☞ **09hr_SC-HHIPPTRR_sb0108_pt01**

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

Senate

Record of Committee Proceedings

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Senate Bill 108

Relating to: mandatory overtime hours and on-call time worked by health care workers and providing penalties.

By Senators Robson, Taylor, Carpenter, Hansen, Plale, Lehman, Coggs, Erpenbach, Wirch and Miller; cosponsored by Representatives Pasch, Benedict, Cullen, Berceau, Pope-Roberts, Zepnick, Colon, Mason, Staskunas, A. Williams, Sinicki, Danou, Black, Kessler, Pocan, A. Ott, Toles, Richards, Hixson, Young, Turner and Grigsby.

March 11, 2009 Referred to Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

April 22, 2009 **PUBLIC HEARING HELD**

Present: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Absent: (0) None.

Appearances For
- Judy Robson — Senator
- Sandy Pasch — Rep.
- Stephanie Bloomingdale — Wisconsin Federation of Nurses and Health Professionals
- Mary Malaney, Madison — SEIU RN's
- Ann Louise Tetrenult, Madison
- Allison Sorg, Stoughton — SEIU
- Gina Dennick-Champion, Madison — Wisconsin Nurses Association
- Marian Stokes, Madison — SEIU
- Margaret Couillard, Milwaukee — Wisconsin Federation of Nurses and Health Professionals
- Dee Ives, Westfield — 1199 SEIU/WI Vets
- Rebecca Wolfe, Ridgeway — SEIU
- Dian Palmer, Milwaukee
- Elaine Tombari, Milwaukee — Nurses and Healthcare Professionals
- Kathleen Filipiak
- Linda Traxel-Stevens, South Milwaukee — AFT

- Rita Rae Marsh, Milwaukee — Federation of Nurses and Health Care Professionals
- Barbara Patterson, Grafton
- Robert Kraig, Milwaukee — Citizen Action of Wisconsin

Appearances Against
- Doris Mulder, Beloit
- Jeremy Levin — Rural Wisconsin Health Cooperative
- Judith Warmuth, Madison — Wisconsin Hospital Association
- R.J. Pirlot — Wisconsin Manufacturers and Commerce
- Tim Gengler, Wausau — Aspirus Wausau Hospital
- Peg Haggerty, Columbus — Columbus Community Hospital
- Susan Schweitzer, Columbus — Columbus Community Hospital
- Mary Cieslak-Duchelk, Milwaukee — Aurora Health Care
- Kristi Hund, Stoughton — Stoughton Hospital

Appearances for Information Only
- None.

Registrations For
- Mark Leroux, South Milwaukee
- Ralph Myah, Mukwonago
- Greg Uselman, Hartland
- Laura Francis, Madison
- Scott Hanson, Middleton
- Vern Lynn, Milwaukee
- Barbara Boehm, Madison
- Linda Baumann, Fitchburg
- Bobby Peterson, Madison — ABC for Health
- Patricia Paulson, Brooklyn
- Bethany Ordaz, Madison — SEIU WI State Council
- Carol Lemke, Madison — SEIU
- Jennifer Peeters, McFarland
- Joanne Ricca, Milwaukee — AFL-CIO
- Rebecca Minsley, Madison
- Ronald Hudson, Madison — SEIU
- Sheri Pauer, Cross Plains — UW HC SEIU 1199
- Cindy Grinde, DeForest
- Loretta Vogts, DeForest
- Susan Marking, Waunakee
- Bonita Strauss, Fredonia — SEIU
- Thy Tran, Madison
- Regina Fisher, Waunakee — SEIU
- Shelley White, Brooklyn

- Jeff Plale — Senator
- Sarah Schuler, Madison
- Victoria Gutierrez, Madison
- Juan Carlos Cabrera, Monona
- Rahun Angomdome, Madison
- Donna Heidema, Madison
- Sherryl Abplanalp
- James Eichstadt, DeForest
- Maureen Eichstadt, DeForest
- Judy McDonalad, Madison
- Kathryn Stiller, Fitchburg
- Steven Sears, West Allis

Registrations Against
- Karla Ashenhurst, Milwaukee — Ministry Health Care
- Jim McGinn, Madison — Wisconsin Health Care Association
- Scott Tyre — Wisconsin Hospital Association
- David Krahn, Waukesha — Waukesha County
- Sarah Diedrick-Kasdorf, Madison — Wisconsin Counties Association
- Peggy Ose, Wisconsin Rapids — Riverview Medical Center
- Kay Caldwell, Columbus — Columbus Community Hospital
- LuAnn Reuter, Columbus

Registrations for Information Only
- None.

September 17, 2009 **EXECUTIVE SESSION HELD**

Present: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Absent: (0) None.

Moved by Senator Carpenter, seconded by Senator Robson that **Senate Amendment 1 to Senate Substitute Amendment 1** be recommended for introduction.

Ayes: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Noes: (0) None.

INTRODUCTION OF SENATE AMENDMENT 1 TO SENATE SUBSTITUTE AMENDMENT 1 RECOMMENDED, Ayes 7, Noes 0

Moved by Senator Carpenter, seconded by Senator Robson that **Senate Amendment 1 to Senate Substitute Amendment 1** be recommended for adoption.

Ayes: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Noes: (0) None.

ADOPTION OF SENATE AMENDMENT 1 TO SENATE SUBSTITUTE AMENDMENT 1 RECOMMENDED, Ayes 7, Noes 0

Moved by Senator Carpenter, seconded by Senator Lassa that **Senate Amendment 2 to Senate Substitute Amendment 1** be recommended for introduction.

Ayes: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Noes: (0) None.

INTRODUCTION OF SENATE AMENDMENT 2 TO SENATE SUBSTITUTE AMENDMENT 1 RECOMMENDED, Ayes 7, Noes 0

Moved by Senator Carpenter, seconded by Senator Lassa that **Senate Amendment 2 to Senate Substitute Amendment 1** be recommended for adoption.

Ayes: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.
Noes: (0) None.

ADOPTION OF SENATE AMENDMENT 2 TO SENATE SUBSTITUTE AMENDMENT 1 RECOMMENDED, Ayes 7, Noes 0

Moved by Senator Carpenter, seconded by Senator Robson that **Senate Substitute Amendment 1** be recommended for adoption.

Ayes: (6) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich and Darling.
Noes: (1) Senator Kanavas.

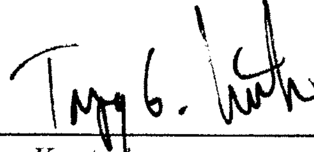
ADOPTION OF SENATE SUBSTITUTE AMENDMENT 1 RECOMMENDED, Ayes 6, Noes 1

Moved by Senator Carpenter, seconded by Senator Robson that **Senate Bill 108** be recommended for passage as amended.

Ayes: (4) Senators Erpenbach, Carpenter, Robson and Lassa.

Noes: (3) Senators Lazich, Kanavas and Darling.

