TIME FOR TRIAGE:
A SUMMARY OF BEST PRACTICES, STATE REQUIREMENTS, AND SUCCESSFUL EFFORTS TO REDUCE NURSE STAFFING SHORTAGES

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Report No. 1, 2024

Legislative Reference Bureau
State Capitol
Honolulu, Hawaii
https://lrb.hawaii.gov

This report has been cataloged as follows:

Choy, Devin + Grey, Valerie + Ching, Lance
Time for triage : a summary of best practices, state requirements, and successful efforts to reduce nurse staffing shortages.
Honolulu, Hawaii : Legislative Reference Bureau, January 2025.

1. Nursing – Standards – United States – States.
2. Nursing – Personnel management – Statistical methods.
3. Hospitals – Administrations – Statistical methods.

KFH421.5 L35 A25 24-1

FOREWORD

This report was prepared in response to House Concurrent Resolution No. 187, House Draft 1, Senate Draft 1 (2024). The concurrent resolution directed the Legislative Reference Bureau to conduct a study on nurse staffing.

The Bureau requested input from stakeholder organizations in the State. The Bureau extends its appreciation to the following organizations for providing information regarding issues pertaining to nurse staffing: Department of Health, Hawaii Government Employees Association, Hawaii Center for Nursing, Hawaii Nurses' Association, Healthcare Association of Hawaii, and University of Hawaii at Manoa Nancy Atmospera-Walch School of Nursing. The Bureau also acknowledges and extends its appreciation for the prior research conducted by Nursa, National Consumer Voice for Quality Long-Term Care, the Medicaid and CHIP Payment and Access Commission, IntelyCare, and NurseJournal.

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January 2025

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EXECUTIVE SUMMARY

The Legislative Reference Bureau (Bureau) prepared this report pursuant to House Concurrent Resolution No. 187, H.D. 1, S.D. 1 (2024), which requested the Bureau "to conduct a study on best practices for nurse staffing in health care facilities which shall assess and discuss: (1) Existing nursing staffing standards and regulations in other states; and (2) A literature review of best practices for staffing and workforce development, along with successful efforts in other states to address the nursing workforce shortage[.]"

The Bureau conducted a literature review of best practices for nurse staffing and workforce development as summarized in Chapter 2, reviewed nursing staffing standards and regulations in other states as described in Chapter 3, and researched successful efforts in other states to address the nursing workforce shortage as discussed in Chapter 4.

There appears to be a consensus that nurses who are assigned to fewer patients have better patient outcomes and experience preferrable employment conditions compared to nurses who are assigned to more patients in the same healthcare setting. It also appears that states have taken a multitude of approaches to achieving better patient outcomes and preferrable nursing employment conditions including:

(1) Nurse staffing ratios established by law;

(2) Staffing committees to establish nurse staffing ratios;

(3) Requirements to have at least one nurse on duty;

(4) Public reporting of nurse staffing levels;

(5) Team nursing strategies; and

(6) Prohibitions or restrictions on nurse overtime.

Each of these has some evidentiary support, though there is no clear evidence that one approach or a particular combination of approaches is the most effective in achieving better patient outcomes or more preferrable employment conditions. Accordingly, the Bureau recommends considering a combination of approaches, but makes no specific recommendation.

Additionally, the Bureau recommends a multi-faceted approach to addressing the nursing workforce shortage, including increasing the number of nurse graduates by funding programs to support nurse preceptors, incentivizing nursing schools to increase enrollment, and increasing nursing student clinical placements, while also funding existing programs established to address Hawaii's nursing workforce shortage.

Chapter 1

INTRODUCTION

House Concurrent Resolution No. 187, House Draft 1, Senate Draft 1 (2024) (hereafter "Resolution") directs the Legislative Reference Bureau (the Bureau) to conduct a study on nurse staffing. (*See* Appendix A). Specifically, the Resolution states:

> BE IT RESOLVED by the House of Representatives of the Thirty-second Legislature of the State of Hawaii, Regular Session of 2024, the Senate concurring, that the Legislative Reference Bureau is requested to conduct a study on best practices for nurse staffing in health care facilities which shall assess and discuss:
>
> (1) Existing nursing staffing standards and regulations in other states; and
>
> (2) A literature review of best practices for staffing and workforce development, along with successful efforts in other states to address the nursing workforce shortage; and
>
> BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to submit a report of its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2025

Scope of the Report

In this report, the Bureau focused on the information requested by the Resolution.

The Bureau separated the substantive response to the Resolution into three chapters. The literature review of best practices for staffing and workforce development appears in Chapter 2 and the information regarding the existing nursing staffing standards and regulations in other states appears in Chapter 3.

Chapter 4 includes background information on the Hawaii nursing workforce shortage to provide context for the discussion on the successful efforts made by other states mentioned in the second part of that chapter.

Methodology

In preparing this report, the Bureau reviewed relevant laws, rules, and regulations; contacted various nursing entities in the State for input on documents responsive to the Resolution; and reviewed numerous journals and publications.

Chapter 2

LITERATURE REVIEW OF BEST PRACTICES FOR NURSE STAFFING AND WORKFORCE DEVELOPMENT

This chapter provides an overview of multiple approaches that states and healthcare facilities have taken to address nurse staffing shortages. A more detailed review of state laws related to nurse staffing is provided in chapter 3.

This chapter also examines recommendations made by healthcare associations and professional advocacy groups and explores how these recommendations are evaluated in academic literature. Our review was limited by time and access to materials and is not intended to be comprehensive.

Since Bureau staff do not have specialized medical or nursing expertise, we express no opinion regarding the validity, feasibility, or definitiveness of these "best practices."

Background: State and National Nurse Staffing Shortages

The United States Bureau of Labor Statistics estimates that between 2023 and 2033, approximately 194,500 new Registered Nurses (RNs) per year will be needed to meet the country's health care needs.[1] This projection is based primarily on the number of nurses who are expected to retire or change occupations.[2] Prior to 2020, nurse retirements were already outpacing new hires, and an aging population increased demand for nursing services.[3] The 2019 coronavirus disease pandemic (COVID-19) highlighted and exacerbated these issues.[4]

In Hawaii, employment projections suggest that the State will need approximately 90 new Licensed Practical Nurses (LPNs) each year through 2030 to account for increased demand, retirements, and career changes.[5] According to the United States Health Resources and Services Administration (HRSA), Hawaii currently has approximately seventy percent of the RNs needed

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[1] *See* U.S. Bureau of Labor Statistics Occupational Outlook Handbook for Registered Nurses, https://www.bls.gov/ooh/healthcare/registered-nurses.htm.
[2] *See id.*
[3] *See* Nurses in the Workforce, American Nurses Association, https://www.nursingworld.org/practice-policy/workforce/.
[4] *See id.*
[5] *See* Hawaii State Center for Nursing (2024), 2023 Hawaii Nursing Workforce Supply: Statewide Report, https://www.hawaiicenterfornursing.org/wp-content/uploads/2024/04/2023HawaiiNursingWorkforceSupply.vFinal.pdf at 6-7.

to meet the State's health care demands.[6] Absent any major changes to the workforce, the State is projected to have approximately eighty-eight percent of the RNs required by 2036.[7]

Nurse Staffing Standards: A Legislative Approach to Improving Nurse Staffing

Legally mandated nurse staffing standards are one way in which states have attempted to address critical nurse staffing shortages. Generally, these laws fall into two broad categories:

1. General nurse staffing standards that leave staffing levels to the healthcare facilities' discretion; and

2. Specific nurse staffing ratios that require a certain number of nurses, or nursing hours, per patient.

Many states utilize both general nurse staffing standards and specific nurse staffing ratios, depending on the healthcare setting.

General Nurse Staffing Standards

Some states' laws address nurse staffing standards only in very general terms.[8] They require healthcare facilities to maintain staffing levels that are "sufficient,"[9] "adequate,"[10] or "necessary,"[11] to meet patients' needs. In many states, these general standards are applicable only to certain types of healthcare facilities. For example, Hawaii requires skilled nursing facilities and intermediate care facilities to "have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents."[12] Most states with general staffing standards, including Hawaii, do not statutorily define terms like "sufficient," "adequate," or "necessary." The Bureau

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[6] *See id.* at 8 (*citing* Heath Resources and Services Administration (2024), *Workforce Projections.* Data, HRSA.gov, https://data.hrsa.gov/topics/health-workforce/workforce-projections).
[7] *See id.*
[8] Federal regulations also include general staffing standards. For example, the Conditions of Participation for Hospitals, which are mandatory for all hospitals accepting Medicare and Medicaid payments, require nurse staffing to be "adequate." *See* 42 C.F.R. Chapter IV, Subchapter G, Part 482, *available at* https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482. Recently-enacted Medicare and Medicaid standards for long-term care facilities require "sufficient numbers" of certain types of personnel "to provide nursing care to all residents in according with resident care plans," and "a sufficient number of staff with the appropriate competencies and skill sets necessary to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident[.]" Licensed nurses in Medicare and Medicaid long-term care facilities are required to have "the specific competencies and skill sets necessary to care for residents' needs[.]" *See* 89 Fed. Reg. 40876, *available at* https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08273.pdf.
[9] *See* Mo. Rev. Stat. §197.289; 175 Neb. Admin. Code §12-006.04(D); Ohio Admin. Code 3701-84-62(H).
[10] *See* S.C. Code Ann. Regs. 61-17-605 (A); Ala. Admin. Code r. 420-5-7-.11(1); N.M. Code R. §8.370.12.27(C)(1).
[11] *See* R.I. Gen. Laws § 23-17.5-32(a) and W. Va. Code R. § 64-13-8.1.
[12] Haw. Code. R. §11-94.2-39(a) .

found no literature directly addressing the efficacy or outcomes of laws containing general nurse staffing standards.

Nurse Staffing Ratios

Many states have specific, mandated nurse staffing ratios that are applicable only in certain circumstances or healthcare settings. For example, California requires different nurse staffing ratios for critical care units, labor and delivery suites, post-anesthesia recovery units, and other healthcare settings.[13] Georgia dictates the number of hours that a registered professional nurse or licensed practical nurse must be on site at a residential care home or health care facility, depending on the number of patients or residents, and with different standards for assisted living communities, memory care centers, and nursing homes.[14] Maine has different nurse staffing standards for day shift, evening shift, and night shift. Often, the circumstances in which the ratios apply are defined by a combination of healthcare setting and patient acuity. California has multiple nurse staffing ratios that apply, in the alternative, to emergency departments, depending on whether a patient requires basic emergency services or critical care services.[15]

Nurse staffing ratios based on a combination of healthcare setting and patient acuity are supported by many nurse advocacy groups and professional nursing associations. In 2023, the Nurse Staffing Task Force, convened by the Partners for Nurse Staffing Think Tank, published recommended actions to address the country's nurse staffing crisis.[16] These included recommendations to "[c]ollaborate with specialty organizations to implement Think Tank recommendations on developing minimum staffing standards for specific populations," and to "[s]et minimum nurse-to-patient ratios, unit-based ratios, or minimum nursing hours per patient day based on the clinical setting."[17]

The American Association of Critical-Care Nurses made similar recommendations in its 2024 publication "AACN Standards for Appropriate Staffing in Adult Critical Care."[18] Among other standards, the Association recommended that "[f]or every shift, patient assignments are based on an accurate assessment of the current nursing workload generated by each patient's needs and align nurse competency with patient characteristics."[19] More specifically, the Association recommended that "[o]rganizational staffing plans anticipate that critically ill or injured patients generally require a ratio of 1 nurse to 2 patients."[20] This 1:2 ratio mirrors California's mandated staffing ratio for critical care patients.[21]

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[13] *See* Cal. Health & Safety Code § 1276.4(a).
[14] *See* Ga. Comp. R. & Regs. 111-8-22-.06(2)(b)(4)(i); Ga. Comp. R. & Regs. 111-8-63-.09(18)(c); Ga. Comp. R. & Regs. 111-8-63-.19(1)(c)(iv); Ga. Comp. R. & Regs. 111-8-56-.04(4); and Ga. Comp. R. & Regs. 111-8-56-.04(6).
[15] *See* Cal. Health & Safety Code § 1276.4(a).
[16] *See* Nurse Staffing Task Force. Nurse Staffing Task Force Imperatives, Recommendations, and Actions. American Association of Critical-Care Nurses and American Nurses Association; 2023.
[17] *Id.*
[18] AACN Standards for Appropriate Staffing in Adult Critical Care, American Association of Critical-Care Nurses; 2024.
[19] *Id.*
[20] *Id.*
[21] *See* Cal. Health & Safety Code § 1276.4(a).

