dispute impacts the operations at an institution. Teamsters Local 406 respectfully submits that based upon the foregoing information, the State should take action as outlined above to ensure that a health organization's obligation to provide quality care in a fiscally prudent manner is adhered to even when faced with a labor stoppage.