PASSAGE AS AMENDED RECOMMENDED, Ayes 4, Noes 3



Tryg Knutson
Committee Clerk

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9.17.09

Moved by: SEN. CARPENTER Seconded by: SEN. ROBSON

AB ______ SB 108 Clearinghouse Rule ______

AJR ______ SJR ______ Appointment ______

AR ______ SR ______ Other ______

A/S Amdt ______

A/S Amdt ______ to A/S Amdt ______

A/S Sub Amdt ______

A/(S) Amdt 1 (A0698) to A/(S) Sub Amdt 1 (S0103)

A/S Amdt ______ to A/S Amdt ______ to A/S Sub Amdt ______

Be recommended for:

- ☐ Passage
- ☒ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Confirmation
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence
- ☐ Indefinite Postponement

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☒	☐	☐	☐
Senator Tim Carpenter	☒	☐	☐	☐
Senator Judith Robson	☒	☐	☐	☐
Senator Julie Lassa	☒	☐	☐	☐
Senator Mary Lazich	☒	☐	☐	☐
Senator Ted Kanavas	☒	☐	☐	☐
Senator Alberta Darling	☒	☐	☐	☐
Totals:	7	0	___	___

☒ Motion Carried ☐ Motion Failed

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9-17-09

Moved by: SEN. CARPENTER Seconded by: SEN. ROBSON

AB ____ SB 108 Clearinghouse Rule ____

AJR ____ SJR ____ Appointment ____

AR ____ SR ____ Other ____

A/S Amdt ____

A/S Amdt ____ to A/S Amdt ____

A/S Sub Amdt ____

A/S Amdt (S circled) 1 (A0698) to A/S Sub Amdt (S circled) 1 (S0103)

A/S Amdt ____ to A/S Amdt ____ to A/S Sub Amdt ____

Be recommended for:

- ☐ Passage
- ☐ Introduction
- ☒ Adoption
- ☐ Rejection
- ☐ Confirmation
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence
- ☐ Indefinite Postponement

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☑	☐	☐	☐
Senator Tim Carpenter	☑	☐	☐	☐
Senator Judith Robson	☑	☐	☐	☐
Senator Julie Lassa	☑	☐	☐	☐
Senator Mary Lazich	☑	☐	☐	☐
Senator Ted Kanavas	☑	☐	☐	☐
Senator Alberta Darling	☑	☐	☐	☐
Totals:	7	0	____	____

☑ Motion Carried ☐ Motion Failed

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9.17.09

Moved by: SEN. CARPENTER Seconded by: SEN - LASSA

AB______ SB 108 Clearinghouse Rule______

AJR______ SJR______ Appointment______

AR______ SR______ Other______

A/S Amdt ______

A/S Amdt ______ to A/S Amdt ______

A/S Sub Amdt ______

A/(S) Amdt 2 to A/(S) Sub Amdt 1 (S0103)

A/S Amdt ______ to A/S Amdt ______ to A/S Sub Amdt ______

FLOOR AMEND. - DELETE PG. 6 OF SUB. AMEND. 1 - LINES 11 & 12

Be recommended for:

- ☐ Passage
- ☑ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Confirmation
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence
- ☐ Indefinite Postponement

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☑	☐	☐	☐
Senator Tim Carpenter	☑	☐	☐	☐
Senator Judith Robson	☑	☐	☐	☐
Senator Julie Lassa	☑	☐	☐	☐
Senator Mary Lazich	☑	☐	☐	☐
Senator Ted Kanavas	☑	☐	☐	☐
Senator Alberta Darling	☑	☐	☐	☐
Totals:	7	0		

☑ Motion Carried ☐ Motion Failed

Vote Record
Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9-17-09

Moved by: SEN. CARPENTER Seconded by: SEN. LASSA

AB ______ SB 108 Clearinghouse Rule ______

AJR ______ SJR ______ Appointment ______

AR ______ SR ______ Other ______

A/S Amdt ______

A/S Amdt ______ to A/S Amdt ______

A/S Sub Amdt ______

A/S Amdt 2 to A/S Sub Amdt 1 (S0103)

A/S Amdt ______ to A/S Amdt ______ to A/S Sub Amdt ______

FLOOR AMEND. - DELETE PG. 6 OF SUB. AMEND. 1 - LINES 11 & 12

Be recommended for:
- ☐ Passage
- ☐ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Confirmation
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence
- ☐ Indefinite Postponement

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☑	☐	☐	☐
Senator Tim Carpenter	☑	☐	☐	☐
Senator Judith Robson	☑	☐	☐	☐
Senator Julie Lassa	☑	☐	☐	☐
Senator Mary Lazich	☑	☐	☐	☐
Senator Ted Kanavas	☑	☐	☐	☐
Senator Alberta Darling	☑	☐	☐	☐
Totals:	7	0		

☑ Motion Carried ☐ Motion Failed

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9-17-09

Moved by: SEN. CARPENTER Seconded by: SEN. ROBSON

AB ______ SB 108 Clearinghouse Rule ______

AJR ______ SJR ______ Appointment ______

AR ______ SR ______ Other ______

A/S Amdt ______

A/S Amdt ______ to A/S Amdt ______

A/(S) Sub Amdt 1 (S0103) AS AMENDED.

A/S Amdt ______ to A/S Sub Amdt ______

A/S Amdt ______ to A/S Amdt ______ to A/S Sub Amdt ______

Be recommended for:

☐ Passage ☒ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement
☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☒	☐	☐	☐
Senator Tim Carpenter	☒	☐	☐	☐
Senator Judith Robson	☒	☐	☐	☐
Senator Julie Lassa	☒	☐	☐	☐
Senator Mary Lazich	☒	☐	☐	☐
Senator Ted Kanavas	☐	☒	☐	☐
Senator Alberta Darling	☒	☐	☐	☐
Totals:	7	1		

☒ Motion Carried ☐ Motion Failed

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 9.17.09

Moved by: SEN. CARPENTER Seconded by: SEN. ROBSON

AB ______ SB 108 ______ Clearinghouse Rule ______

AJR ______ SJR ______ Appointment ______

AR ______ SR ______ Other ______

A/S Amdt ______ AS AMENDED.

A/S Amdt ______ to A/S Amdt ______

A/S Sub Amdt ______

A/S Amdt ______ to A/S Sub Amdt ______

A/S Amdt ______ to A/S Amdt ______ to A/S Sub Amdt ______

Be recommended for:

- [x] Passage
- [ ] Adoption
- [ ] Confirmation
- [ ] Concurrence
- [ ] Indefinite Postponement
- [ ] Introduction
- [ ] Rejection
- [ ] Tabling
- [ ] Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☑	☐	☐	☐
Senator Tim Carpenter	☑	☐	☐	☐
Senator Judith Robson	☑	☐	☐	☐
Senator Julie Lassa	☑	☐	☐	☐
Senator Mary Lazich	☐	☑	☐	☐
Senator Ted Kanavas	☐	☑	☐	☐
Senator Alberta Darling	☐	☑	☐	☐
Totals:	4	3	___	___

☒ Motion Carried ☐ Motion Failed

FORWARD

To : Members of the Assembly Committee on Health Care and Health Care Reform

From: Terri Harmon RN, Director of Nursing Administration, Beloit Memorial Hospital

Date: April 15, 2009

Regarding: Written testimony in opposition to Senate Bill 108

I am sorry I am unable to be in attendance at today's hearing, but I want to submit my written testimony in opposition to Senate Bill 108, thank you for accepting this.

My name is Terri Harmon, and I have been a nurse since 1982, and am currently the Director of Nursing Administration at Beloit Memorial Hospital in Beloit, Wisconsin. I am writing in opposition to Senate Bill 108 banning mandatory overtime for healthcare workers.

I am in my 27th year of employment at Beloit Memorial Hospital, as a nurse, and 14 years of that was as a Critical Care Nurse, and the last nine in my present managerial position. As a staff nurse, in critical care, nor anytime during my employment at Beloit Memorial has it ever been mandatory to work overtime. It has always been the culture here, to give high quality patient care no matter what the circumstance might be. Heart attacks, motor vehicle accidents, and other traumas do not wait until hospitals have adequate staffing. Since we do live in the mid west, we do have to contend with the affects of snowstorms, and the inability of staff getting to work in a timely fashion. This bill provides no option for times such as this!

As Director of Nursing Administration, I have direct responsibility for staffing and in my career at Beloit Memorial Hospital, I know of no instance of mandatory overtime.
We encourage our staff to work overtime by offering them good pay, treating them with respect, and giving them the option not to work overtime. This bill does not provide solutions to problems; it promotes obstacles to good and safe healthcare.

I urge you to vote against Senate Bill 108, and together address real healthcare issues in our state.