In its updated standards, the Association of Women's Health, Obstetric, and Neonatal Nurses offered more specific recommendations for nurse staffing ratios in perinatal units.[22] Its recommendations are based on patient acuity and address thirty-one clinical situations. Recommended nurse-to-patient ratios include 1:1 for a patient who requires more intensive monitoring, including for a woman with antepartum complications who is unstable, a woman receiving oxytocin during labor, and a newborn requiring complex critical care; 1:3 for women who are postpartum with complications but are stable; and 1:5 for women who are postpartum without complications, when their newborns are cared for by another nurse.[23] The highest recommended ratio is "1 or more to 1" for an "[u]nstable newborn requiring complex critical care."[24]

The healthcare associations' recommendations for setting-based and acuity-based nurse staffing ratios are also supported by academic studies. While most studies stop short of recommending specific nurse staffing ratios, they provide relevant data to suggest that both patient acuity and healthcare setting should be considered when determining appropriate ratios. For example, a 2011 study, published in the *Journal of Advanced Nursing,* found that while there is a correlation between nurse staffing ratios and in-hospital mortality or unplanned readmissions, "the relationship is moderated by volume and severity of illness, respectively."[25] Looking at patients who underwent coronary artery bypass surgery or heart valve procedures in twenty-eight Belgian acute care hospitals, the authors of the study found that, for patients who were less ill, there was a stronger correlation between nurse staffing levels and readmission to the intensive care unit.[26] The authors speculated that for more severely ill patients, their readmissions were caused primarily by underlying comorbidities and were unrelated to nurse staffing or quality of care.[27] The authors therefore recommended that a distinction be made between the nurse staffing ratios needed for postoperative intensive care units versus the ratios needed for postoperative general nursing units. They argued that "a blanket proposal for all nursing units might not lead to any improvement in the healthcare delivery system."[28]

A 2017 study, published in the *European Journal of Cardiovascular Nursing* found that "patient factors," defined as "patient nursing needs according to acuity and dependency levels," were one of three factors that should be considered when determining the optimal nurse staffing ratios for acute specialist units.[29] Other factors included "ward factors" or patient volume, and "nurse staff factors," or nurses' skill levels.[30] Considering the effects of nurse staffing ratios on

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[22] *See* Association of Women's Health, Obstetric, and Neonatal Nurses, *Standards for Professional Registered Nurse Staffing for Perinatal Units* (2022).
[23] *See id.* at 9-10.
[24] *Id.* at 10.
[25] Luwis Diya, et al., *The Relationship Between In-Hospital Mortality, Readmission Into the Intensive Care Nursing Unit and/or Operating Theatre and Nurse Staffing Levels,* J. of Advanced Nursing, 68 (5), 1073-1081, 1073 (2011).
[26] *See id.* at 1078.
[27] *See id.*
[28] *Id.* at 1079.
[29] *See* Driscoll, A., et al., *The Effect of Nurse-to-Patient Ratios on Nurse-Sensitive Patient Outcomes in Acute Specialist Units: A Systematic Review and Meta-Analysis,* European Journal of Cardiovascular Nursing, 17 (1), 6-22, 7 (2018).
[30] *See id.* at 7.

"nurse-sensitive patient outcome measures," defined as "adverse events . . . that have been sensitive to changes in nurse staffing," the authors of the study found that, for acute patients, higher nurse-to-patient staffing ratios produced fourteen percent fewer deaths. The authors prefaced their findings by noting that "[t]he notion of an optimal level of nurse staffing is somewhat controversial because there is no one size fits all approach to assessing staffing levels."

Higher Staffing Levels: Outcomes for Nurses, Patients, and Hospitals

Many studies have considered the outcomes for nurses, patients, and hospitals when nurse staffing levels are increased. The studies the Bureau reviewed were congruent in finding positive outcomes for nurses and patients when nurse-to-patient ratios are higher. A few studies suggested that, for hospitals, the outcomes of higher staffing ratios were mixed, with some cost savings and some added expenses and risks. However, the Bureau found no data on the net costs for hospitals.

Nurse Outcomes

Nurse retention issues, nurse burnout, and high turnover rates have been identified as leading contributors to national nurse shortages. Attrition rates are especially high among newly licensed nurses. A 2012 study found that roughly thirty percent of new nurses left their jobs within the nurse's first year of practice, and up to fifty-seven percent left within the second year.[31] The nurses who left their positions reported experiencing low job satisfaction, based primarily on heavy workloads and an inability to ensure patient safety.[32]

The COVID-19 pandemic highlighted and worsened the impact of overwork and understaffing.[33] In late 2020, many Hawaii nurses reported increased stress, insomnia, and depression and showed signs of post-traumatic stress disorder and burnout.[34] One in five of the Hawaii nurses surveyed said they had considered leaving the nursing workforce.[35] Job fatigue was among the top three reasons that nurses cited for considering leaving their careers.[36] A similar study on nurse shortages in Michigan found that in 2022, thirty-nine percent of the nurses surveyed planned to leave their jobs within one year.[37] Reasons cited included workplace abuse or violence, emotional exhaustion, and understaffing.[38]

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[31] *See* Renee Twibell, et al., *Why New Nurses Don't Stay and What the Evidence Says We Can Do About It,* Am Nurs Today (2012).
[32] *See id.*
[33] *See* Holly B. Fontenot, et al., *Impact of the COVID-19 Pandemic on the Hawaii Nursing Workforce: A Cross-Sectional Survey*, 81 (5) Hawaii Journal of Health & Social Welfare 119-126 (2022).
[34] *See id.* at 119.
[35] *See id.* at 125.
[36] *See id.*
[37] *See* Christopher R. Friese, et al., *Changes in Registered Nurse Employment Plans and Workplace Assessments,* JAMA Network Open (2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821342?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2024.21635.
[38] *See id.*

While nurse understaffing was exacerbated by the pandemic, nurses' dissatisfaction with their jobs appears to have been preexisting. A 2022 study published in *Nursing Outlook* noted that, while COVID-19 contributed to nurses wanting to leave their positions, the pandemic was not the root cause.[39] The authors of the study found that, even prior to the COVID-19 outbreak, forty-eight percent of the nurses surveyed in New York and Illinois reported experiencing burnout.[40] The authors argued that "[c]hronic nurse understaffing and poor work environments in hospitals that existed prior to the COVID-19 pandemic and worsened during the pandemic are major explanations for why many hospitals cannot hire and keep enough nurses even though COVID-19 hospitalizations have dropped."[41] Consequently, research has suggested that "[p]olicies that prevent chronic hospital nurse understaffing have the greatest potential to stabilize the hospital nurse workforce at levels supporting good care and clinician wellbeing."[42]

In 2022, a study published in the *Journal of Nursing Regulation* surveyed a total of 33,462 RNs working in hospitals and nursing homes concerning their workplace conditions and views on staffing policies.[43] Forty-one percent of hospital nurses and forty-four percent of nursing home nurses reported that they were experiencing burnout.[44] More than ninety-five percent of hospital nurses and ninety-two percent of nursing home nurses rated policies to improve staffing as having "very high importance."[45] Only twelve percent of all RNs surveyed agreed that they had "enough staff to get the work done."[46]

Some research suggests that higher staffing ratios can lessen nurse burnout and improve job satisfaction. A 2013 study comparing job satisfaction in California, Pennsylvania, and New Jersey found that "nurses working in hospitals with staffing levels within the parameters set by California's nurse-to-patient ratio reported lower job dissatisfaction and burnout and were less likely to leave their jobs."[47] The author noted that healthcare leaders at the observed hospitals also reported that nurse turnover decreased after the ratios were implemented.[48]

Studies suggest that improved nurse-to-patient ratios may also help reduce occupational illnesses and injuries. A 2013 study published in the *International Archives of Occupational and Environmental Health* found that California's nurse staffing mandate resulted in approximately 31.6 percent fewer workplace-related illnesses and injuries for RNs and approximately 33.6

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[39] *See* Linda H. Aiken, et al., *A Repeated Cross-Sectional Study of Nurses Immediately Before and During the COVID-19 Pandemic: Implications for Action,* 71 (1) Nursing Outlook 101903 (2023).
[40] *See id.* at 4.
[41] *Id.* at 9.
[42] *Id.* at 1.
[43] *See* Rachel French, et al., *Conditions of Nursing Practice in Hospitals and Nursing Homes Before COVID-19: Implications for Policy Action,* 13 Journal of Nursing Regulation 45-53 (April 2022).
[44] *See id.* at 47.
[45] *Id.*
[46] *Id.* at 49.
[47] Teresa Serratt, *California's Nurse-to-Patient Ratios, Part 1: 8 Years Later, What Do We Know About Nurse-Level Outcome?,* 43 (9) Journal of Nurse Administration, 475-480, 478 (2013).
[48] *See id.* at 478.

percent fewer for LPNs than would be expected without the law.[49] Related studies, cited by the authors, found that needle-stick injuries among nurses were twice as high in hospital units reported to be understaffed[50] and that repositioning and physically assisting patients without help, which may be more likely to occur in understaffed hospital units, contributed to back injuries.[51] The authors also noted that, among nurses, low job satisfaction has been found to be a strong predictor of back injuries.[52]

Patient Outcomes

Studies have demonstrated that patient outcomes improve when nurses are assigned to attend to fewer patients. Researchers have found that when nurse staffing ratios are higher, patients generally experience shorter hospital stays, fewer complications, fewer readmissions, and less risk of death. A 2021 study observing eighty-seven acute care hospitals in Illinois found that in these hospitals, the odds of a patient's in-hospital death increased by sixteen percent for each additional patient in the nurse's workload.[53] The odds of a longer hospital stay increased by five percent for every additional patient.[54] The authors concluded that if the observed hospitals had used 4:1 nurse-to-patient ratios during the one-year study period, they might have avoided 1,595 deaths.[55]

Increased staffing has been shown to significantly reduce the risk of hospital-acquired infections.[56] These include catheter-related bloodstream infections, Clostridium difficile infections (C.diff), catheter-related urinary tract infections, Methicillin-resistant S. aureus (MRSA) infections, and surgical site infections.[57]

Higher nurse staffing ratios have also been shown to increase patient satisfaction, which may, in turn, impact clinical outcomes.[58] According to one study, hospitals with higher staffing levels experienced fewer instances of verbal abuse by patients and their family members.[59] Hospitals also saw improved patient compliance with treatment plans, which can result in lower rates of urinary tract infections, improved pain management, and fewer medication errors.[60]

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[49] *See* J. Paul Leigh, et al., *California's Nurse-to-Patient Ratio Law and Occupational Injury,* 88 Int Arch Occup Environ Health, 477-484, 477 (2015).
[50] *See id.* at 478 (citing SP Clarke, et al., *Effects of Hospital Staffing and Organizational Climate on Needlestick Injuries to Nurses,* 92(7) Am J Public Health 1115-1119 (2002)).
[51] *See id.* at 478 (citing YB Yip, *A Study of Work Stress, Patient Handling Activities and the Risk of Low Back Pain Among Nurses in Hong Kong,* 36(6) J Adv Nurs 794-804 (2001)).
[52] *See id.* at 478 (citing AE Ready et al., *Fitness and Lifestyle Parameters Fail to Predict Back Injuries in Nurses,* 18(1) Can J Appl Physiol 80-90 (1993)).
[53] *See* Karen B. Lasater, et al., *Patient Outcomes and Cost Savings Associated With Hospital Safe Nurse Staffing Legislation: An Observational Study.* BMJ Open. (November 2021).
[54] *See id.*
[55] *See id.*
[56] *See* Abbey Pirie Anderson, *Patient Protection and Registered Nurse Retention: Model Legislation Addressing Inadequate Registered Nurse Staffing in Hospitals,* 25(1) Journal of Health Care Law and Policy 91-132, 105 (2022).
[57] *See id.*
[58] *See id.* at 104.
[59] *See id.*
[60] *See id.*

An article published in the *Journal of the American Geriatrics Society* suggested that nurse staffing ratios may be especially important for patients of color, who historically suffer from poorer health outcomes.[61] The data reviewed by the authors showed that older surgical patients, and specifically older black surgical patients, had higher mortality rates than similarly situated white patients.[62] The authors argued that "[a]lthough . . . all patients are adversely affected by higher patient-to-nurse ratios, older black patients are more likely than white patients to suffer unfavorable outcomes when cared for by nurses with higher workloads and patient demands."[63] The authors attributed this difference to the black patients having complex comorbidities that required closer nurse surveillance.[64]

Hospital Costs

Improved nurse staffing levels may reduce hospital readmissions, which in turn may provide some cost benefits for some hospitals. Under the Affordable Care Act's Hospital Readmissions Reduction Program, hospitals are financially penalized for certain "excess readmissions."[65] Hospitals are evaluated based on the number of readmissions during a thirty-day period for patients experiencing a heart attack, heart failure, pneumonia, hip or knee replacement, or chronic obstructive pulmonary disease.[66] If a hospital's readmission rates for these categories exceed the expected rates of readmission, as calculated by Medicare, the hospital's base inpatient payments may be reduced by up to three percent.[67]

A 2013 study published in *Health Affairs* found that hospitals having higher levels of registered nurse staffing were twenty-five percent less likely to be penalized under the Hospital Readmissions Reduction Program than similarly situated hospitals having fewer nurses.[68] The authors of the study attributed this finding to the fact that nurses are responsible for many of the evidence-based interventions that are associated with lower readmission rates.[69] These interventions include discharge preparation, complication surveillance and prevention, knowledge assessment, care coordination, and patient education.[70] The authors noted that reduced staffing can affect all of these aspects of care, stating that, "[w]hen nurses have excessive workloads . . . they cannot complete these important processes effectively, and they are more likely to leave this vital work undone because of competing priorities and a lack of staff and resources."[71]

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[61] *See* J. Margo Brooks Carthon, et al., *Nurse Staffing and Post Surgical Outcomes in Black Patients,* 60(6) J Am Geriatr Soc 1078-1084 (2012).
[62] *See id.* at 1.
[63] *Id.* at 7.
[64] *See id.*
[65] *See* American Hospital Association Factsheet, Hospital Readmissions Reduction Program, https://www.aha.org/system/files/2018-01/fs-readmissions.pdf.
[66] *See id.*
[67] *See id.*
[68] *See* Matthew D. McHugh, et al., *Hospitals with Higher Nurse Staffing Had Lower Odds of Readmissions Penalties Than Hospitals with Lower Staffing,* 32 Health Affairs 1740-1747, 1740 (2013).
[69] *See id.* at 1744.
[70] *See id.*
[71] *Id.*

However, despite savings from reduced patient readmissions, studies have found that higher staffing ratios may also increase hospitals' labor costs. A 2013 study looking at the outcome of California's staffing mandate found that hospitals' labor costs were higher after the implementation of staffing ratios.[72] In a survey of twenty-three executives from twelve California hospitals, "respondents indicated costs associated with labor such as recruitment bonuses, training for new staff, and increased use of temporary staff increased after the implementation of the staffing ratios."[73] Other studies have found that after implementing mandated staffing ratios, the operating margins for California's hospitals declined significantly.[74] The Bureau found no articles comparing the cost of implementing staffing ratios with costs saved through nurse retention, patient satisfaction, and other factors. According to the authors of one study, "the larger and so far unanswered question is whether the incremental increases in quality are worth the cost."[75]

Evaluating Outcomes: The Efficacy of State-Mandated Nurse Staffing Ratios

Because California's mandated nurse staffing ratios have been in effect since 2004, researchers have used California as a model for evaluating whether staffing ratios should be legislated in other states. However, the literature reviewed by the Bureau provided contradictory opinions on whether the California law has successfully increased nurse staffing levels. A 2007 study argued that "California's shortage has been exacerbated by [the] enactment of legislation that took effect from January 1, 2004, mandating minimum licensed nurse staffing ratios in all hospitals."[76] However, the author did not provide a source for that statement or any further analysis.

