Testimony of Lawrence Massa FINAL
President & CEO, Minnesota Hospital Association
House Labor, Workplace & Regulated Industries Committee
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Thank you for the opportunity to testify before you today. My name is Lawrence Massa, president and CEO of the Minnesota Hospital Association. We represent 144 hospitals and health systems that deliver quality health care to patients 24 hours a day, 7 days a week, 365 days a year throughout the state. With me this morning are Carolyn Wilson, the president of University of Minnesota Medical Center, Fairview; Sandra “Mac” McCarthy, chief nursing officer from Essentia Health System in Duluth; Roger Lloyd, an RN and nurse leader from Essentia; and Mary Pynn, chief nursing officer from HealthEast here in St. Paul.

Before taking this position, I was the CEO of Rice Memorial Hospital in Willmar. I know firsthand that nurses are essential to the well earned reputation of our state. I am convinced that nurses and hospitals share the same goals of delivering safe patient care.

However, the legislation before you today isn't about standards of care, it's about government mandated staffing quotas. I know that in this era of rhetorical embellishments, it's popular to say black is white and white is black. But facts are stubborn. Whatever label MNA puts on this bill, it is a ratio bill pure and simple and staffing ratios equal quotas. Let me explain why:

First, take the MNA's own words at face value. In announcing the legislation at the Feb. 13 news conference, Linda Hamilton, president of MNA, said the bill is needed so that hospitals staff to "standards of care that have been developed through professional judgment in every hospital, on every shift, in every unit across the state." That is a quota.

Second, the bill calls on Minnesota to follow the lead of four professional organizations. The facts are clear. In health care, there are dozens of professional organizations. They don't set national standards of care. Their purpose is to represent a host of special interests. Two of the organizations cited in the legislation promote ratios – staffing quotas. The other two propose a different model for setting standards.

In other words, the four organizations are in conflict. No doubt, that is the MNA's intention, because the legislation says that in “the absence of an evidence based standard,” a politically-appointed work group – with three-fourths of the slots designated for nurses – will make the decision. The only outcome from an MNA workgroup is quotas.

The third issue this Committee should be aware of is the impact of this legislation on collective bargaining. MNA represents just 20 percent of nurses in the state. Just 64 hospitals out of 148 have MNA contracts. These collective bargaining agreements include provisions for joint work groups within each hospital to cooperatively determine staffing and other work rules. This is what we did at Rice, an MNA hospital, and it happens across the state.

MNA now is trying to undermine the collective bargaining process, asking the legislature to impose by government mandate the quotas that they haven't won through negotiation.
And one reason they haven’t succeeded in getting quotas through collective bargaining is because of the devastating impact quotas will have on other hospital caregivers and workers, including members represented by other unions.

Mandatory staffing quotas would increase hospital labor costs — TOTAL labor costs, not just nursing costs — by an average of 4 percent. Hospital reimbursement rates already are under pressure from every payer. This additional cost is unaffordable, by hospitals and the employers, individuals and taxpayers who pay the cost of health care. It would have two immediate effects: health costs would increase and hospitals would be forced to lay off caregivers and other employees to accommodate the higher costs of Registered Nurses.

Finally, one bill supporter was quoted at the Feb. 13 press conference as saying the legislation “puts the decision at the bedside and not at the Capitol.” The irony is that decisions already are made at the bedside. That’s what is expected of nurses — their critical thinking.

This bill takes us in the opposite decision. It takes decisions away from local hospitals and the nurse leaders who work closely with nurses and other caregivers to determine staffing and turns it over to government.

If Minnesota hospitals had a crisis of quality or safety, we would be having a different discussion. But, again, the facts are clear, even though they stand in contrast to what the MNA would have you believe.

In 2012, Minnesota was ranked first in the nation for health care quality by the Agency for Healthcare Research and Quality. In addition, multiple independent quality improvement organizations rank Minnesota the top in the nation for patient safety and quality of care measures.

And, if you want to discuss standards, then look at the gold standard of patient satisfaction measures — The Hospital Consumer Assessment of Healthcare Providers and Systems survey. On every single measure of patient satisfaction, across the board, Minnesota hospitals rank higher than California, the only state with government-imposed staffing quotas, and higher than the national average.

The simple truth is this: quotas do not equal quality. And what is being proposed is a quota bill no matter what it is called. Thank you.