FORWARD
E PLURIBUS UNUM

Government Affairs
Forest Home Center
3305 West Forest Home Avenue
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Milwaukee, WI 53234-3910

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www.AuroraHealthCare.org

Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Senator, Jon Erpenbach, Chair

Testimony of Mary Cieslak Duchek
Director of Nursing Integration, Aurora Health Care
2009 Senate Bill 108
Relating to the banning of mandatory overtime for certain health care workers.
Room 411, South, State Capitol
Wednesday, April 22, 2009, 10:00 a.m.

Chairperson Erpenbach and members of the Committee, thank you for the opportunity to appear on behalf of Aurora Health Care to speak about our concerns regarding 2009 Senate Bill 108.

My name is Mary Cieslak Duchek, and I direct nursing integration at Aurora Health Care. Aurora is a not-for-profit integrated health care system with over 28,000 caregivers serving two million patients annually through our 13 hospitals, 120 outpatient clinics, 120 pharmacies, visiting nurse association and hospice services. We are Wisconsin's largest private employer serving patients in 95 urban and rural communities covering the eastern half of Wisconsin, from the Illinois border to the Michigan border. In addition to my executive role at Aurora, and I have been a nurse for over 30 years and also currently serve as the Co-Chair of the Legislative Committee of the Wisconsin Organization of Nurse Executives.

I have been the chief nurse at a small community hospital as well as at a large tertiary care facility. In both these roles I had been challenged with staffing unpredictable community emergencies that required the hospital to quickly manage crisis situations. These experiences, as well as an understanding of our hospitals recent challenges bring me today to explain why such legislation is not safe for patients.

The leadership of Aurora Health Care is committed to continuously evaluating the needs of patients and the resources required to care for them. Patient safety is the first priority when planning staffing needs. Mandatory overtime is sometimes necessary based upon specific circumstances impacting patient safety. At Aurora, mandatory overtime is used on rare occasions as a last resort.

Mandatory overtime bans don't reflect the realities of providing a diverse range of patient care in the hospital setting. Patients' care needs are increasingly complex as the population ages; care protocols prescribe consistent treatment plans, socioeconomic factors influence disease management and outcomes are monitored. Patient care is simply more complex than a ban on mandatory overtime would suggest.

The following real life examples demonstrate the difficulty with imposing a one-size-fits-all ban on mandatory overtime.

- A bus crash occurred which involved 13 patients, which were also unfortunately incarcerated prisoners and required further security measures. Our facility was able to address this situation but it not only required clinical staff but additional security staff to manage the unique needs of the situation.

- In February of this year the transplant unit at Aurora St. Luke's Medical Center received word that three patients would receive organs within a few hours of each other. So this miraculous event required staff from four areas to quickly add staff to the day's schedule.

- Normal public health determinations to declare an outbreak can take days and even weeks before becoming an official "disaster." A cryptosporidium outbreak in metro-Milwaukee several years ago resulted in patients rapidly appearing at hospitals. Two weeks later the City of Milwaukee Health Department became aware of the epidemic, which led to the Mayor declaring a "boil water advisory."

It is ambiguous as to whether these examples would meet the definition of a "disaster" or "unforeseen" event given the bill draft's wording. SB 108 also contains definitions that appear incomplete for "on call" scheduling.

The enforcement mechanism is very broadly worded, and the Department of Workforce Development is tasked with being the first stop for an employee grievance, with no filtering process prior to that.

Our concern is that legislation like this has a chilling effect for nurse supervisors who might fear that any decision on how to parse this bill's language could lead to hefty fines, simply based on a difference of opinion, or misperception by a health care worker or DWD staffer.

To address staffing challenges employment agreements currently serve to create a common understanding around the employees' work schedule and the employer requirements for staffing. Work/ life balance is needed for employees and employment agreements add predictability to schedules yet address the patients' needs in clinical areas.

Aurora Health Care appreciates the bill's intent to promote the safety of Wisconsin patients. All caregivers and their employers share this same concern as a priority.

However, SB 108 will not help us achieve greater patient safety.

Thank you for allowing me to appear today to share our concerns with you.

FORWARD

Assembly Bill 152/Senate Bill 108 (ban mandatory overtime)

Ministry Health Care position: Oppose

Ministry Health Care registered against the legislation because the current language does not allow for unforeseen circumstances, which may include high patient census, multi-case trauma, ill workforce, inclement weather, and more.

Ministry Health Care does not use mandatory overtime as a standard business practice. It is only used in emergencies, to avoid understaffing which could compromise patient quality and safety. This happens only on rare occasions. As written, the legislation would not permit even one hour of overtime.

Ministry Health Care supports, and provided input in development of the Wisconsin Hospital Association guiding principles to prevent worker fatigue. This includes practices allowing adequate time off between scheduled shifts, and minimizing prolonged shifts. We believe these principles are a better strategy to prevent fatigue among health care professionals.

About Ministry Health Care: We earn trust by working together as One Ministry to keep PATIENTS FIRST in everything we do. This is our promise to our patients, to each other, and to the communities we serve. Founded 126 years ago by the Sisters of the Sorrowful Mother, Ministry Health Care is an integrated, mission-driven health care system serving primarily rural and underserved communities across Wisconsin and into Minnesota.

MINISTRY HEALTH CARE
Sponsored by Sisters of the Sorrowful Mother

KARLA ASHENHURST
DIRECTOR OF GOVERNMENT AFFAIRS

11925 West Lake Park Drive, Suite 100, Milwaukee, WI 53224-3014
Phone 414.359.3154 Fax 414.359.1033 Cell 414.507.1357
karla.ashenhurst@ministryhealth.org

FORWARD
E PLURIBUS UNUM

Rural Wisconsin Health Cooperative

TO: Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
Senator Jon Erpenbach, Chairperson

FROM: Jeremy Levin, Director of Advocacy
Rural Wisconsin Health Cooperative

DATE: April 22, 2009

RE: **OPPOSE** Senate Bill 108 – Prohibiting Mandatory Overtime Hours by Health Care Workers

On behalf of our thirty-five member rural hospitals, who take pride in serving their communities, the Rural Wisconsin Health Cooperative (RWHC) thanks you for this opportunity to share our thoughts on Senate Bill 108, relating to mandatory overtime hours and on-call time worked by health care workers and providing penalties. The RWHC opposes the prohibition of using mandatory overtime to cover unanticipated health care worker shortages at a health care facility.

According to a 2008 study prepared for the Wisconsin Organization of Nurse Executives, different factors lead to nurses working long hours. Among them:

- Patients in acute care facilities must be cared for by nurses around the clock.
- Hospitalized patients are more acutely ill requiring lower nurse to patient ratio.

These factors are just some of the contributing sources of fatigue that nurses experience in the modern health care system. Combating fatigue among all our health care workers is everyone's goal. There is a well-documented nursing shortage, although Wisconsin is not experiencing the degree in the shortage of nurses as compared to other regions of the country. Over 30 schools of nursing provide over 2000 graduates yearly to Wisconsin's health care agencies. However, even with a better supply of nurses than other regions, we could still use more and even the best staffing strategies cannot completely avoid the use of overtime, a majority of which is voluntarily taken.

In the 24-hour, year-round environment of hospitals and other health care facilities, making sure proper patient coverage and care is paramount. Patient intake can uptick quickly, adverse weather conditions can delay or nurses may become ill themselves. All of these occurrences are amplified in rural areas, where travel time and options are more stressed. Even with these unpredictable changes, mandatory overtime is never the first strategy for staffing. Senate Bill 108 is a "one-size-fits-all" approach to hospital staffing and it does not reflect the fact, which is borne out by studies that mandatory overtime rarely occurs. A Wisconsin Hospital Association study of nurses conducted with the Wisconsin Department of Workforce Development indicates that only 7.8% of RNs had ever experienced mandatory overtime. Often times that mandatory overtime is not for another complete shift, but to cover until the scheduled nurse arrives or until the shift is filled on a voluntary basis.