Conversely, some studies have concluded that the nurse staffing legislation has improved California's nursing workforce shortage and reduced nursing shortages experienced by individual hospitals. One study found that "[m]ost California nurses, bedside nurses as well as managers, believe the ratio legislation achieved its goals of reducing nurse workloads, improving recruitment and retention of nurses, and having a favorable impact on quality of care."[77] Citing a 2008 article by the Sacramento Business Journal, a National Nurse United publication found that "[v]acancies for RNs at Sacramento-area hospitals plummeted 69 percent since early 2004 when the ratios were first implemented," and that "[t]hroughout the state, many of California's biggest hospital systems

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[72] *See* Teresa Serratt, *California's Nurse-to-Patient Ratios, Part 2: 8 Years Later, What Do We Know About Hospital Level Outcomes?*, 43(10) Journal of Nursing Administration 549-553, 549 (2013).
[73] *Id.* at 550.
[74] *See* Barbara A. Mark, et al., *California's Minimum Nurse Staffing Legislation: Results from a Natural Experiment,* 48:2 Health Services Research 435-454, 451 (April 2013).
[75] *Id.* at 451.
[76] Linda H. Aiken, *U.S. Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency*, 42 (3) Health Services Research, 1299, 1308 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955371/pdf/hesr0042-1299.pdf
[77] Linda H. Aiken, et al., *Implications of the California Nurse Staffing Mandate for Other States*, 45 (4) Health Services Research, 904 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908200/pdf/hesr0045-0904.pdf. We note that this article was co-authored by the same author who, in 2007, found that California's legislation had exacerbated the state's nurse staffing shortage (*see* note 76). It is unclear whether the data on California's nurse staffing shortage changed significantly between 2007 and 2010 or whether there is another explanation for the author's change in position.

have seen their turnover and vacancy rates fall below 5 percent, far below the national average."[78] Additionally, the number of actively licensed registered nurses in California increased by an average of ten thousand per year, compared to under three thousand per year before the legislation, and registered nurse applications increased by sixty percent after the law was enacted.[79]

Accordingly, it appears that some evidence suggests that California's nurse staffing legislation has attracted nurses to California, forestalled early retirements, and helped to retain nurses who may have otherwise left the nursing field. However, the Bureau found no evidence definitively establishing that mandated staffing ratios are the best approach in every state.

Staffing Committees: An Alternative Approach to Mandated Staffing Ratios

As an alternative to mandating specific nurse staffing ratios, some states require healthcare facilities to form staffing committees to determine the facility's nurse staffing needs.[80] This approach has been supported by the Partners for Nurse Staffing's Nurse Staffing Task Force. The Task Force recommended that health care facilities "[e]stablish empowered professional governance committees that include direct-care nurses and have authority to create and sustain flexible staffing approaches."[81]

As currently used, most staffing committees operate on either a hospital-wide or per-unit basis.[82] In addition to determining staffing ratios or staffing levels, some committees address other issues, like nurse retention, patient safety, and workplace systems.[83] Most states mandating staffing committees specify that nurses should comprise at least fifty percent of the committees' members.[84] Most committees also include nurse managers, nurse executives, and non-nurse hospital executives.[85] Staffing committees vary in whether they are empowered to make decisions or just recommendations.[86]

One benefit of this approach for direct care nurses is that it, arguably, gives the nurses a voice in facility staffing decisions. One study found that "[p]atient outcomes . . . improve when nurses are structurally empowered to act autonomously and be involved in hospital policy and procedure formulation."[87] The study's authors called staffing committees "a compromise to improve patient outcomes while maintaining flexibility in hospital profit margins" but warned that in states with mandated staffing committees, some hospitals have failed to comply with the

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[78] *RN Staffing Ratios A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals*, National Nurses United, 14, (2023) https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1123_Ratios_Booklet_NNU.pdf.
[79] *See id.*
[80] *See* table in chapter 3.
[81] Nurse Staffing Task Force Imperatives, Recommendations, and Actions, *supra* note 16.
[82] *See* Marissa Bartmess, et al., *Original Research: A Real 'Voice' or 'Lip Service'? Experiences of Staff Nurses Who Have Served on Staffing Committees,* 124(2) American Journal of Nursing, 20-31, 23 (2024).
[83] *See id.* at 24.
[84] *See* Col. Rev. Stat. § 25-3-128 (2); Conn. Gen. Stat. § 19a-89e(c); and 210 Ill. Comp. Stat. 85/10.10(d)(1).
[85] *See* Bartmess, et al., *supra* note 82 at 23.
[86] *See id.* at 24.
[87] *See* Marissa Bartmess, et al., *Nurse Staffing Legislation: Empirical Evidence and Policy Analysis,* 56 Nursing Forum, 600-675, 670 (2021).

mandates.[88] Consequently, the authors felt that "further political intervention may be necessary after the policy is implemented."[89]

Staffing committees can also be formed through nurses' contract negotiations, rather than by state mandate. For example, in October 2024, the Hawaii Nurses' Association agreed to a new, committee-based staffing plan for nurses at Kapiolani Medical Center for Women and Children.[90] Although the plan includes unit-based and acuity-based nurse staffing ratios, the ratios are not fixed and may be adjusted by a Staffing Council.[91] The Council will comprise direct care nurses and nurse leaders, who will meet monthly to discuss nurse staffing issues and will annually review the units' nurse staffing ratios.[92] The Council will also implement a "staffing and acuity tool," to help determine nurse staffing needs.[93]

The overall success of staffing committees may depend on how the committees are implemented. In Illinois, where "Nursing Care Committees" have been legally mandated since 2007, research suggests that the committees may lack efficacy or enforcement. A survey conducted in 2022 and 2023 by the Illinois Economic Policy Institute and the Project for Middle Class Renewal at the University of Illinois found that almost forty-five percent of the Illinois nurses surveyed were unaware that the staffing committees existed.[94] Additionally, more than forty-five percent of nurses surveyed said that the committees' recommended staffing levels were used less than twenty-five percent of the time.[95] Sixty-one percent said that the committees' recommended staffing levels were not based on patients' needs.[96]

In a 2024 study published in the *American Journal of Nursing,* authors interviewed fourteen staff nurses from five states on their experiences with nurse staffing committees.[97] Based on the interviews, the authors made four recommendations to help ensure that staffing committees provided nurses with meaningful representation. First, they recommended consideration of the committee's *structure and scope*.[98] Nurses generally reported feeling like they had more autonomy and representation in unit-level staffing committees. The authors also noted that any legislation requiring the use of staffing committees should be clear on the extent of the committees' decision-making authority.[99] Some nurses interviewed expressed frustration that they could

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[88] *Id*.
[89] *Id.*
[90] *See* Hawaii Pacific Health, *We Are Moving Forward Together,* http://www.hawaiipacifichealth.org/kapiolani/hna-negotiations.
[91] *See id.*
[92] *See id.*
[93] *See id.*
[94] *See* Jessica Nye, *Unsafe Nurse-to-Patient Ratios Cited as Main Reason Many Are Leaving Field.* Clinical Advisor (Mar. 12 2024).
[95] *See id.*
[96] *See id.*
[97] The study's authors note that twelve of the nurses interviewed had served on staffing committees for one to five years, and two participants had served for six years or longer. *See* Bartmess et al., *supra* note 82 at 23. The authors do not disclose which five states the interviewed nurses were from but note that selection criteria required participants to be from one of the following states: Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, or Washington. *See id.* at 22.
[98] *See id.* at 23.
[99] *See id.* at 30.

provide input on some issues but not others, based on the hospital's interpretations of their state's mandate.[100] Second, the authors recommended consideration of the committee's *benefits to nurses and patients.*[101] Nurses reported more satisfaction with their committees' work when they were allowed to advocate for policies that would support patient safety.[102] Third, they recommended a *holistic consideration of staffing factors.*[103] Nurses argued that staffing ratios could offer a starting point but should be flexible, taking into account patient acuity, care intensity, nurses' experience level, and other factors.[104] Finally, the authors recommended that nurses' *roles and frustrations* be taken into account when structuring staffing committees.[105] Nurses serving on the committees saw themselves as unit liaisons and collaborators in developing safe nurse staffing standards.[106] They expressed frustration with "vague" staffing laws that weren't adequately enforced, unsupportive or uncompromising leadership, and the "'slow' process of change." The authors concluded that "the state laws that govern nurse staffing committees should be enforceable and evaluable, while committee practices should contribute to positive patient, nurse, and organizational outcomes; otherwise, they're just another form of paying lip service to change."[107]

Assessing Alternatives: The Efficacy of State-Mandated Nurse Staffing Committees

In the 2024 *American Journal of Nursing* study, the authors noted that "[t]here has been little quantitative research in the area of nurse staffing committees, particularly with regard to the impact of state-mandated committees on nurse, patient, and hospital system outcomes."[108] Although one study found that, after Texas mandated staffing committees in 2002, RN employment and the ratio of nurses to patients improved, the authors noted that hospitals may have hired more nurses in response to worsening patient acuity, rather than at the recommendation of staffing committees.[109] A separate, multistate study conducted in 2021 found that although staffing levels increased in states that enacted staffing committee mandates, the increases were not statistically significant, when compared with states lacking mandates.[110]

The Bureau found no literature discussing the outcomes when staffing committees are voluntarily implemented by hospitals or negotiated by nurses and collective bargaining units, instead of being mandated by the state.

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[100] *See id.* at 24.
[101] *See id.* at 25-26.
[102] *See id.* at 27-28.
[103] *See id.* at 26.
[104] *See id.*
[105] *See id.* at 27-28.
[106] *See id.* at 27-28.
[107] *Id.* at 30.
[108] *Id.* at 21.
[109] *See* Terry Jones, et al., *Texas Nurse Staffing Trends Before and After Mandated Nurse Staffing Committees.* 16(3-4) Policy Polit. Nurs. Pract. 79-96 (2015).
[110] *See* Bartmess, et al., *supra* note 82 at 21-22 (*citing* Han X, et al., *Alternative Approaches to Ensuring Adequate Nurse Staffing: The Effect of State Legislation on Hospital Nurse Staffing.* Med Care 2021; 59 (Suppl 5): S463-S470).

Workplace Management: Additional Practices That May Improve Nurse Staffing

Articles reviewed by the Bureau suggested additional practices that may help to improve nurse staffing. Some of these practices are controversial, and some are mentioned only briefly in the literature without much evidentiary support. Although this report addresses these practices as possible parts of a multi-faceted approach to improving nurse staffing, the Bureau expresses no opinion on whether the practices are effective, advisable, or feasible.

Team Nursing

"Team nursing" or "team-based care" is an approach supported by some academics and nurse advocacy groups[111] and highly criticized by others.[112] The term "team nursing" appears to be defined differently by its opponents than by its supporters. Advocates for the approach say that it involves "developing models consisting of an array of professionals such as pharmacists, respiratory therapists, virtual care nurses, and advanced practice providers, among others."[113] They argue that this approach allows front-line nurses to focus on patients who have more complex needs.[114] Opponents suggest that the model "is designed with significantly fewer RNs supervising lower-wage personnel such as nurses' aides and [LPNs] to provide most of the direct care to patients."[115] They argue that it involves "not a multidisciplinary team of professionals, which research shows enhances patient outcomes, but substitutes lower-wage workers for RNs, the effect of which is a reduction of RN care to patients."[116]

Using data on patient outcomes and nursing skill mix, a 2024 study published in *Medical Care* found that, among more than six million Medicare patients in critical care hospitals nationally, a ten percent reduction in patient care by RNs was associated with a seven percent increase in the patients' odds of in-hospital death, one percent higher odds of readmission, two percent increase in expected length of stay, and lower measures of patient satisfaction.[117] However, the American Organization for Nursing Leadership has criticized this study, arguing that it "is undermined by the authors' heavy reliance on some of their own previously published research in favor of RN staffing ratios, and underplays other factors that would influence these

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[111] *See* American Organization for Nursing Leadership. *Misleading Research Fuels Unnecessary Fears About Innovative Health Care Advancements.* June 26, 2024, https://www.aonl.org/press-releases/misleading-research-fuels-unnecessary-fears-about-innovative-health-care-advancements ; *see also* https://www.aha.org/news/blog/2024-06-26-setting-record-straight-make-believe-model-stokes-unfounded-fears-team-based-care.
[112] *See* Karen B. Lasater, et al., *Alternative Models of Nurse Staffing May Be Dangerous in High-Stakes Hospital Care.* 62:7 Medical Care, 434-440 (July 2024).
[113] American Organization for Nursing Leadership, *supra* note 111.
[114] *See id.*
[115] Lasater, et. al., *supra* note 112 at 434.
[116] *Id.*
[117] *See id.*

outcomes, such as the expertise and experience of the clinicians delivering care, patient acuity, and the organization's overall care model[.]"[118]

In the United Kingdom, where hospitals also experience nurse staffing shortages, a study examined the association between reduced RN care and patient mortality.[119] The authors noted that team nursing, including the use of greater numbers of nursing assistants, is more common in the United Kingdom than in the United States.[120] They found that "[f]or each day that a patient spent on a ward with RN staffing below the mean for that ward, the hazard of death was increased by 3%."[121] The authors concluded that "[w]hile nursing assistants also have an important part to play in maintaining the safety of hospital wards, they cannot act as substitutes for RNs. When assessing staffing requirements . . . RN and assistant hours should not be treated as equivalent."[122]

A study of hospitals in Australia similarly found that staffing requirements should not be met by substituting nurse assistants for nurses.[123] The authors of the study found "significantly higher rates of . . . failure to rescue,[124] [urinary tract infections], and falls with injury on wards that introduced nursing assistants."[125]

Reporting Requirements

Some states require hospitals to publicly report their staffing ratios for RNs, LPNs, and other nursing personnel. These requirements are intended to facilitate informed decision-making by the public and to put market pressures on understaffed hospitals.[126] However, there appears to be very little evidence that reporting laws reduce nurse staffing shortages. One 2021 study found "a very small positive association of public reporting approach laws and RN staffing," but found that it was not statistically significant.[127] The authors concluded that "for states unable or unwilling to mandate ratios, it is possible that there could be a small benefit of public reporting."[128]

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[118] American Organization for Nursing Leadership, *supra* note 111.
[119] *See* Peter Griffiths, et al., *Nurse Staffing, Nursing Assistants, and Hospital Mortality: Retrospective Longitudinal Cohort Study.* BMJ Qual Saf 2019:28, 609-617.
[120] *See id.* at 610.
[121] *Id.* at 612.
[122] *Id.* at 616.
[123] *See* Christine Duffield, et al., *Uncovering the Disconnect Between Nursing Workforce Policy Intentions, Implementation, and Outcomes: Lessons Learned from the Addition of a Nursing Assistant Role,* 20(4) Policy, Politics & Nursing Practice, 228-238 (2019).
[124] "Failure to rescue" is defined as the inability to prevent a patient's death after the patient develops a complication. *See* Agency for Healthcare Research and Quality, *Failure to Rescue,* September 7, 2019, https://psnet.ahrq.gov/primer/failure-rescue.
[125] Duffield, et al., *supra* note 123 at 232.
[126] *See* Xinxin Han, et al. *Alternative Approaches to Ensuring Adequate Nurse Staffing,* 59 Med Care S463-S470 (October 2021).
[127] *Id.* at S468.
[128] *Id.* at S469.