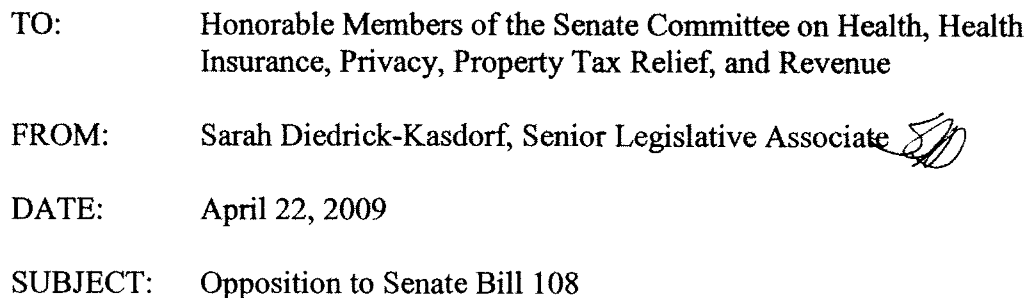
Limiting the tools available to hospitals impairs their ability to insure that the correct number of staff is available whenever and wherever the need presents. SB 108would limit the options available to healthcare facilities as they struggle to staff for unpredictable patient care demands. It is not possible to simply not care for patients. Their safety is compromised when sufficient staffing is unavailable. While a last resort of many existing ways to manage patient care needs, mandatory overtime should remain a tool to be used in times of extreme circumstances.

Wisconsin's rural hospitals are strongly committed to improving patient safety. Our goal is to strike the appropriate balance between safety, quality and patient-centered care. The RWHC asks the committee members to **OPPOSE** Senate Bill 108, prohibiting the use of mandatory overtime. Hospitals and other health care facilities need self-determination over their individual staffing situation and the flexibility to handle any unintended staff coverage emergencies.

FORWARD

22 EAST MIFFLIN STREET, SUITE 900
MADISON, WI 53703
TOLL FREE: 1.866.404.2700
PHONE: 608.663.7188
FAX: 608.663.7189
www.wicounties.org

MEMORANDUM



TO: Honorable Members of the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Sarah Diedrick-Kasdorf, Senior Legislative Associate

DATE: April 22, 2009

SUBJECT: Opposition to Senate Bill 108

The Wisconsin Counties Association (WCA) opposes Senate Bill 108, relating to mandatory overtime hours and on-call time worked by health care workers.

Wisconsin's counties operate several health care facilities, including skilled nursing facilities, hospitals and mental health centers, adult family homes and assisted living facilities, as well as provide health care services in our county jails and houses of correction.

In speaking with several counties about this legislation, managers of county facilities use mandatory overtime as a last resort; in other words, mandatory overtime is required only if no other employee volunteered to work the shift and contracted staff was not available. If facilities are prohibited from mandating overtime, care for residents will be compromised, and facilities risk federal and state citations for falling below minimum staffing requirements.

Although Senate Bill 108 makes significant changes to previous versions of the bill, the Wisconsin Counties Association continues to oppose such legislation at this time.

Thank you for considering our comments.

LYNDA BRADSTREET
DIRECTOR OF ADMINISTRATION & FINANCE

JON HOCHKAMMER
DIRECTOR OF INSURANCE OPERATIONS

JOHN REINEMANN
LEGISLATIVE DIRECTOR

J. MICHAEL BLASKA
DIRECTOR OF PROGRAMS & SERVICES

MARK D. O'CONNELL, EXECUTIVE DIRECTOR

FORWARD
E PLURIBUS UNUM

5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038
Phone: 608-268-1806 Fax: 608-274-8554

Position Statement of the Wisconsin Organization of Nurse Executives
Scheduling Practices
January 28, 2009
March 26, 2009 Updated

The Wisconsin Organization of Nurse Executives (W-ONE) recognizes that health care agencies have invested in effective measures to increase staffing levels in response to patient need. Health care facilities utilize a variety of supplemental staffing resources including internal float nurses, local agency staff, call and per diem programs and long term travel nurses. For these and other reasons, W-ONE opposes any legislation on mandatory overtime.

An adequate supply of nurses is currently available in Wisconsin communities and their healthcare facilities. At the current time no counties are reporting acute shortages of nurses and very few graduates are required to relocate to find employment. Mandatory overtime is not being used for routine staffing needs.

Restrictive staffing rules may result in limiting access to emergent care. Hospitals do not directly control patient volumes or acuity levels. Staffing needs are unpredictable and can change very quickly. Variations are most often seen in Labor and Delivery units, Emergency Departments and Medical units. Scheduling restrictions may limit the amount of legally available staff and unintentionally decrease availability of some of these essential unpredictable service needs. These staffing limitations may reduce patient access to critical hospital services.

W-ONE also recognizes that Healthcare professional fatigue is an emerging concern in many settings and is considered when increases in census or acuity require unexpected increases in the planned staffing. Many factors may contribute to fatigue however it is frequently attributed to excessive work hours. Excessive work hours either mandated or voluntary, contribute to a variety of unsafe conditions. Therefore any legislation which addresses mandatory limits on work hours, should also address hours voluntarily worked and hours worked by one individual at several organizations. Any use of overtime in emergency staffing situations must include an assessment of the healthcare provider's fitness to continue providing safe care.

It is W-ONE's position that:

- responsible, planned programs to address unpredicted surges in capacity can and should be monitored and regulated by the professions involved;
- that mandatory overtime is not used as a routine staffing mechanism in health care facilities; and
- that no legislation is necessary to address mandatory overtime.

W-ONE is committed to providing leadership to address the quality and safety of patient care in our organizations. To do less would be to abdicate our responsibility to safely staff healthcare organizations.

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White Paper: Nurse Scheduling and Fatigue in the Acute Care 24 Hour Setting

Prepared at the request of
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White Paper:
Nurse Scheduling and Fatigue in the Acute Care 24 Hour Setting

The nursing profession, which many consider vital to patient safety and care in the hospital, is examining the relationship between hours spent at the bedside without sufficient rest to the quality of care provided. Currently nurses in acute care facilities work long hours and overtime ranging from a few hours to full shifts; they do so either by choice or as a condition of employment. Missing breaks and lunches during these long stretches of work occurs regularly (Rogers, Hwang & Scott, 2004a; Scott, Rogers, Hwang & Zhange, 2006; Trinkoff, Geiger-Brown, Lispcomb & Mutaneer, 2006). Long work hours can and often do result in poorer patient outcomes (IOM, 2004).

A number of social phenomena are associated with nurses working long hours. Patients in acute care facilities must be cared for by nurses around the clock. Hospitalized patients are more acutely ill than at any other time in history requiring lower nurse to patient ratio. A nursing shortage has been well documented, leaving vacant nursing positions unfilled. Fewer persons are entering nursing and often leave at a younger age than other professions. Health care costs continue to increase and systems are continually challenged to manage budgets, including management of nursing budgets (Honor Society of Nursing, 2001). Other professions have set limits on the number of hours that are worked in a twenty-four hour period without rest. The medical profession restricts the length of their time residents may remain on duty (IOM, 2004). This change has had an impact on other professionals, namely attending physicians and nurses, further heightening the critical need for nurses to function safely and productively.

Researchers consistently identify a relationship between hours worked, nurse fatigue, and errors; with error rates doubling at 12 hours of work and tripling at 16 hours (IOM, 2004; Rogers, Hwang, Scott, Aiken, & Dinges, 2004b). Fatigue is often characterized by a decreased ability to complete work and a subjective complaint of feeling tired. Inadequate rest, sleep loss, and shift work schedules often contribute to fatigue (IOM, 2004). Fatigue has been reported to produce slowed reaction time, omission errors, impaired problem-solving abilities and attention lapses (Van-Griever & Meijman, 1987). Furthermore, fatigue may diminish productivity and lead to errors and accidents (IOM).