Another study found that a lack of consistency may limit the usefulness of public reporting. Looking at all states where public reporting is required, or is done voluntarily,[129] the authors found that "there is no standardization for how the states publicly report, nor how consumer friendly the reports may be; therefore, consumers may not have the ability to simply compare hospitals."[130] The authors argued that "although the states should be commended for attempting to provide transparency of staffing information, these data were not necessarily meaningful for a consumer who may be unknowledgeable about appropriate staffing."[131] They recommended that states wanting to enact public reporting legislation ensure that the laws require uniformity; public accessibility; and clarity, with defined terminology and no medical jargon.[132]

Pay-for-Performance Systems

A 2015 paper on the correlation between nurse staffing and patient mortality noted that, in South Korea, the government provides financial incentives for hospitals to maintain high nurse staffing ratios.[133] The hospitals are assigned a grade from one (highest) to seven (lowest), based on their nurse staffing levels.[134] South Korea's National Health Insurance pays higher fees for inpatient nursing care to hospitals with higher nurse staffing standards.[135] The authors noted that, although many hospitals in South Korea had improved their nurse staffing since the policy was implemented in 1999, almost sixty percent of the country's acute care hospitals still received the lowest grade for being understaffed.[136]

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[129] *See* Appendix B.
[130] Pamela B. de Cordova, *Public Reporting of Nurse Staffing in the United States,* 10 (3) J. Nursing Reg., 14-20 (2019). Citations are to the author's manuscript, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC6996505/pdf/nihms-1067311.pdf.
[131] *Id.* at 7.
[132] *See id.* at 8.
[133] *See* Eunhee Cho, et al., *Effects of Nurse Staffing, Work Environments, and Education on Patient Mortality: An Observational Study*, 52(2) International Journal of Nurse Studies, 535-542 (2015). Citations are to the author's manuscript, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC4286441/pdf/nihms625887.pdf.
[134] *See id.* at 7-8.
[135] *See id.* at 7.
[136] *See id.* at 7-8.

Chapter 3

EXISTING NURSING STAFFING STANDARDS AND REGULATIONS IN OTHER STATES

Introduction

Existing nursing staffing standards and regulations in other states can generally be categorized into six general types of requirements:[1]

(1) Requirements for sufficient or adequate staffing;

(2) Requirements to have one or more nurses on duty all day or for a portion of a day;[2]

(3) Requirements for a minimum nurse staffing with minimum nurse-to-patient ratios or minimum number of hours per resident per day for a nurse;[3]

(4) Requirements for a staffing committee to set a nurse-to-patient ratio, number of nurse hours per resident per day, or another similar standard;

(5) Requirements for the health care facility to publicly report nurse staffing levels; and

(6) Requirements prohibiting or limiting mandatory overtime.

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[1] This study does not discuss staffing requirements applicable to nurse assistants and other staff that are generally not a "nurse," as defined by Haw. Rev. Stat. § 457-2 (""Nurse" means a person licensed under this chapter or a person who holds a license under the laws of another state or territory of the United States that is equivalent to a license under this chapter.").

[2] Many states require that the Director of Nursing of a hospital or a comparable position be a registered nurse. *See, e.g.*, Neb. Rev. Stat. §§ 71-6018.01 and 71-6018.02 ("The Director of Nursing Services shall be a licensed registered nurse[.]") https://nebraskalegislature.gov/laws/statutes.php?statute=71-6018.01 and https://nebraskalegislature.gov/laws/statutes.php?statute=71-6018.02. Since the director or other head of nursing is generally not considered a "staff," we have not included those provisions in this report.

[3] Many states also require the availability a staff member, which may be fulfilled by a nurse or non-nurse. We have not included a summary of those requirements here since they do not specifically require at least one nurse. Similarly, we have generally not included a summary of states that require that healthcare facilities provide "nursing services," which generally means services provided by nurses and non-nurse staff. However, we have included portions of those requirements that specifically require a nurse to provide a portion of those services (*e.g.*, if a state requires twenty-four-hour nursing services with a nurse providing each patient with thirty minutes per day of services, we included the portion specifically addressing the nurse services).

Hawaii appears to apply two of the above general requirements, namely sufficient staffing and requiring a nurse on duty for all or some of the day. In Hawaii, each skilled nursing facility[4] and intermediate care facility[5] must "have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents"[6] and have "at least one registered nurse[7] at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse[8] at work on the evening and night shifts, unless otherwise determined by the department."[9]

The table below summarizes state implementation of the six nurse staffing requirements described above. A summary of each state's requirements is provided in the following sections.

	Sufficient or Adequate Staffing	Nurse on Duty	Set Nurse Ratios	Staffing Committee	Report on Staffing Levels	No Mandatory overtime
Alabama	✓	✓				
Alaska		✓				✓
Arizona	✓					
Arkansas		✓	✓			
California			✓			✓
Colorado	✓	✓		✓		
Connecticut			✓	✓		✓
Delaware			✓			
District of Columbia		✓	✓			
Florida			✓			
Georgia			✓			
Hawaii	✓	✓				
Idaho						
Illinois		✓	✓	✓	✓	✓
Indiana			✓			
Iowa		✓	✓			
Kansas		✓				
Kentucky	✓	✓				
Louisiana						
Maine						✓

[4] In Hawaii, "skilled nursing facility" means "a health facility that provides skilled nursing and related services to residents who require twenty-four hour a day medical or nursing care, or rehabilitation services, including but not limited to physical therapy, occupational therapy, and speech therapy services." Haw. Code. R. § 11-94.2-2 (2022), https://health.hawaii.gov/opppd/files/2022/10/11-94.2-2022.pdf#page=9.

[5] In Hawaii, "intermediate care facility" means "a health facility to which a physician has referred individuals who do not need twenty-four hour a day skilled nursing care but who do require the following services for appropriate care:

(A) Twenty-four hours a day assistance with the normal activities of daily living; and

(B) Care provided by licensed nursing and paramedical personnel on a regular, long-term basis."

Id.

[6] Haw. Code. R. § 11-94.2-39(a) (2022), https://health.hawaii.gov/opppd/files/2022/10/11-94.2-2022.pdf#page=37.

[7] For a discussion of registered nurses, licensed practical nurses, and advanced practice registered nurses, *see Chapter 4*.

[8] "Licensed nurse" is not defined by Hawaii statute or administrative rule, but appears to mean any individual licensed under Chapter 457, Hawaii Revised Statutes, the chapter setting forth licensure requirements for nurses.

[9] *Id.*

	Sufficient or Adequate Staffing	Nurse on Duty	Set Nurse Ratios	Staffing Committee	Report on Staffing Levels	No Mandatory overtime
Maryland			✓			✓
Massachusetts			✓		✓	✓
Michigan		✓				
Minnesota		✓			✓	✓
Mississippi		✓				
Missouri	✓	✓				✓
Montana		✓				
Nebraska	✓					
Nevada		✓		✓		
New Hampshire		✓				✓
New Jersey		✓			✓	✓
New Mexico	✓					
New York			✓	✓	✓	✓
North Carolina		✓				
North Dakota	✓					
Ohio	✓			✓		
Oklahoma		✓				
Oregon			✓			✓
Pennsylvania		✓	✓			✓
Rhode Island	✓	✓				✓
South Carolina	✓	✓				
South Dakota		✓				
Tennessee		✓				
Texas	✓	✓		✓		✓
Utah			✓			
Vermont		✓			✓	
Virginia	✓					
Washington		✓	✓	✓	✓	✓
West Virginia	✓	✓	✓			✓
Wisconsin			✓			
Wyoming		✓				
Total:	**15**	**29**	**19**	**8**	**7**	**18**

Requirements for Sufficient or Adequate Staffing

Fourteen other states require one or more types of healthcare facilities to provide sufficient, adequate, or similar nurse staffing.[10] These states generally leave the specifics of staffing levels to the discretion of the facilities. Many states also combine the requirement to have adequate staffing with the requirement to have at least one nurse on duty (discussed in the next section).

[10] In addition to state requirements, federal regulations (42 C.F.R. § 482.23(b) (2024)) require that "[t]he nursing service [at hospitals] must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed" to participate in Medicare. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.23.

- Alabama requires that:
    - Hospitals have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all patients as needed.[11]
    - Nursing facilities provide services by a sufficient number of licensed nurses in accordance with resident care plans.[12]
- Arizona requires that hospitals have "a process for obtaining sufficient nursing personnel to meet the needs of patients[.]"[13]
- Connecticut requires that chronic and convalescent nursing homes and rest homes with nursing supervision:
    - Employ sufficient nurses to provide appropriate care to patients housed in the facility 24 hours a day;[14] and
    - Have a minimum of one registered nurse on duty at all times.[15]
- Kentucky requires that health care facilities have a "staffing plan that specifies staffing levels of licensed and unlicensed personnel required to safely and consistently meet the performance and clinical outcomes-based standards as outlined in the facility's or service's quality improvement plan[.]"[16]
- Missouri requires that hospitals, ambulatory surgical centers, and abortion facilities:
    - Develop and implement a methodology that "ensures adequate nurse staffing that will meet the needs of patients";[17] and

[11] *See* Ala. Admin. Code r. 420-5-7-.11(3) (2023), https://admincode.legislature.state.al.us/administrative-code/420-5-7-.11.
[12] *See* Ala. Admin. Code r. 420-5-10-.11 (2023), https://admincode.legislature.state.al.us/administrative-code/420-5-10-.11.
[13] Ariz. Admin. Code § R9-10-203(C)(2)(d) (2021), https://apps.azsos.gov/public_services/Title_09/9-10.pdf#page=42.
[14] *See* Conn. Agencies Regs. § 19-13-D8t(m)(1) (2023), https://eregulations.ct.gov/eRegsPortal/Browse/getDocument?guid=%7bA5561062-AB9F-4B60-833E-D75A4D74023C%7d#page=15.
[15] *See* Conn. Agencies Regs. § 19-13-D8t(m)(4). (2023), https://eregulations.ct.gov/eRegsPortal/Browse/getDocument?guid=%7bA5561062-AB9F-4B60-833E-D75A4D74023C%7d#page=15.
[16] *See* Ky. Rev. Stat. Ann. § 216B.160(5) (2022), https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=52541.
[17] Mo. Rev. Stat. § 197.289 (2023), https://revisor.mo.gov/main/OneSection.aspx?section=197.289&bid=34858.

  - Have "on duty at all times a sufficient number of licensed registered nurses to provide patient care requiring the judgment and skills of a licensed registered nurse and to oversee the activities of all nursing personnel."[18]

- Nebraska requires that:

  - Skilled nursing facilities, nursing facilities, and intermediate care facilities provide sufficient nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;[19] and

  - Skilled nursing facilities and nursing facilities to use the services of a registered nurse for at least 8 consecutive hours per day, unless otherwise waived.[20]

- New Mexico requires that acute care hospitals, limited services hospitals, and special hospitals have an adequate number of professional registered nurses on duty at all times to meet the nursing care needs of the patients.[21]

- North Dakota requires that nursing facilities have sufficient qualified nursing personnel on duty at all times to meet the nursing care needs of the residents, with a minimum of:

  - One registered nurse on duty 8 consecutive hours per day, 7 days a week; and

  - One licensed nurse on duty and designated to oversee the staff 24 hours a day.[22]

- Ohio requires that:

  - Pediatric intensive care units have nursing-to-patient ratios sufficient to accommodate the acuity level and volume of patients, ranging from 1:1 to 1:3 and adjusted as needed;[23]

  - Open heart surgery service units have an appropriate number of scrub and circulating nurses, with at least one of each;[24]

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[18] *Id.*
[19] *See* 175 Neb. Admin. Code § 12-006.04(D) (2024), https://rules.nebraska.gov/rules?agencyId=37&titleId=104.
[20] *See* Neb. Rev. Stat. §§ 71-6018.01 and 71-6018.02, https://nebraskalegislature.gov/laws/statutes.php?statute=71-6018.01 and https://nebraskalegislature.gov/laws/statutes.php?statute=71-6018.02.
[21] *See* N.M. Code R. § 8.370.12.27(C)(1) (2024), https://www.srca.nm.gov/parts/title08/08.370.0012.html.
[22] *See* N.D. Admin Code 33-07-03.2-14 (2023), https://ndlegis.gov/information/acdata/pdf/33-07-03.2.pdf#page=10.
[23] *See* Ohio Admin. Code 3701-84-62(H) (2023), https://codes.ohio.gov/ohio-administrative-code/rule-3701-84-62.
[24] *See* Ohio Admin. Code 3701-84-37(C)(3) (2023), https://codes.ohio.gov/ohio-administrative-code/rule-3701-84-37.