Numerous factors potentially affect work schedules and fatigue. Among these factors are staffing schedules, number of full and part-time personnel on unit, lifestyle decisions nurses make related to family and sleep, use of agency nurses, patient acuity, type of unit (intensive care unit, specialty unit, general unit), teaching or community hospital, personal preferences for shift worked and management support for staffing schedules. Recommendations to combat fatigue and decrease the potential for errors have been proposed by the Institute of Medicine (IOM) in "Keeping Patients Safe: Transforming the Work Environment of Nurses". The IOM states that "...to reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24 hour period and in excess of 60 hours per 7 day period" (2004, p. 237).

In general, studies of nursing work schedules have been researched using descriptive or correlation designs resulting in conclusions that are associational rather than causative. Across these studies (see Evidence Tables I & II) there is agreement that working over 12 hours, working overtime, and inadequate rest (i.e. less than 8 hours in between shifts) are associated with higher error rates. This IOM recommendation, related to limiting number of hours worked per week is based on writing of Jha, Duncan, and Bates and a 2002 descriptive study of American Nurses Association nurses (Rogers et al., 2004b). This conclusion was drawn based on how other safety industries have responded to work fatigue and the above mentioned study. In this study, Rogers and colleagues (2004b) did find that working greater than 40 hours per week increased errors, but did not delineate what type of shifts were worked to equal greater than 40 hours (i.e. four twelve-hour shifts, four sixteen-hour shifts, etc..). No other studies were found in which number of hours worked per week was evaluated in nurses. There is some suggestion that longer work hours are particularly fatiguing for nurses over 40 years old or nurses working the night shift (Kunert, King & Kolkhorst, 2007; Muecke, 2005). There is some evidence that persons working 12 hours rather than 8 hours with longer rest periods (i.e., greater number of days off between tours of duty) actually experienced less fatigue (Gillespie & Curzio, 1996).

Implementation of the IOM recommendation would limit the capacity for health care systems to generate and test alternative methods of scheduling nurse work. Upon examination the recommendation to limit nursing to a 60 hour work week has been inadequately validated by research at this point. Many hospitals have been able to develop creative staffing solutions aimed at improving staffing and attending to the preference of nurses. Models such as 4/40 (four ten-hour shifts), 7/70 (seven ten-hour shifts) and three twelve-hour shifts per week, have demonstrated their ability to maintain optimal patient outcomes and high nurse retention rates (Froedtert Hospital, 2006). These scheduling models have thus far not been researched in relation to fatigue in nurses.

The increased risk of error associated with fatigue has necessitated the development of recommendations based on evidence in order to decrease fatigue in relation to nurse scheduling. Based on the evidence available, recommendations were synthesized from the literature. Please note that "on call" nursing was not included in this synthesis and could be a focus for future study.

Synthesis of Evidence with Recommendations for Practice and Future Research

Problem

- As many as 40% of nurses reported working overtime (Rogers et al., 2004b).
- Over two-thirds of nurses reported working more than 12 hours in one day (Scott et al., 2006).
- Fourteen percent of nurses worked 16 or more hours at least once over a four-week period (Rogers et al., 2004b).
- Almost two-thirds of nurses reported working overtime 10 or more times during a four-week period (Rogers et al., 2004b).
- Nurses reported having a break or meal period free of patient care responsibilities less than half of the shifts worked (Rogers et al., 2004a).
- Twenty percent of nurses reported falling asleep once during their work shift (Scott et al, 2006).
- Chance of error increases with prolonged work shifts (IOM, 2004).

Definitions

- "Direct patient care encompasses activities carried out in the presence of the patient and family, such as performing a physical exam and other assessments of the patient, administering medications, and performing treatments and procedures" (IOM, 2004, p. 36).
- Fatigue is a protective response, an indicator of an individual's response to physical and psychological demands. It is an awareness of a decreased capacity of activity (physical and/or mental) attributed to an imbalance in the availability, utilization and or restoration of the resources an individual needs to perform activity (Ruggiero, 2003).
- Chronic fatigue is a general tiredness and lack of energy irrespective of sleep quantity or hard work (Ruggeiro, 2003).

Scientific Merit

- A number of primary studies reviewed included nurses' work schedules, measures of nurse responses to the work schedule or patient outcomes. A number of review articles were located. See evidence tables for detailed information.
- One study (Smith-Coggins, 2006) used an experimental design. All others studies used descriptive (including qualitative) or correlational designs hence evidence is weak as it is associational, not causative.
- Samples were drawn from acute care facilities. Sample size varied widely ranging from 6 to 2273 (5 studies with samples under 100; four under 200; 6 under 400; 2 greater than 1100). Consistent with the profession, the samples were primarily females. All samples except Scott (2006) were convenience samples.
- The most common work schedules included in the studies were 8, 10, or 12 hours; but also included 9 or 11 hour shifts (Josten, Ng-A-Tham & Theirry, 2003). Some studies explored differences between shifts (morning, evening, and night) (Dorrian et al., 2006; Kunert et al, 2007: Ruggiero, 2003). In the review of literature, overtime was evaluated and ranged from less than ten minutes past the end of ones shift to working a complete extra shift (Rogers et al., 2004b; Scott et al., 2006; Trinkoff et al., 2006).

- Although fatigue and error were the most commonly measured, outcomes were numerous and included driving drowsiness, sleep patterns, patient satisfaction, communication, depression, anxiety, and health complaints.
- Measurement instruments consisted primarily of self-report via logbooks or verbal report (Dorrian et al., 2006). Measures also included neurobehavioral performance simulated testing (Dorrian, Lamond, & Dawson, 2000); measures of brain waves polysomnography (Smith Coggins et al., 2006); review of medical records (Gillespie & Curzio, 1996); personnel records (e.g., absenteeism) (Gillespie & Curzio, 1996); and psychometric instruments (Ruggiero, 2003).
- Common threats to the internal validity of the studies included selection bias, low response rates (20%) (Josten et al., 2003), and use of measurement tools without established reliability and validity.
- Potentially confounding factors not studied included staffing adequacy (acuity of patients and nurse-to-patient ratios), additional professional commitments, full-time vs. part-time, critical versus acute care units, personal preference, and use of agency staffing.

Findings

- Evidence was weak but consistent in that working more than 12 hours in a single day was associated with errors (Montgomery, 2007; Rogers et al., 2004b; Scott et al., 2006). The IOM (2004) reports error rate doubles after 12 hours.
- Again, evidence is weak, but consistent overtime is associated with errors (Montgomery, 2007; Rogers et al., 2004; Scott et al., 2006). However, no evidence that the reason (mandatory vs. voluntary) for overtime makes a difference (Rogers et al., 2004b).
- One descriptive article reported that the risks of nurses making an error were increased when they worked greater than 40 hours per week (Rogers et al., 2004b). However, there was no delineation as to what type of shifts were worked to exceed 40 hours.
- The only other study referring to impact of number of hours worked per week was a recommendation for truck drivers (Jha et al., 2001; IOM, 2004).
- In a state of the science article Knauth (1993) recommended at least two successive days off if 5 to 7 days are worked consecutively.
- There was weak and limited evidence that night nurses reported increased fatigue and nurses over the age of 40 reported more fatigue when working longer hours (Kunert et al., 2007; Muecke, 2005).
- There was weak and limited evidence that recovery time between shifts decreases fatigue, a factor affecting rotation and alternative scheduling systems (Hughes, 2004; IOM, 2004; Meucke, 2005). One study found that increasing shift length while increasing recovery time resulted in less fatigue (Josten et al., 2003); a recommendation supported by Knauth (1993)
- Scheduling naps was the only intervention tested and was associated with both positive and negative outcomes (Smith-Coggins et al., 2006).
- The 60 hour work week limit suggested by the IOM has been inadequately validated by research, specifically in relation to nurse scheduling (see Evidence Tables I & II).

Recommendations for Future Research Based on Gaps in the Evidence

1. Recommend support of state and national organizations to fund studies related to work schedule, nurse fatigue, and patient outcomes.
2. Evaluate the impact of time-off between shifts and recovery time needed to minimize fatigue.
3. Evaluate the impact of personal preference of work schedule related to fatigue and errors.
4. Study the combination of work schedule and staffing on patient safety and nurse fatigue.
5. Evaluate the cumulative effect of hours per day worked with hours per week worked.

Summary of Recommendation for Practice Based on Synthesis of the Evidence

1. **Limit scheduled shifts to 12 hours or less in a 24 hour period** (Caruso, Hitchcock, Dick, Russo, & Schmit, 2004; Gillespie & Curzio, 1996; IOM, 2004; Montgomery, 2007; Rogers et al., 2004b; Scott et al., 2006; Trinkoff et al., 2006).
2. **Increase awareness that fatigue varies across shifts and consider this when developing staffing schedules** (Dorrian et al., 2006; Ruggierro, 2003).
3. **Strongly recommend adequate rest to be obtained between shifts (i.e. 10 hours after an 8-hour shift and 12 hours after a 12-hour shift)** (Gillespie & Curzio, 1996; Hughes, 2004; Knauth, 1993).
4. **Encourage staff to schedule time for breaks and meals. Management must put a structure in place that allows this to occur** (Rogers et al., 2004a; Hughes, 2004).
5. **Avoid shift rotation. If necessary to rotate shifts, facilitate shifts with forward rotations (morning to night)** (Dean et al., 2006; Hughes, 2004; Knauth, 1993; Muecke, 2005).
6. **Educate nurses about proper sleep hygiene** (Dean et al., 2006).
7. **Educate staff on personal responsibility to not work when too fatigued** (Department of Government Affairs, 2007; Hughes, 2005).
8. **Encourage state and national funding agencies to support study of innovative work schedules.**

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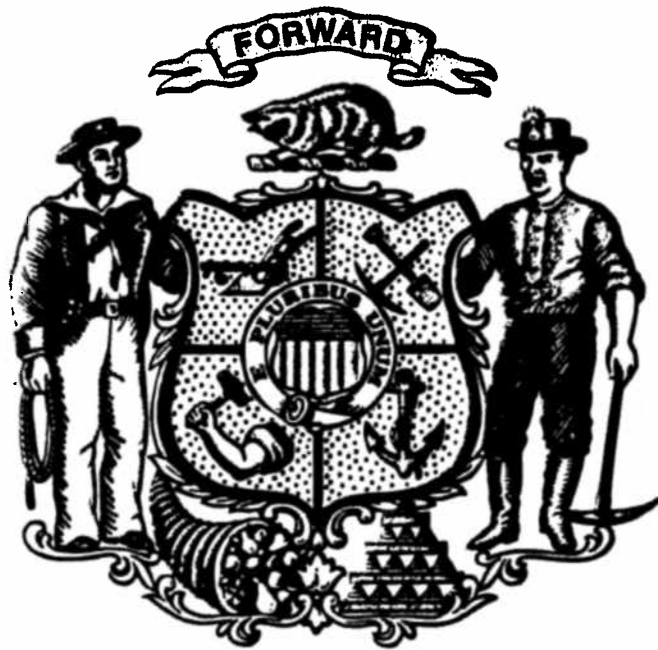

FORWARD

SB 108

From: [redacted]
Sent: Monday, April 20, 2009 11:00 AM
To: 'Rep.Berceau@legis.wisconsin.gov'
Subject: AB 152

Dear Ms. Berceau,

I am quite concerned about the pending legislation in the Assembly and Senate regarding mandatory overtime. As your constituent I wanted to express my concerns. As a healthcare worker I feel that I have seen both sides of this issue. No one likes to be mandated, and no one likes to mandate staff.

I have worked in the Birthing Center at Meriter Hospital for 21 years, the first 16 as a staff nurse and the past 4 years as the nurse manager. We have worked hard to track census patterns and adjust staffing accordingly. The number of mandates on my unit has been reduced accordingly. However, there are always those times when an influx of laboring women or a large number of sick calls causes us to need more RN's to provide safe patient care than we have readily available.

The Birthing Center does not cap census, and we do not divert patients when busy. We essentially are never "full" and take care of who ever comes in for evaluation. A dramatic example occurred last December. We admitted 8 laboring women toward the end of our PM shift, one of whom required an urgent cesarean section. We already had one patient in surgery from the floor. We staff a cesarean section with 2 RN's - so that was 4 RN's needed right there. Add on the 9 still in labor on the floor and another 9 delivered families to care for and we needed 16 nurses to start the shift. We had 10 RN's scheduled - fully staffed for nights. We had 1 nurse come in to work an extra night shift, and our on-call nurse came in to help. That still left 4 nurses short.

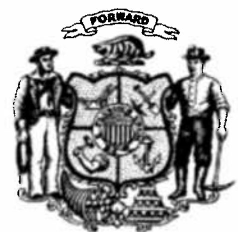
Ordinarily, on an extraordinarily busy night like that you might think that the PM shift would offer to stay to help out. **However, on this night, no one would voluntarily stay. (Related to the fact that their union was actively telling them not to ever volunteer - that it was "to their benefit" to be mandated?)** We had 4 mandates. One nurse was required to stay for 1.5 hours, one for 2.5 hours and the remaining 2 mandated RN's were sent home at 3.2 hours.

I believe that it is the responsibility of the hospital to provide adequate staffing on the unit. That said, when the schedule provides an adequate number of staff, but there are a number of sick calls or an unexpected influx of patients, there needs to be some safety valve if all other options have been exhausted. I do not interpret the language in AB 152 and SB 108 to provide any recourse in those situations and I am concerned about the resultant impact on patient safety without it.

This is why I am respectfully asking you to oppose this legislation in its current form.

- **Mandatory overtime represents less than one tenth of one percent of total hours worked by nurses at Meriter.**
  - 2008 nursing hours **945,424**
  - 2008 overtime hours **38,833 (4.1% of total hours)**
  - 2008 mandatory overtime hours **668 (0.07% of total hours)**
- **Mandate Occurrences in 2008**
  - 2007 117 occurrences
  - 2008 97 occurrences
  - 2009 annualized 20 occurrences

WISCONSIN STATE LEGISLATURE



04/21/09

Good Morning Chair Erpenbach and Members of the Committee,

My name is Beverly Hoege and I am writing today to testify in opposition to Senate Bill 108 / Assembly Bill 152 on behalf of the Wisconsin Organization of Nurse Executives (WONE) and Reedsburg Area Medical Center. WONE represents over 225 nurse administrators, managers and faculty members of Wisconsin's hospitals, health care agencies and schools of nursing. The WONE opposes Senate Bill 108 /Assembly Bill 152 because health care agencies currently maintain effective staffing resources and rarely utilize Mandatory Overtime (MOT). I believe these staffing issues need not be legislated.

I am the Chief Nursing Officer at Reedsburg Area Medical Center, a 25 bed critical access facility. We deliver about 275 babies, perform 2500 surgical procedures, care for 13,223 ER/UC patients, and 1883 inpatient (IP) annually.

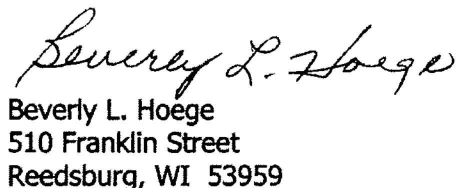
The issue in small facilities is the major fluctuations in census, or unanticipated staff absences, and the need to deal with major traumas or disaster that may come through our door. Interestingly enough, women labor and babies are born according to their time clock and not necessarily convenient to a staffing pattern. On New Year's Day the OB Unit was closed and within 1 hour four mothers presented inactive labor and delivered within a few hour timeline. We typically staff for two babies and moms. We asked for extra staff to provide safe, quality care. Fortunately, we have not had to mandate.