- Cardiac surgical intensive care units "be staffed at the appropriate nurse patient ratio commensurate with the acuity of the patients and the amount of time following surgery that such care is necessary";[25] and

- Pediatric cardiovascular surgery service units have:

  - Appropriate numbers of scrub nurses or technicians and circulating nurses or technicians, with a minimum of one scrub nurse and one circulating nurse or technician alternative; and

  - An appropriate nurse-to-patient ratio commensurate with the acuity of each individual patient and the amount of time following surgery that such care will be necessary.[26]

- Rhode Island requires that nursing facilities have:

  - The necessary nursing service personnel; and

  - A registered nurse on the premises 24 hours a day.[27]

- South Carolina requires that licensed nursing homes have an adequate number of licensed nurses on duty to meet the total nursing needs of the residents.[28]

- Texas requires that nursing facilities provide a sufficient number of nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.[29] However, this requirement may be waived by the state of Texas if the facility cannot recruit appropriate personnel and satisfies various requirements to ensure patient safety and care.[30]

- Virginia requires that nursing facilities "provide qualified nurses and certified nurse aides on all shifts, 7 days per week, in sufficient number to meet the assessed nursing care needs of all residents."[31]

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[25] Ohio Admin. Code 3701-84-37(C)(4) (2023).
[26] *See* Ohio Admin. Code 3701-84-82(C)(3) and (4) (2023), https://codes.ohio.gov/ohio-administrative-code/rule-3701-84-82.
[27] *See* R.I. Gen. Laws § 23-17.5-32(a) (2021), http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.5/23-17.5-32.htm.
[28] *See* S.C. Code Ann. Regs. 61-17-605(A) (2016), https://scdhec.gov/sites/default/files/Library/Regulations/R.61-17.pdf#page=23.
[29] *See* 26 Tex. Admin. Code § 554.1001(a)(1)(A)(i) (2024), https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=554&rl=1001.
[30] *See* 26 Tex. Admin. Code § 554.1001(a)(5)(A).
[31] 12 Va. Code Ann. § 5-371-210(B) (2023), https://law.lis.virginia.gov/admincode/title12/agency5/chapter371/section210/.

- West Virginia requires that nursing homes provide "necessary care and services[.]"[32]

Requirements to Have One Nurse on Duty All Day or For a Portion of a Day

Twenty-nine states require that each healthcare facility have a nurse on duty at all times or for a particular number of hours per day. Generally, the requirement does not take into account the number of patients or residents, although some states have incremental requirements for facilities to have one additional nurse on duty for each additional block of fifty to one hundred patients.

- Alabama requires that:
    - Hospitals provide 24-hour nursing services;[33] and
    - Nursing facilities use the service of a registered nurse for at least 8 consecutive hours per day.[34]
- Alaska requires that nursing facilities:
    - Having 60 occupied beds or less:
        - For the day shift, have a registered nurse on duty 7 days a week;
        - For the evening shift, have a registered nurse on duty 5 days a week; and
        - For the night shift and the remaining 2 days of the evening shift, a licensed practical nurse must be on duty if a registered nurse is not on duty;[35]
    - Having more than 60 occupied beds:
        - For the day shift, 2 registered nurses on duty; and
        - For the evening and night shifts, 1 registered nurse on duty;[36] and

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[32] W. Va. Code R. § 64-13-8.1 (2021), https://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=54121&Format=PDF#page=39.
[33] *See* Ala. Admin. Code r. 420-5-7-.11(1) (2023), https://admincode.legislature.state.al.us/administrative-code/420-5-7-.11.
[34] *See* Ala. Admin. Code r. 420-5-10-.11(2)(a) (2023), https://admincode.legislature.state.al.us/administrative-code/420-5-10-.11.
[35] *See* Alaska Admin. Code tit. 7 § 12.275(a) (2023), https://www.akleg.gov/basis/aac.asp#7.12.275.
[36] *See* Alaska Admin. Code tit. 7 § 12.275(b).

  - That share the same building as a hospital:
    - For the day shift, a registered nurse must be on duty 7 days a week;
    - For the evening and night shifts, a licensed practical nurse must be on duty, with a registered nurse from the hospital available to make rounds at the nursing facility and be available as needed; provided that a nursing facility with 14 or fewer occupied beds may use an on-duty registered nurse from the hospital to meet the night shift nurse staffing requirement.[37]

- Arizona requires that nursing care institutions have a minimum nurse-to-resident ratio of 1 to 64.[38]
- Colorado requires that nursing care facilities:
  - Be staffed at all times with at least one registered nurse on the premises;[39] and
  - Be staffed with at least one licensed nurse in each resident care unit.[40]
- The District of Columbia requires that nursing facilities:
  - Have a licensed registered nurse or licensed practical nurse on each unit, 24 hours a day;[41] and
  - Ensure that the licensed registered nurse or licensed practical nurse has experience in geriatric, rehabilitation, psychiatric, or other appropriate nursing discipline.[42]
- Illinois requires that:
  - Skilled nursing facilities:

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[37] *See* Alaska Admin. Code tit. 7 § 12.275(c).
[38] *See* Ariz. Admin. Code § R9-10-412(B)(3) (2019), https://apps.azsos.gov/public_services/Title_09/9-10.pdf#page=93.
[39] *See* 6 Colo. Code Regs. § 1001-1:5-9.3(B) (2020), https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8836&fileName=6%20CCR%201011-1%20Chapter%2005#page=15.
[40] *See id.*
[41] *See* D.C. Mun. Regs. tit. 22, ch. B32, § 3210.1 (2011), https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_Facility_Regulations_Health_Care_Facilities_Improvement_2012.pdf#page=11.
[42] *See* D.C. Mun. Regs. tit. 22, ch. B32, § 3210.2.

        - Have at least one registered nurse on duty for 8 consecutive hours per day;[43]
        - For the other hours of the day, have a registered nurse or a licensed practical nurse on duty;[44] and
        - For each floor that houses residents, have at least one registered nurse or licensed practical nurse on duty;[45] and
    - Intermediate care facilities have at least one registered nurse or licensed practical nurse on duty at all times.[46]

- Iowa requires that nursing facilities:
    - Have a health services supervisor who is a qualified nurse;[47]
    - Having 50 beds or more, have a qualified nurse employed to relieve the health services supervisor of nursing responsibilities;[48]
    - Having less than 75 beds with a health services supervisor who is a licensed practical nurse, employ a registered nurse for consultation for at least 4 hours each week during the same duty shift as the health service supervisor;[49]
    - Having 75 beds or more, have a qualified nurse on duty 24 hours a day;[50] and
    - Provide 2.0 hours of care per day to residents who need intermediate nursing care, of which 20% must be provided by qualified nurses.[51]

- Kansas requires that nursing facilities:
    - Have a registered nurse on duty at least 8 consecutive hours per day;
    - Have a licensed nurse on duty at all times;
    - Have the same number of licensed nurses as there are nursing units; and

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[43] *See* Ill. Admin. Code tit. 77, § 300.1240(c) (2023), https://www.ilga.gov/commission/jcar/admincode/077/077003000F12400R.html.
[44] *See* Ill. Admin. Code tit. 77, § 300.1240(d).
[45] *See* Ill. Admin. Code tit. 77, § 300.1240(e).
[46] *See* Ill. Admin. Code tit. 77, § 300.1240(d).
[47] *See* Iowa Admin. Code r. 481-58.11(1)(h) (2023), https://www.legis.iowa.gov/docs/iac/rule/06-16-2021.481.58.11.pdf.
[48] *See* Iowa Admin. Code r. 481-58.11(2)(d).
[49] *See* Iowa Admin. Code r. 481-58.11(2)(j).
[50] *See* Iowa Admin. Code r. 481-58.11(2)(i).
[51] *See* Iowa Admin. Code r. 481-58.11(2)(g).

  - Have a registered nurse immediately available by telephone if a licensed practical nurse is the only licensed nurse on duty.[52]

- Kentucky requires that nursing home facilities have at least:
  - One registered nurse on duty at all times; [53] or
  - One licensed practical nurse on duty at all times while a registered nurse is on call.[54]
- Michigan requires that:
  - Nursing homes have a licensed nurse on duty at all times;[55] and
  - Psychiatric hospitals and psychiatric units of a hospital have a licensed registered nurse with a minimum of one year of psychiatric nursing experience, on duty during each work shift.[56]
- Minnesota requires that:
  - Nursing homes have:
    - A nurse on duty 8 hours per day;[57] and
    - A registered nurse on call when a registered nurse is not on duty;[58] and
  - Assisted living facilities have a registered nurse on call, 24 hours a day.[59]
- Mississippi requires that:
  - Facilities known as "personal care homes - assisted living" have a licensed nurse on the premises 8 hours per day;[60]

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[52] *See* Kan. Admin. Regs. § 28-39-154(a) (2023), https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=28-39-154.
[53] *See* 902 Ky. Admin. Regs. 20:048 § 2(10)(l) (2024), https://apps.legislature.ky.gov/law/kar/titles/902/020/048/.
[54] *See id.*
[55] *See* Mich. Comp. Laws § 333.21720a(1) (2023), https://www.legislature.mi.gov/Laws/MCL?objectName=MCL-333-21720A.
[56] *See* Mich. Admin. Code r. 330.1285(6) (2023), https://ars.apps.lara.state.mi.us/AdminCode/DownloadAdminCodeFile?FileName=454_10429_AdminCode.pdf&ReturnHTML=True.
[57] *See* Minn. R. 4658.0510, Subpart 3 (2023), https://www.revisor.mn.gov/rules/4658.0510/.
[58] *See* Minn. R. 4658.0510, Subpart 4.
[59] *See* Minn. Stat. § 144G.41, Subd. 1(13) (2023), https://www.revisor.mn.gov/statutes/cite/144G.41.
[60] *See* 15 Miss. Code R., pt. 16, subpart 1, § 47.11.4(3) (2023).

- Opioid treatment programs:
  - Have at least one full-time registered nurse for the first 100 or fewer people in the program;[61] and
  - Have enough additional nurses to provide one hour of nursing care per week for every 5 additional people more than 100 people in the program;[62] and
- Nursing facilities must have a registered nurse on duty during the day shift each day.[63]

- Missouri requires that:
  - Skilled nursing facilities:
    - For the day shift, have a registered nurse on duty; and
    - For the evening and night shifts, have:
      - A registered professional nurse on duty; or
      - A licensed practical nurse on duty with a registered nurse on call;[64]
  - Intermediate care facilities:
    - With a director of nursing who is a licensed practical nurse must have a registered nurse who is employed as a consultant for at least 4 hours per week;[65]
    - Have a licensed practical nurse or registered nurse on call at all times;[66]
    - Have a licensed practical nurse or registered nurse on duty during the day shift;[67]

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[61] *See* 24 Miss. Code R., pt. 2, § 53.2(C) (2023), https://www.sos.ms.gov/adminsearch/ACCode/00000219c.pdf#page=372.
[62] *See id.*
[63] *See* 15 Miss. Code R., pt. 16, subpart 1, § 45.4.1(2)(a) (2023).
[64] *See* Mo. Code Regs. Ann. tit. 19, § 30-85.042(35)(B) (2021), https://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-85.pdf#page=17.
[65] *See* Mo. Code Regs. Ann. tit. 19, § 30-85.042(36)(B).
[66] *See* Mo. Code Regs. Ann. tit. 19, § 30-85.042(36)(D).
[67] *See* Mo. Code Regs. Ann. tit. 19, § 30-85.042(36)(C).

- Montana requires that skilled nursing facilities:
    - Comply with the Centers for Medicare and Medicaid Services' standards and certification requirements for states and long-term care facilities under Title 42 Code of Federal Regulations, Chapter IV, Subchapter G, Part 483;[68] and
    - Provide services by a sufficient number of nurses[69] with at least one registered nurse on duty 24 hours a day, subject to waivers for facilities that:
        - Cannot recruit appropriate personnel despite reasonable efforts; or
        - Have only patients that do not require nursing services for a 48 hour period.[70]
- New Hampshire requires that nursing homes have:
    - A licensed nurse on duty 24 hours a day; and
    - A registered nurse on duty 8 hours during each 24-hour period.[71]
- New Mexico requires that:
    - Skilled nursing facilities have at least one registered nurse or licensed practical nurse on duty at all times; and
    - Intermediate care facilities have a registered nurse or licensed practical nurse during each shift.[72]

[68] *See* Mont. Admin. R. 37.106.601(1) (2023), https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/8d6002f2-7e61-46b9-a8d1-d2915232080b.
[69] *See* 42 C.F.R. § 483.35(a)(1)(i) (2024), https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.35.
[70] *See* 42 C.F.R. § 483.35(c)(1).
[71] *See* N.H. Code Admin. R. He-P 803.15(d)(1) and (2) (2019), https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-documents/sonh/he-p803-nursing-home-rules.pdf#page=28.
[72] *See* N.M. Code R. § 8.370.16.50 (2024), https://www.srca.nm.gov/parts/title08/08.370.0016.html.

- New Jersey requires that long-term care facilities:
    - Have a full-time director of nursing or nursing administrator who is a registered professional nurse;[73] and if the long-term care facility has 150 licensed beds or more, there must be an assistant director of nursing who is also a registered professional nurse;[74]
    - Having 151 licensed beds or more, a registered professional nurse must be on duty at all times;[75]
    - Provide residents at least 2.5 hours of nursing services per day by registered professional nurses, licensed practical nurses, or nurse aides, plus additional time based on additional services (e.g., an additional 1.25 hours per day if the resident uses a respirator);[76] and
    - Use registered professional nurses or licensed practical nurses to provide at least 20% of the minimum nursing service hours.[77]
- Nevada requires that skilled nursing facilities have:
    - A licensed practical nurse on duty for each shift;[78] and
    - A registered nurse on duty for at least 8 consecutive hours per day.[79]

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[73] *See* N.J. Admin. Code § 8:39-25.1(a) (2024), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=494b9d07-77ec-4b06-af70-574c50925931&nodeid=AALACQABAAAB&nodepath=%2FROOT%2FAAL%2FAALACQ%2FAALACQABA%2FAALACQABAAAB&level=4&haschildren=&populated=false&title=%C2%A7+8%3A39-25.1+Mandatory+policies+and+procedures+for+nurse+staffing&config=00JAA1YTg5OGJlYi04MTI4LTRlNjQtYTc4Yi03NTQxN2E5NmE0ZjQKAFBvZENhdGFsb2ftaXPxZTR7bRPtX1Jok9kz&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A649B-R7H1-FCCX-63PK-00008-00&ecomp=6gf5kkk&prid=4bcda7d0-bf74-437e-aa89-87be755fd6ad. A "registered professional nurse" in New Jersey is synonymous with the term "R.N." or "registered nurse." *See* N.J. Admin. Code § 10:58A-1.2 (2024) ("within the scope of practice of a licensed registered professional nurse (R.N.) . . ."), https://www.law.cornell.edu/regulations/new-jersey/N-J-A-C-10-58A-1-2.

[74] *See* N.J. Admin. Code § 8:39-25.2(d) (2024), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=44f11994-804c-4044-a9f9-254191e0a56a&pdistocdocslideraccess=true&config=00JAA1YTg5OGJlYi04MTI4LTRlNjQtYTc4Yi03NTQxN2E5NmE0ZjQKAFBvZENhdGFsb2ftaXPxZTR7bRPtX1Jok9kz&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A649B-R7H1-FCCX-63Y2-00008-00&pdcomponentid=234124&pdtocnodeidentifier=AALACQABAAAC&ecomp=h2vckkk&prid=bf810e58-35fe-4ab7-b5cd-98722d6543ee.

[75] *See* N.J. Admin. Code § 8:39-25.2(e).

[76] *See* N.J. Admin. Code § 8:39-25.2(b).

[77] *See* N.J. Admin. Code § 8:39-25.2(f).

[78] *See* Nev. Admin. Code § 449.74517(3) (2023), https://www.leg.state.nv.us/nac/nac-449.html#NAC449Sec74517.

[79] *See* Nev. Admin. Code § 449.74517(4).

- North Carolina requires that nursing facilities have:
    - At least one licensed nurse on duty for direct patient care at all times; and
    - A least one registered nurse on duty for at least 8 consecutive hours per day.[80]
- Oklahoma requires that nursing facilities and specialized facilities:
    - Have a licensed nurse on duty 24 hours a day; provided that this requirement may be waived by the Oklahoma State Department of Health if the facility demonstrates that it has been unable, despite diligent effort, to recruit licensed nurses;[81]
    - Have at least one licensed nurse on duty for 8 hours per day during the day shift;[82] and
    - With a director of nursing who is a licensed practical nurse, have a registered nurse must be on duty for at least 8 hours per week as a consultant.[83]
- Pennsylvania requires that the following have a mental health professional or psychiatric nurse as a member of the staff:
    - Children and youth partial hospitalization programs; and
    - Adult partial hospitalization programs.[84]
- Rhode Island requires that nursing facilities have a registered nurse on the premises 24 hours a day.[85]

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[80] *See* 10A N.C. Admin. Code 13D .2303(d) (2023), http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20d/subchapter%20d%20rules.html.
[81] *See* Okla. Admin. Code § 310:675-13-12(d) (2020), https://oklahoma.gov/content/dam/ok/en/osbeltca/documents/rules/osdh/oac310-ch675-nursing-and-specialized-facilities-gzt-from-oar-2020.pdf#page=76.
[82] *See* Okla. Admin. Code § 310:675-13-12(b).
[83] *See* Okla. Admin. Code § 310:675-13-12(c).
[84] *See* 55 Pa. Code § 5210.21(b) (2023), https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter5210/s5210.21.html.
[85] *See* R.I. Gen. Laws § 23-17.5-32(a) (2023), http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.5/23-17.5-32.htm.

- South Carolina requires that:
    - Licensed nursing homes:
        - With 44 or less residents per staff work area, have at least one licensed nurse per shift for each staff work area;[86]
        - With more than 44 residents per staff work area, have:
            - On the first shift, at least 2 licensed nurses; and
            - On the second and third shifts, at least one licensed nurse;[87] and
        - With residents present, have at least one registered nurse on duty in the facility or on call;[88] and
    - Hospice facilities have a nurse on duty at all times.[89]
- South Dakota requires that ambulatory surgery center facilities:
    - Have an organized nursing service under the direction of a registered nurse;[90]
    - Have at least one registered nurse on duty when a patient is in the ambulatory surgery center facility;[91]
    - When using a general anesthetic on a patient, have at least one registered nurse other than the individual administering anesthesia be available in the operating room during the surgical procedure;[92] and
    - "[M]aintain a sufficient number of nursing personnel on duty at all times to provide supervision of and nursing care for all patients."[93]

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[86] *See* S.C. Code Ann. Regs. 61-17-605(A)(2) (2016), https://scdhec.gov/sites/default/files/Library/Regulations/R.61-17.pdf#page=23.
[87] *See id.*
[88] *See* S.C. Code Ann. Regs. 61-17-605(A)(3).
[89] *See* S.C. Code Ann. Regs. 61-78-604 (2023), https://scdhec.gov/sites/default/files/Library/Regulations/R.61-78.pdf#page=17.
[90] *See* S.D. Admin. R. 44:76:06:01 (2024), https://sdlegislature.gov/Rules/Administrative/44:76:06.
[91] *See id.*
[92] *See id.*
[93] *Id.*

- Tennessee requires that:
    - Crisis stabilization unit facilities must have at least one registered nurse, nurse practitioner,[94] or physician assistant on duty at all times;[95] and
    - Nursing homes:
        - Must provide 24-hour nursing services furnished or supervised by a registered nurse;[96]
        - Have a licensed practical nurse or registered nurse on duty at all times;[97]
        - Must have adequate numbers of licensed registered nurses, licensed practical nurses, and certified nurse aides to provide nursing care to all residents as needed;[98] and
        - Must provide a minimum of 0.4 hours of licensed nursing personnel time to each resident per day.[99]

[94] In Tennessee, a nurse practitioner is a type of advanced practice registered nurse. Tenn. Code Ann. § 63-7-126, https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=5574318a-8626-4003-a1f0-ca8c09e43a4c&config=025054JABlOTJjNmIyNi0wYjI0LTRjZGEtYWE5ZC0zNGFhOWNhMjFlNDgKAFBvZENhdGFsb2cDFQ14bX2GfyBTaI9WcPX5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A560D-BHK0-R03M-R3JX-00008-00&pdcontentcomponentid=234179&pdteaserkey=sr0&pditab=allpods&ecomp=6s65kkk&earg=sr0&prid=4c230747-c86c-4cce-828a-fa9df3c3ff1f.
Nurse practitioners have the authority to prescribe certain controlled substances. Tenn. Code Ann. §§ 63-7-123, https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=4b6930a3-c5ae-4b60-bb19-31e3e09823f0&config=025054JABlOTJjNmIyNi0wYjI0LTRjZGEtYWE5ZC0zNGFhOWNhMjFlNDgKAFBvZENhdGFsb2cDFQ14bX2GfyBTaI9WcPX5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5SCV-7VM0-R03N-923H-00008-00&pdcontentcomponentid=234179&pdteaserkey=sr0&pditab=allpods&ecomp=6s65kkk&earg=sr0&prid=25f328e4-1770-4969-8af2-17d4a9966094.

[95] *See* Tenn. Comp. R. & Regs. 0940-05-18-.04 (2018), https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-18.20221201.pdf#page=2.

[96] *See* Tenn. Comp. R. & Regs. 1200-08-06-.06(4)(a) (2018), https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08-06.20181008.pdf#page=23.

[97] *See id.*

[98] *See* Tenn. Comp. R. & Regs. 1200-08-06-.06(4)(d).

[99] *See id.*

- Texas requires that nursing facilities use the services of a registered nurse 8 consecutive hours per day[100] and designate a registered nurse to serve as the director of nursing on a full-time basis, 40 hours per week.[101] However, these requirements may be waived for a Medicare skilled nursing facility that can meet certain other requirements, including if:
    - The facility is located in a rural area;
    - The supply of Medicare skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;
    - The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
    - Either:
        - The residents of the nursing facility do not require skilled nursing services for a 48-hour period; or
        - The facility has made arrangements to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.[102]
- Vermont requires that nursing homes use the services of a registered nurse for at least 8 consecutive hours per day.[103]
- Washington requires that large nonessential community providers of nursing services have a registered nurse on duty directly supervising resident care 24 hours a day.[104]

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[100] *See* 26 Tex. Admin. Code § 554.1001(a)(2)(A) (2024), https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=554&rl=1001.
[101] *See* 26 Tex. Admin. Code § 554.1001(a)(2)(B).
[102] *See* 26 Tex. Admin. Code § 554.1001(a)(6).
[103] *See* 13-110-005 Vt. Code R. § 7.13(c) (2024), https://advance.lexis.com/documentpage/teaserdocument/?pdmfid=1000516&crid=4b1dd968-a58c-46ff-9741-3dd0c52aeb9c&config=00JAA3YmIxY2M5OC0zYmJjLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKuGXoJFNHKuKZG9OqaaI&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5WS0-FPD1-FGRY-B0JK-00008-00&pddocid=urn%3AcontentItem%3A5WS0-FPD1-FGRY-B0JK-00008-00&pdcontentcomponentid=234125&pdteaserkey=h1&pditab=allpods&ecomp=6s65kkk&earg=sr0&prid=e46af32e-2220-4b8e-b0fc-8c422aef8c56.
[104] *See* Wash. Rev. Code § 74.42.360(3)(a) (2023), https://app.leg.wa.gov/rcw/default.aspx?cite=74.42.360, and Wash. Admin. Code § 388-97-1080(3) (2023), https://app.leg.wa.gov/wac/default.aspx?cite=388-97-1080.

- West Virginia requires that nursing homes have a registered nurse on duty for at least 8 consecutive hours per day.[105]

- Wyoming requires that:

    - Critical access hospitals:[106]

        - Use the services of a registered nurse for at least 8 hours per day; and

        - Schedule adequate numbers of licensed registered nurses, licensed practical nurses, certified nursing assistants, and other personnel to provide nursing care as needed;[107] and

    - Other hospitals:

        - Have nursing services at all times that are supervised by a registered nurse;[108]

        - For a special care unit that is occupied:

            - Have a nurse present at all times; and

            - Have a ratio of nurses to patients that depends on the number of patients in the unit and the type of care required;[109] and

        - For obstetric services:

            - Have a registered nurse in charge of labor, delivery room, postpartum, and nursery;[110] and

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[105] *See* W. Va. Code R. § 64-13-8.14.4 (2021), https://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=54121&Format=PDF#page=44.

[106] Very generally, "critical access hospital" is a designation for small rural hospitals located more than thirty-five miles from the nearest hospital and that provide twenty-four-hour emergency care services. The precise requirements are specified in 42 U.S.C. §1395i-4, https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1395i-4&num=0&edition=prelim. Wyoming's rules for designation of critical care hospitals may be found in 048-3 Wyo. Code R. § 3-1, et seq. (2023), https://rules.wyo.gov/DownloadFile.aspx?source_id=14825&source_type_id=81&doc_type_id=110&include_meta_data=Y&file_type=pdf&filename=14825.pdf&token=194070227161213092023225200013160139245117109170.

[107] *See* 48-61-17 Wyo. Code R. § 9 (2023), https://health.wyo.gov/wp-content/uploads/2023/03/FINAL-SOS-CH-17-21551.pdf#page=12.

[108] *See* 48-61-12 Wyo. Code R. § 16 (2023), https://health.wyo.gov/wp-content/uploads/2023/03/FINAL-SOS-CH-12-21552.pdf#page=15.

[109] *See* 48-61-12 Wyo. Code R. § 13(b)(i) (2023), https://health.wyo.gov/wp-content/uploads/2023/03/FINAL-SOS-CH-12-21552.pdf#page=13.

[110] *See* 48-61-12 Wyo. Code R. § 14(c) (2023), https://health.wyo.gov/wp-content/uploads/2023/03/FINAL-SOS-CH-12-21552.pdf#page=14.

- Have a registered nurse present in the delivery room at the time of delivery.[111]

- Nursing stations of nursing care facilities have a registered nurse or qualified licensed practical nurse on duty every day of the week.[112]

Requirements for Minimum Nurse Staffing with Minimum Nurse-to-Patient Ratios or Minimum Number of Hours Per Resident Day for a Registered Nurse

Some states require that a hospital, nursing home, or other healthcare facility have a minimum nurse-to-patient ratio. Other states specify a nurse's minimum time with a patient each hour or day. Nurse-to-patient ratios vary but are generally commensurate with the needs of the patient. For example, California requires a 1:1 nurse-to-patient ratio for critical trauma patients in the emergency department,[113] and Delaware requires that residential health facilities have a 1:30 nurse-to-patient ratio during the night shift.[114]

- Arizona requires the following minimum nurse to patient ratios:

  - 1:2 for intensive care units;[115] and

  - 1:64 for nursing care institutions.[116]

- Arkansas requires that nursing home facilities have a minimum licensed nurse-to-patient ratio as follows:

  - 1:40 during the day and evening shifts; and

  - 1:80 during the night shift.[117]

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[111] *See* 48-61-12 Wyo. Code R. § 14(d).
[112] *See* 48-3-11 Wyo. Code R. § 9(ix)(A) (2020), https://health.wyo.gov/wp-content/uploads/2020/07/FILED-RULES-17704-EFFECT-07-01-2020.pdf#page=16.
[113] *See* Cal. Code Regs. tit. 22, § 70217(a)(8) (2023), https://govt.westlaw.com/calregs/Document/IB0822FCB5B6111EC9451000D3A7C4BC3.
[114] *See* 16-11 Del. Admin. Code § 1162(e) (2023), https://delcode.delaware.gov/title16/c011/sc07/index.html.
[115] *See* Ariz. Admin. Code § 9-10-221(5)(a) (2014), https://apps.azsos.gov/public_services/Title_09/9-10.pdf#page=54.
[116] *See* Ariz. Admin. Code § 9-10-412(B)(3) (2014), https://apps.azsos.gov/public_services/Title_09/9-10.pdf#page=93.
[117] *See* 016.06.01-054 Ark. Code R. § 520.3.1 (2023), http://170.94.37.152/REGS/016.06.04-001F.pdf#page=67.