IP census, number of births occurring or number of patients being seen may vary 200 – 400% within 8 hours. This requires flexibility and creativity of staffing plans. For example, Med/Surg IP census was 9 – within several hours the IP census was 22. Diagnosis and acuity varied, once again requiring flexibility. Staffing is adjusted based on the patient acuity system which identifies the number of RN, LPN, or Nursing Assistant hours needed to provide care. ICU – IP census goes from 0 to 5, admitting and discharging, within 8 hours. These changes require flexibility. How are we to manage unexpected community crisis or deal with unanticipated staff absences?

This bill will eliminate an option from the manager's toolbox. We choose not to use MOT, however, to say we never could use MOT, could impact safe delivery of care. These are management not legislative issues.

For the above reasons I register in opposition to Senate Bill 108 /Assembly Bill 152.

Thank you,



Beverly L. Hoege
510 Franklin Street
Reedsburg, WI 53959

FORWARD

Testimony by Senator Judy Robson

on

SB 108: Mandatory Overtime for Health Care Workers

to the

Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief & Revenue

Wednesday, April 22, 2009, 10 am, Room 411 South

I want to thank the committee for considering this legislation which will help make sure that patients in Wisconsin's health care facilities receive the best possible care. One of the ways to accomplish that goal is the make sure that we have enough nurses to meet the needs of these patients.

Wisconsin is already facing a shortage of nurses and the shortage will continue to increase unless we take steps to retain the qualified nurses we have and to educate and recruit new nurses.

One of those steps toward retaining nurses is to ban mandatory overtime. Among the leading reasons why nurses leave the profession is stress, burnout and clinical errors that are aggravated by mandated overtime.

Mandatory overtime leads us into a vicious downward cycle. Excessive hours and fatigue reduce morale, which in turn contributes to job burnout. Job burnout reduces staff retention. Job loss creates more nursing vacancies, forcing the remaining nurses to pick up the load by working more overtime.

By banning mandatory overtime, we begin to break that cycle. As a result, the nurses who are working today will be more likely to stay in nursing. New nursing graduates will know that there will be decent working conditions that will allow them to practice nursing at the highest level.

We all recognize that nurses who must work 16 hours straight become exhausted and cannot do their jobs adequately.

A study in the national journal *Health Affairs* found that nurses who worked shifts of 12.5 hours or more were three times more likely to commit an error than nurses who worked a standard shift of 8.5 hours or less.

This study confirms research by the Wisconsin Federation of Nurses and Health Professionals which found that fatigue can lead to clinical errors in administrating medications and lead to impaired ability to detect critical changes in a patient's condition.

For these same reasons, laws limit the hours that long-haul truckers, airline pilots, flight attendants and other transportation workers can work. It is well recognized that alertness is critical to the safe performance of their jobs.

It's surprising that nurses and nursing assistants - who make dozens of life and death decisions each day - can be mandated to work double shifts without planning or warning.

This bill prohibits health care institutions, hospitals, nursing homes and other facilities from requiring health care workers to work overtime.

The prohibitions in the bill do not apply:

1) If the health care worker consents to working overtime;

2) If the health care worker's continued presence through the completion of an ongoing medical or surgical procedure is essential to the health and safety of the patient.

Recognizing that under some circumstance mandatory overtime may be necessary, the bill allows a health care facility to mandate overtime in cases of unforeseeable emergency, **if** the health care facility first exhausts all other options.

However, the bill specifics that an "unforeseeable emergency" does not include a situation in which the health care facility has inadequate staff due to chromic short-staffing or other foreseeable causes.

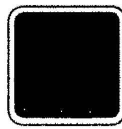
The bill also prohibits a facility from discharging or discriminating against a worker who refuses to work mandatory overtime or files a complaint related to mandated overtime.

This bill is necessary and significant because of the number of health care workers it will affect.

Currently 15 states prohibit the use of mandatory overtime for nurses. Those states are Connecticut, Maine, Maryland, New Jersey, New Hampshire, New York, Oregon, Pennsylvania, Washington West Virginia, California, Missouri Texas and our two closest neighbors -- Illinois and Minnesota.

It is time for Wisconsin to join with those 15 other states that have already acted to restrict mandatory overtime in hospital and other health care settings.

FORWARD
E PLURIBUS UNUM



WMC

WISCONSIN'S BUSINESS VOICE

To:	Chairperson Jon Erpenbach Members of the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue
From:	R.J. Pirlot, Director, Legislative Relations
Date:	April 22, 2009
Subject:	**Opposition to Senate Bill 108**, relating to mandatory overtime hours and on-call time worked by healthcare workers.

Senate Bill (SB) 108 would prohibit a healthcare facility from requiring an employee who is involved in providing direct healthcare services for patients, and who is paid an hourly wage, to work for more than a regularly-scheduled daily work shift that has been determined and agreed to before the performance of the overtime work or to be on "on-call" time. The prohibition would not apply if (1) the employee consents or volunteers to work overtime or to being on on-call time, (2) the employee's presence through the completion of an ongoing medical or surgical procedure in which the employee is actively engaged is essential to the health and safety of a patient, (3) there is an "unforeseeable emergency," or (4) there is an unanticipated or unavoidable disaster that substantially affects or increases the need for healthcare workers. WMC opposes SB 108.

Wisconsin Manufacturers & Commerce (WMC) is the largest representative of Wisconsin businesses with our members employing approximately one-quarter of the state's private-sector workforce. Wisconsin businesses understand that in order to attract and retain good, productive employees, Wisconsin businesses need to ensure their employees have access to high-quality, affordable health care. Employees with access to good health care tend to be more productive and have lower rates of absenteeism than employees without. As such, WMC is keenly interested in and has a long history of promoting patient safety, healthcare quality, and affordable health care.

SB 108 Would Compromise Patient Safety

Mandatory overtime is a little-used, though needed, strategy to ensure healthcare facilities are adequately staffed and able to provide continued, suitable care for patients. WMC is concerned that enactment of SB 108 would place patients at risk by undermining the ability of healthcare facilities to maintain appropriate staffing levels.

Proponents of SB 108 argue SB 108 contains exceptions adequate to ensure staffing levels can be maintained, on a mandatory basis, should circumstances dictate. For example, under SB 108, mandatory overtime would not be prohibited if there is an "unanticipated or unavoidable disaster that substantially affects or increases the need for health care workers." Unfortunately, these one-size-fits-all exceptions are inadequate, poorly defined, and would invite litigation.

SB 108 is Really an Attempt to Settle a Labor-Management Issue

Proponents of SB 108 typically argue the legislation is about promoting patient safety by preventing fatigued healthcare workers from providing patient care. The language of SB 108 indicates otherwise. SB 108 would *still* allow healthcare workers to work overtime, should they

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2/08

volunteer to do so. SB 108 would also allow healthcare workers to voluntarily work a shift in a different facility or different line of work, and then work a shift in a covered facility. From a patient's perspective, if a healthcare worker is fatigued, it makes little difference whether the worker is working long hours on a mandatory or voluntary basis, or due to other reasons, such as working a second job.

What SB 108 actually appears to be intent on is settling, by state fiat, an issue regarding which employers and their employees typically negotiate or bargain.

Wisconsin Healthcare Facilities are National Leaders in Patient Safety, Quality

Wisconsin healthcare facilities, in particular Wisconsin hospitals, are national leaders in promoting patient safety and quality improvement. For example, the Wisconsin Hospital Association's *CheckPoint* initiative, in which 128 hospitals voluntarily participate, collects and disseminates easy-to-understand patient safety and quality indicators on a host of issues, such as heart attacks, pneumonia, error prevention and surgical infection prevention. A second example is the Wisconsin Collaborative for Healthcare Quality (WCHQ), a consortium of healthcare organizations and purchasers which collects and reports healthcare quality data, in a consumer-oriented format, on subjects such as patient safety, effectiveness of care, and system efficiency Both *CheckPoint* and the WCHQ are held up as national models to be emulated.

WMC supports and promotes *CheckPoint* and the WCHQ.

WMC respectfully requests you oppose SB 108.