- California specifies various minimum nurse-to-patient ratios for units or locations of hospitals.[118] The minimum nurse-to-patient ratios are:
    - 1:2 for critical care units;
    - 1:2 labor and delivery suites of the perinatal service for patients in active labor;
    - 1:4 for antepartum patients who are not in active labor;
    - 1:4 for mother-baby couplets in postpartum areas of the perinatal service;
    - 1:8 for mothers with multiple births with the mother and each infant counted individually;
    - 1:6 for postpartum areas consisting of mothers only;
    - 1:3 in combined labor/delivery/postpartum areas of the perinatal service;
    - 1:4 in pediatric service units;
    - 1:2 in post-anesthesia recovery units of the anesthesia service;
    - 1:4 for patients who are receiving treatment in hospitals providing basic emergency medical services or comprehensive emergency medical services, and no fewer than 2 licensed nurses must be physically present in the emergency department when a patient is present;
    - 1:2 for critical care patients when licensed nursing staff are attending critical care patients in the emergency department;
    - 1:1 for critical trauma patients in the emergency department;
    - 1:3 in step-down units;
    - 1:4 in telemetry units;
    - 1:5 in medical/surgical care units;
    - 1:4 in specialty care units; and

[118] *See* Cal. Health & Safety Code § 1276.4(a) (2023), https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1276.4, and Cal. Code Regs. tit. 22, § 70217(a) (2023), https://govt.westlaw.com/calregs/Document/IB0822FCB5B6111EC9451000D3A7C4BC3.

- 1:6 in psychiatric units.[119]

- Connecticut requires that:
  - Chronic and convalescent nursing homes:
    - Have at least one licensed nurse on duty on each patient-occupied floor at all times;[120]
    - From the hours of 7:00 a.m. to 9:00 p.m., the number of licensed nursing personnel shall not be less than 0.47 hours per patient; and
    - From the hours of 9:00 p.m. to 7:00 a.m., the number of licensed nursing personnel shall not be less than 0.17 hours per patient;[121] and
  - Rest homes with nursing supervision:
    - Have at least one nurse's aide on duty on each patient-occupied floor at all times and intercom communication shall be available with a licensed nurse;[122]
    - From the hours of 7:00 a.m. to 9:00 p.m., the number of licensed nursing personnel shall not be less than 0.23 hours per patient; and
    - From the hours of 9:00 p.m. to 7:00 a.m., the number of licensed nursing personnel shall not be less than 0.08 hours per patient.[123]

- Delaware requires that residential health facilities have a registered nurse- or licensed practical nurse-to-patient ratio of:
  - 1:15 during the day;
  - 1:20 in the evening; and
  - 1:30 at night.[124]

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[119] *See* Cal. Code Regs. tit. 22, § 70217(a)(1) to (10) (2023), https://govt.westlaw.com/calregs/Document/IB0822FCB5B6111EC9451000D3A7C4BC3.
[120] *See* Conn. Agency Regs. § 19-13-D8t(m)(4)(A) (2023), https://eregulations.ct.gov/eRegsPortal/Browse/getDocument?guid=%7bA5561062-AB9F-4B60-833E-D75A4D74023C%7d#page=15.
[121] *See* Conn. Agency Regs. § 19-13-D8t(m)(5)(A) (2023), https://eregulations.ct.gov/eRegsPortal/Browse/getDocument?guid=%7bA5561062-AB9F-4B60-833E-D75A4D74023C%7d#page=15.
[122] *See* Conn. Agency Regs. § 19-13-D8t(m)(4)(B).
[123] *See* Conn. Agency Regs. § 19-13-D8t(m)(6)(A).
[124] *See* 16-11 Del. Admin. Code § 1162(e) (2023), https://delcode.delaware.gov/title16/c011/sc07/index.html.

- The District of Columbia requires that nursing facilities have an advanced practice registered nurse or registered nurse provide a minimum of 0.6 hours of direct nursing care to each resident daily.[125]

- Florida requires that:

    - Facilities[126] determine their own staffing needs and at a minimum provide a minimum of 1.0 hours of direct care by a licensed nurse per resident of the facility per day and a minimum ratio of one licensed nurse per 40 residents of the facility;[127]

    - Nursing home facilities with:

        - Residents under 21 years of age who require skilled care, have a licensed nursing staffing of at least 1.0 hours of direct care per resident per day;[128]

        - Residents under 21 years of age who are medically fragile, have a licensed nursing staffing of at least 1.7 hours of direct care per resident per day;[129]

        - A unit where children reside, have a registered nurse on duty in that unit at all times.[130]

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[125] *See* D.C. Mun. Regs. tit. 22 § 3211.5 (2011), https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_Facility_Regulations_Health_Care_Facilities_Improvement_2012.pdf#page=13.

[126] Fla. Stat. § 400.021(7) (2023) defines "facility" as:

> [A]ny institution, building, residence, private home, or other place, whether operated for profit or not, including a place operated by a county or municipality, which undertakes through its ownership or management to provide for a period exceeding 24-hour nursing care, personal care, or custodial care for three or more persons not related to the owner or manager by blood or marriage, who by reason of illness, physical infirmity, or advanced age require such services, but does not include any place providing care and treatment primarily for the acutely ill. A facility offering services for fewer than three persons is within the meaning of this definition if it holds itself out to the public to be an establishment which regularly provides such services.

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.021.html.

[127] *See* Fla. Stat. § 400.023(3)(b) (2023), http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.23.html.

[128] *See* Fla. Stat. § 400.023(5)(b)(1)(b).

[129] *See* Fla. Stat. § 400.023(5)(b)(2)(b).

[130] *See* Fla. Stat. § 400.023(5)(b)(2)(d).

- Georgia requires that:
    - End stage renal disease facilities provide one licensed and qualified nurse for every 12 patients receiving dialysis care;[131]
    - Assisted living communities:
        - Have a registered professional nurse or licensed practical nurse on-site to support care and oversight of the residents, as follows:
            - For communities with 1 to 30 residents, a minimum of 8 hours per week;
            - For communities with 31 to 60 residents, a minimum of 16 hours per week;
            - For communities with 61 to 90 residents, a minimum of 24 hours per week; and
            - For communities with more than 90 residents, a minimum of 40 hours per week;[132]
        - That also hold a certificate to operate a memory care center have one registered professional nurse or licensed practical nurse on-site or available in the building at all times as follows:
            - For 1 to 12 residents, a minimum of 8 hours per week;
            - For 13 to 30 residents, a minimum of 16 hours per week;
            - For 31 to 40 residents, a minimum of 24 hours per week; and
            - For memory care centers with more than 40 residents, a minimum of 40 hours per week;[133] and
    - Nursing homes:
        - Have one nurse on duty during each 8-hour shift;[134] and

[131] *See* Ga. Comp. R. & Regs. 111-8-22-.06(2)(b)(4)(i) (2023), https://rules.sos.ga.gov/GAC/111-8-22-.06.
[132] *See* Ga. Comp. R. & Regs. 111-8-63-.09(18)(c) (2023), https://rules.sos.ga.gov/GAC/111-8-63-.09.
[133] *See* Ga. Comp. R. & Regs. 111-8-63-.19(1)(c)(iv) (2023), https://rules.sos.ga.gov/GAC/111-8-63-.19.
[134] *See* Ga. Comp. R. & Regs. 111-8-56-.04(4) (2023), https://rules.sos.state.ga.us/GAC/111-8-56-.04.

        - For every 7 total nursing personnel required, the nursing home shall not employ less than one registered nurse or licensed practical nurse.[135]

- Illinois requires that each resident:
    - Requiring skilled care receive 3.8 hours of nursing and personal care per day with a minimum of:
        - At least 25% of nursing and personal care time (0.95 hours) be provided by a licensed nurse; and
        - At least 10% of nursing and personal care time (0.38 hours) be provided by a registered nurse;[136] and
    - Requiring intermediate care receive 2.5 hours of nursing and personal care per day[137] with a minimum of:
        - At least 25% of nursing and personal care time (0.625 hours) be provided by a licensed nurse; and
        - At least 10% of nursing and personal care time (0.25 hours) be provided by a registered nurse;[138]
- Indiana, subject to certain waivers, requires that comprehensive care facilities:
    - Staff enough nurses to provide 0.5 hours of licensed nurse time per resident per day, averaged over each one-week period; and
    - Use the services of a registered nurse for at least 8 consecutive hours per day.[139]
- Maine requires licensed nursing facilities:
    - To have a registered professional nurse on duty for at least 8 consecutive hours per day;[140] and
    - To have staffing on shifts as follows:

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[135] *See* Ga. Comp. R. & Regs. 111-8-56-.04(6).
[136] *See* 210 Ill. Comp. Stat. 45/3-202.05(e).
[137] *See* 210 Ill. Comp. Stat. 45/3-202.05(d)(5) (2013), https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021000450HArt%2E+III+Pt%2E+2&ActID=1225&ChapterID=21&SeqStart=11400000&SeqEnd=14700000.
[138] *See* 210 Ill. Comp. Stat. 45/3-202.05(e).
[139] *See* 410 Ind. Admin. Code 16.2-3.1-17(b) (2019), https://www.in.gov/health/files/A00162.pdf#page=46.
[140] *See* 10-144-110 Me. Code R. § 9.A.3(a) (2023), https://www.maine.gov/sos/cec/rules/10/144/ch110/14411009.doc.

- For the day shift:
    - A licensed nurse must be on duty 7 days a week; and
    - If the licensed nursing facility has more than 20 beds, the facility must have an additional licensed nurse on duty, with
        - One additional nurse for every 50 beds above the first 50 beds; and
        - One more additional licensed nurse for each multiple of 100 over the first 100 beds;[141]
- For the evening shift:
    - A licensed nurse on duty 8 hours each evening; and
    - An additional licensed nurse for each 70 beds, and
        - If the facility has over 100 beds, one of the additional licensed nurses must be a registered professional nurse;[142] and
        - For a night shift with less than 100 beds, a licensed nurse must be on duty for 8 hours with a registered professional nurse on call;[143] and
- For a night shift in a facility with 100 or more beds, a licensed nurse must be on duty for 8 hours plus an additional licensed nurse for each 100 beds, a registered professional nurse on duty, and a registered professional nurse on call.[144]

- Maryland requires that nursing homes having:
    - 1-99 residents, have 1 registered nurse;[145]
    - 100-199 residents, having 2 registered nurses;
    - 200-299 residents, having 3 registered nurses; and

[141] *See* 10-144-110 Me. Code R. § 9.A.3(b)(1).
[142] *See* 10-144-110 Me. Code R. § 9.A.3(b)(2).
[143] *See* 10-144-110 Me. Code R. § 9.A.3.b(3).
[144] *See id.*
[145] *See* Md. Code Regs. 10.07.02.19(C)(1) (2019), https://health.maryland.gov/regs/Pages/10-07-020219-5111.aspx.

- 300-399 residents, having 4 registered nurses.[146]

- Massachusetts requires that:
  - Intensive care units:
    - Develop an acuity tool[147] using an advisory committee with at least half the members being staff nurses;[148] and
    - Use that acuity tool under the restrictions that staffing will use a 1:1 or 1:2 nurse-to-patient ratio depending upon the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit for the determination;[149]
  - A registered nurse provide at least 0.508 hours of care to each resident per day in the following facilities:[150]
    - Intensive nursing and rehabilitative care facilities (Level I),[151] which must also have a nurse present 24 hours a day for each unit;[152]
    - Skilled nursing care facilities (Level II),[153] which must also have a charge nurse present 24 hours a day for each unit;[154] and
    - Supportive nursing care facilities (Level III),[155] which must also have a nurse present during the day and evening shifts.[156]

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[146] *See* Md. Code Regs. 10.07.02.19(A)(1).
[147] 958 Mass. Code Regs. 8.02 (2023) defines "Acuity Tool" as " A decision support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators (including Clinical Indicators of Patient Stability and Indicators of Staff Nurse Workload) and used in the determination of a Patient Assignment." https://www.mass.gov/doc/958-cmr-8-patient-assignment-limits-for-registered-nurses-in-intensive-care-units-in-acute-hospitals/download.
[148] *See* 958 Mass. Code Regs. 8.06(2) (2023), https://www.mass.gov/doc/958-cmr-8-patient-assignment-limits-for-registered-nurses-in-intensive-care-units-in-acute-hospitals/download#page=3.
[149] *See* Mass. Gen. Laws ch. 111, § 231 (2023), https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section231.
[150] *See* 105 Mass. Code Regs. 150.007(B)(2)(d), (3)(d), and (4)(d).
[151] *See* 105 Mass. Code Regs. 150.001 for levels of long-term care facilities or units, https://www.mass.gov/doc/105-cmr-150-standards-for-long-term-care-facilities/download#page=5.
[152] *See* 105 Mass. Code Regs. 150.007(B)(2)(c) (2023), https://www.mass.gov/doc/105-cmr-150-standards-for-long-term-care-facilities/download#page=22.
[153] *See* 105 Mass. Code Regs. 150.001 (2023) for levels of long-term care facilities or units.
[154] *See* 105 Mass. Code Regs. 150.007(B)(3)(c) (2023).
[155] *See* 105 Mass. Code Regs. 150.001 (2023) for levels of long-term care facilities or units.
[156] *See* 105 Mass. Code Regs. 150.007(B)(4)(b) (2023).