FORWARD
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Ban Mandatory Overtime for Nurses and Health Care Professionals
Senate Committee on Health, Health Insurance, Privacy,
Property Tax Relief, and Revenue
Support for SB 108
Wednesday, April 22, 2009

Testimony of Stephanie Bloomingdale
Director of Public Policy, Wisconsin Federation of Nurses and Healthcare Professionals

My name is Stephanie Bloomingdale and I am here on behalf of the Wisconsin Federation of Nurses and Health Professionals (WFNHP). WFNHP is a labor union that represents more than 3,000 nurses and healthcare professionals throughout Wisconsin. I am here today to urge your support of SB108 which would ban the dangerous practice of forcing nurses and healthcare workers to work past the end of their shift except for cases of unforeseen emergencies such as a major disaster.

The legislature now has the opportunity to make hospitals safer for patients in Wisconsin. Hospitals that force nurses to work beyond the end of their shift put patients at risk and drive nurses out of bed-side nursing. Nurses who are mandated to work overtime, sometimes for up to 16 hours in a row, are forced to put patient safety in jeopardy. By passing this legislation, the legislature will make hospitals safer for patients and better for nurses.

In an attempt to cut costs and maximize profits hospitals routinely force nurses to work mandatory overtime to care for patients. Nurses provide the majority of hands-on care for patients and therefore, are one of the largest cost centers in hospitals. Over the past decade hospitals, in the race to compete with each other and build more hospitals, have slimmed nursing staff and relied on mandatory overtime to make up the difference. Using mandatory overtime to staff hospitals may result in short term savings – but actually results in huge needless expenditures, both in terms of patient safety and nurse retention.

Mandatory overtime exists in Wisconsin. While it is true that not all hospitals engage in the risky policy of forcing nurses to work mandatory overtime, many still do. According to nurses surveyed by the WFNHP, 42% have been forced to work overtime at least once a month, with 12% mandated once a week.[1] Mandatory overtime is sometimes called required overtime, essential overtime, or compassionate overtime. Some hospital administrators have gone so far as to ask their managers to remove the word "mandatory" from their vocabulary, instead asking them to call it "essential" or "required" overtime. Regardless of the label attached, it is still the practice of forcing a nurse to work beyond the end of her shift.

Local 5001
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Milwaukee County
St. Francis Hospital

Local 5011
Sheboygan City Professionals
Sheboygan County Health Care Centers
Sheboygan County Divisions of Public Health & Community Programs

Local 5012
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Local 5024
Dodge County Public Health & Human Services

Local 5032
Clement J Zablocki Veterans Administration Medical Center

Local 5033
Langlade Memorial Hospital

Local 5034
Eagle River Memorial Hospital

Local 5035
Middle River Health & Rehabilitation Center

Local 5037
Wood County Health Department

Local 5038
West Allis Health Department

Local 5039
Ridgewood Care Center

Local 5040
Cumberland Memorial Hospital

Local 5061
Brookside Care Center
Kenosha County Division of Health

Local 5068
Manitowoc County Health Department

Local 5084
Columbia County Department of Health & Human Services

An affiliate of the American Federation of Teachers, AFL-CIO

Staffing and ensuring quality patient care are the same. Some hospital administrators have tried to separate the idea of staffing from delivering quality care in an attempt to defend mandatory overtime. Let's not be confused – "staffing" is "ensuring quality patient care."

Fatigued nurses are more likely to make mistakes. Everyone knows that you can't be on the top of your game when you are exhausted. So why would nurses and healthcare workers be any different. Fatigued nurses may miss subtle changes in a patient's condition or even make mistakes that could potentially harm the patient. Studies show that after 17–19 hours without sleep, the performance of subjects was equivalent or worse than at a blood alcohol level of 0.05 percent. After 24 hours of sustained wakefulness, the impairment was equivalent to that caused by a blood alcohol concentration of 0.10 percent.[2]

What do the nurses say about the effects of mandatory overtime on patient safety? Hospitals do not share information about mandatory overtime rates or error rates. So we have to rely on what the nurses tell us. Nurses agree that quality care suffers when nurses are required to work forced overtime. In fact, 96% said that quality suffers, and 56% said quality suffers a great deal, and 43% of nurses said they were aware of errors in care that have occurred as a result of nurse fatigue.[1] Over 500 nurses listed examples of errors. The overwhelming number of examples centered on medication errors. The errors reported by the nurses included giving the wrong medication, the wrong dosages, administering drugs at the wrong time and to the wrong patients. The other concerns cited were examples of nurses falling asleep at work or while driving home.[1]

What is it like to be a nurse forced to work 16 hours in a row? Imagine an oncology nurse who works a night shift from 11:00 pm until 7:30 am. All night long she delivers chemotherapy and care for patients with complex medical needs, many with multiple IV's. At 6:00 in the morning her supervisor tells her she can't go home and she needs to cover the next shift. She can hardly keep her eyes open and says that she was very afraid of making a mistake. She was afraid for her patients. This was not an emergency. The schedule had been out for four weeks without a nurse scheduled for that shift.

Mistakes cost lives. The Institute of Medicine estimates that 98,000 people die from preventable medical mistakes in the U.S. every year.[3] Medication errors are among the most common medical error, harming at least 1.5 million people every year.[4]

Mistakes cost money. A study by HealthGrades, estimates that patient safety incidents cost the federal Medicare program $8.8 billion and has resulted in 238,337 potentially preventable deaths during 2004 through 20006.[5] The extra medical cost of treating drug related injuries occurring in hospitals alone conservatively amount to $3.5 billion a year, and this estimate does not take into account lost wages and productivity.[4]

MOT forces nurses out of the profession. When a nurse is told she must work mandatory overtime she is forced to choose between her license and her job. Often she must also choose between her family and her patients. Working in an environment where nurses don't know if they will be able to leave after their shift or whether their fatigue may result in severe medical errors is difficult and stressful for nurses. Some choose to leave bedside nursing altogether because of the untenable working conditions. In fact, 30% of nurses who were not eligible to retire were considering leaving the profession due to poor working conditions including mandatory overtime.[1]

Hiring and training new nurses is expensive. The cost to replace a medical/surgical nurse averages about $46,000 and replacing a critical care nurse costs an average of $64,000.[6]

Other states have passed bills to ban mandatory overtime. Since 2000, 15 states have either banned mandatory overtime or have passed laws restricting its use in healthcare facilities. (The 15 states include: California, Connecticut, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, Washington and West Virginia.) Wisconsin patients deserve the same safety protections afforded to the patients in these other 15 states.

Hospitals can eliminate forced overtime AND deliver quality care to patients. In fact, not all Wisconsin hospitals choose to engage in the risky practice of forcing nurses to work mandatory overtime. It is the responsibility of management to ensure proper staffing to meet the needs of patients. Responsible staffing requires planning and forward thinking. It should not be a surprise to hospital administrators that patient census is likely to change and should therefore be taken into consideration when doing initial staffing grids. The number one solution is hiring enough nurses in the first place, after that hospitals can utilize internal pool and external agencies to fill in slots as necessary. The bottom line is that Wisconsin patients deserve safe patient care and that quality care is jeopardized when nurses and healthcare workers are forced to work overtime.

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1 Wisconsin Federation of Nurses and Health Professionals; 2008 Survey of Milwaukee-area nurses.

2 Williamson, AM and Feyer,AM. "Moderate Sleep Deprivation Produces Impairments in Cognitive and Motor Performance Equivalent to Legally Prescribed Levels of Alcohol Intoxication," Occupational and Environmental Medicine; October 2000; 57(10): 649-655.

3 "To Err is Human," Institute of Medicine of the National Academies; November 1999.

4 "Preventing medication errors," Institute of Medicine committee on identifying and preventing medication errors; July 2006.

5 HealthGrades; Fifth annual patient safety in America hospitals study; April 8, 2008.

6 Voluntary Hospital Association.