- New York requires:
    - For intensive care or critical care patients, at least one registered professional nurse for every 2 patients;[157]
    - For burn units or centers, at least one registered professional nurse for every 3 patients;[158] and
    - For nursing homes:
        - 1.1 hours of care per patient must be provided by a registered professional nurse or licensed practical nurse;[159] and
        - A registered nurse must be present for at least 8 consecutive hours per day or more, as necessary to satisfy minimum hourly staffing requirements.[160]
- Oregon requires minimum nurse-to-patient ratios as follows:
    - In emergency departments, the minimum direct care registered nurse to patient ratio shall be:
        - 1:1 for trauma patients;
        - An average of no more than 1:4 over a 12-hour shift (direct care registered nurses assigned to trauma patients may not be taken into account in determining the average ratio); and
        - 1:5 at any time;[161]
    - 1:2 in intensive care units;
    - In labor and delivery units:
        - 1:2 if the patients are not in active labor or experiencing complications; and

[157] *See* N.Y. Comp. Codes R. & Regs. tit. 10, § 405.22(a)(5) and (d)(1)(ii)(b) (2023), https://regs.health.ny.gov/content/section-40522-critical-care-and-special-care-services.
[158] *See* N.Y. Comp. Codes R. & Regs. tit. 10, § 405.22(d)(1)(ii)(c).
[159] *See* N.Y. Pub. Health Law § 2895-B(3)(b) (2022), https://www.nysenate.gov/legislation/laws/PBH/2895-B, and N.Y. Comp. Codes R. & Regs. tit. 10, § 415.13(b)(2)(ii), https://regs.health.ny.gov/content/section-41513-nursing-services.
[160] *See* N.Y. Comp. Codes R. & Regs. tit. 10, § 415.13(c) (2022).
[161] *See* Or. Rev. Stat. § 441.765(2)(a) (2023), https://www.oregonlegislature.gov/bills_laws/ors/ors441.html.

        - 1:1 if the patient is in active labor or if the patient is in any stage of labor and is experiencing complications;

    - 1:6 in postpartum, antepartum, and well-baby nurseries (counting mother and baby each as separate patients);

    - 1:8 in mother-baby units (counting mother and baby each as separate patients);

    - 1:1 in operating rooms;

    - 1:4 in oncology units;

    - 1:2 in post-anesthesia care units;

    - 1:3 in intermediate care units;

    - 1:4 in medical-surgical units;

    - 1:4 in cardiac telemetry units; and

    - 1:4 in pediatric units.[162]

- Pennsylvania requires that long-term care facilities provide:

    - A minimum of one licensed practical nurse per:

        - 25 residents during the day shift;

        - 30 residents during the evening shift; and

        - 40 residents during the overnight shift;[163] and

    - At least one registered nurse per 250 residents during all shifts.[164]

- Utah requires that:

    - Skilled nursing facilities:

        - Have a registered nurse be on duty at least 16 hours per 24-hour period to plan, assign, supervise or provide, and evaluate the nursing care needs of the residents; and

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[162] *See* Or. Rev. Stat. § 441.765(2).
[163] *See* 28 Pa. Code § 211.12(f.1)(4) (2024), https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter211/s211.12.html.
[164] *See* 28 Pa. Code § 211.12(f.1)(5).

        - Provide each resident with at least 45 minutes of nursing care by a registered nurse or licensed practical nurse per day;[165] and

    - Intermediate care facilities provide each resident with at least 36 minutes of nursing care per day from a registered nurse or licensed practical nurse.[166]

    - End-state renal disease facilities:

        - Have a nurse supervising clinical care whenever patients are receiving dialysis services;[167]

        - Have registered nurse supervising the clinical care of not more than:

            - 10 patients if arranged in an open setting; or

            - 12 patients if arranged in three pods of 4 patients;[168] and

        - Have a 1:4 minimum ratio of patients to dialysis technicians or licensed practical nurses assigned to patient clinical care;[169] and

    - Skilled-level of care nursing facilities employ a registered nurse for at least 8 consecutive hours per day.[170]

- Washington requires that pediatric transitional care services:

    - Have one registered nurse on duty at all times; and

    - Have one registered nurse or licensed practical nurse per 8 infants.[171]

- Wisconsin requires that nursing homes:

    - Have a charge nurse who is either a:

        - Professional nurse; or

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[165] *See* Utah Admin. Code r. 432-151-20(2)(b) and (7) (2022), https://adminrules.utah.gov/public/rule/R432-151/Current%20Rules?searchText=432-151-20#.
[166] *See* Utah Admin. Code r. 432-151-20(7).
[167] *See* Utah Admin. Code r. 432-650-7(3) (2021), https://adminrules.utah.gov/public/rule/R432-650/Current%20Rules?searchText=432-650-7#.
[168] *See* Utah Admin. Code r. 432-650-7(3)(a).
[169] *See* Utah Admin. Code r. 432-650-7(3)(c).
[170] *See* Utah Admin. Code r. 432-150-5(3)(d) (2023), https://adminrules.utah.gov/public/rule/R432-150/Current%20Rules?searchText=432-150-5#.
[171] *See* Wash. Rev. Code § 71.12.684(3)(a) and (b) (2023), https://app.leg.wa.gov/rcw/default.aspx?cite=71.12.684.

        - Licensed practical nurse acting under the supervision of a professional nurse or physician;[172] and

    - Have registered enough nurses or licensed practical nurses to provide:

        - For residents in need of intensive skilled nursing care, 0.65 hours per day;

        - For residents in need of skilled nursing care: 0.5 hours per day; and

        - For residents in need of intermediate or limited nursing care: 0.4 hours per day.[173]

- West Virginia requires neonatal abstinence centers:

    - Have a minimum registered professional nurse to patient ratio of 1:4; and

    - Have at least 2 licensed nurses on each shift, one of which must be a registered professional nurse.[174]

Requirements for the Establishment of a Staffing Committee

At least eight states require healthcare facilities to establish a committee to develop staffing plans for the facility, including minimum nurse-to-patient ratios. Typically, at least 50% of the committee members must be nurses providing direct care to patients, though a few states specify a higher percentage.

- Colorado requires that:

    - Hospitals use a committee to determine a master nurse staffing plan;

    - At least 60% of the committee members are nurses.

    - The master nurse staffing plan must, among other things:

        - Be recommended by at least 60% of the committee members;

        - Establish minimum staffing requirements;

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[172] *See* Wis. Stat. § 50.04(2)(b) (2023), https://docs.legis.wisconsin.gov/statutes/statutes/50/i/04.
[173] *See* Wis. Stat. § 50.04(2)(d).
[174] *See* W. Va. Code R. § 69-9-9.3.b and -9.7.d (2023), https://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=27502&Format=PDF#page=35.

- Include guidance to reduce nurse-to-patient assignments based on patient acuity; and

- Be approved by the hospital's senior nurse executives and hospital's governing body.[175]

- Connecticut requires that:

  - Hospitals establish a hospital staffing committee to assist in preparing a nurse staffing plan that includes nurse-to-patient ratios for the various care units;[176] and

  - 50% of hospital staffing committee members are registered nurses employed by the hospital whose primary responsibility is to provide direct patient care.[177]

- Illinois requires that:

  - Hospitals have a nursing care committee;

  - At least 55% of the nursing care committee members are registered professional nurses providing direct inpatient care;[178] and

  - The nursing care committee prepares a written hospital-wide staffing plan, specifying minimum staffing levels, among other things,[179] and make that plan available to the public.[180]

- Massachusetts, as discussed previously,[181] requires a committee to determine nurse-to-patient ratios in an intensive care unit, but only at a 1:1 or 1:2 ratio specified by law.[182]

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[175] *See* Colo. Rev. Stat. § 25-3-128(2) (2023), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=f07fb241-c02f-4a7e-b905-4f4095460e87&nodeid=AAZAADAABAACABI&nodepath=%2FROOT%2FAAZ%2FAAZAAD%2FAAZAADAAB%2FAAZAADAABAAC%2FAAZAADAABAACABI&level=5&haschildren=&populated=false&title=25-3-128.+Hospitals+-+nurses%2C+nurse+aides%2C+and+EMS+providers+-+staffing+requirements+-+enforcement+-+waiver+-+rules+-+definitions.&config=014FJAAyNGJkY2Y4Zi1mNjgyLTRkN2YtYmE4OS03NTYzNzYzOTg0OGEKAFBvZENhdGFsb2d592qv2Kywlf8caKqYROP5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A65TC-V483-GXF6-81B9-00008-00&ecomp=6gf59kk&prid=89803f03-86c4-4384-9bc3-baedf349b743.

[176] *See* Conn. Gen. Stat. §19a-89e(c) (2023), https://www.cga.ct.gov/current/pub/chap_368a.htm#sec_19a-89e.

[177] *See id.*

[178] *See* 210 Ill. Comp. Stat. 85/10.10(d)(1) (2023), https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K10.10.

[179] *See* 210 Ill. Comp. Stat. 85/10.10(c) and (d)(2.5).

[180] *See* 210 Ill. Comp. Stat. 85/10.10(c)(3) and (d)(4).

[181] *See* note 148, *supra*.

[182] *See* note 149, *supra*.

- Nevada requires that:
    - Hospitals having 70 or more beds, in counties with a population of 100,000 or more:
        - Establish a staffing committee[183] that adequately meets the needs of the patients, including, "[t]he number, skill mix and classification of licensed nurses required in each unit in the health care facility, which must take into account the experience of the clinical and nonclinical support staff with whom the licensed nurses collaborate, supervise or otherwise delegate assignments";[184] and
        - That the staffing committee consist of licensed nursing staff and certified nursing assistants providing direct patient care at the hospital,[185] but the law also allows the staffing committee to be established through collective bargaining instead of by the hospital;[186] and
    - Facilities for skilled nursing have a registered nurse on duty for at least 8 consecutive hours per day.[187]
- New York requires that:
    - General hospitals maintain a clinical staffing committee;[188]
    - At least 50% of the clinical staffing committee members are nurses and frontline individuals providing direct patient care;[189] and
    - The clinical staffing committee develops a clinical staffing plan that specifies staffing with ratios or a similar measure for each patient care unit and work shift, based on the needs of patients.[190]

[183] *See* Nev. Rev. Stat. § 449.242(1) (2023), https://www.leg.state.nv.us/nrs/nrs-449.html#NRS449Sec242.
[184] Nev. Rev. Stat. § 449.2421 (2023), https://www.leg.state.nv.us/nrs/nrs-449.html#NRS449Sec2421.
[185] *See* Nev. Rev. Stat. § 449.242(1)(a).
[186] *See* Nev. Rev. Stat. § 449.242(4).
[187] *See* Nev. Admin Code § 449.74517(4) (2021), https://www.leg.state.nv.us/nac/nac-449.html#NAC449Sec74517.
[188] *See* N.Y. Pub. Health Law § 2805-T(2)(a) and (c) (2021), https://www.nysenate.gov/legislation/laws/PBH/2805-T.
[189] *See id.*
[190] *See* N.Y. Pub. Health Law § 2805-T(4)(a).

- Ohio requires that:
    - Hospitals establish a hospital-wide nursing care committee[191] to recommend a nursing services staffing plan;[192] and
    - At least 50% of the hospital-wide nursing care committee members are registered nurses who provide direct patient care in the hospital.[193]
- Texas requires that:
    - Hospitals establish a committee to determine nurse staffing; and
    - At least 60% of the committee members are nurses.[194]
- Washington requires that:
    - Hospitals establish a staffing committee to create a staffing plan;[195] and
    - At least 50% of the staffing committee members are nursing staff.[196]

Requirements for Public Reporting of Nurse Staffing Levels

Eight states require some form of public reporting[197] of nurse staffing levels. These mandates generally require hospitals to report their nurse-to-patient ratios to their applicable state health department and to make their reports available to the public through either the hospital's website, the health department's website, or both. Some states require quarterly reporting, while other states require annual reporting. Supporters of public reporting argue that it allows consumers to base their healthcare decisions on hospital ratings.[198] However, one study concluded that "[i]t

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[191] *See* Ohio Rev. Code § 3727.51 (2023), https://codes.ohio.gov/ohio-revised-code/section-3727.51.
[192] *See* Ohio Rev. Code § 3727.52 (2023), https://codes.ohio.gov/ohio-revised-code/section-3727.52.
[193] *See supra* note 191.
[194] *See* Tex. Health & Safety Code Ann. §§ 257.003 and 257.004 (2023), https://statutes.capitol.texas.gov/Docs/HS/htm/HS.257.htm.
[195] *See* Wash. Rev. Code § 70.41.420 (2023), https://app.leg.wa.gov/rcw/default.aspx?cite=70.41.420.
[196] *See* Wash. Rev. Code § 70.41.420(2)(a).
[197] This section does not address public *access* to nurse staffing data through a state's equivalent freedom of information law or other applicable statute or rule. *See, e.g.,* 26 Tex. Admin. Code § 554.1001(b)(3) (2024) ("The [nursing] facility must, upon oral or written request, make copies of nurse staffing data available to the public for review at a cost not to exceed the community standard rate."). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=207303&p_tloc=9699&p_ploc=1&pg=2&p_tac=&ti=26&pt=1&ch=554&rl=1001.
[198] *See* Pamela B. de Cordova, et al., *Public Reporting of Nurse Staffing in the United States*, 10(3) J. Nursing Reg., 14-20 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6996505/pdf/nihms-1067311.pdf#page=3.

remains unclear whether consumers use nurse staffing reports when selecting a hospital and whether these data improve hospital nurse staffing."[199]

- Illinois requires that:
    - Hospitals prepare a quarterly report that includes, among other things, nursing hours per patient day, average daily census, and average daily hours worked for each clinical service area;[200]
    - Hospitals make all reports available to the public on-site; and
    - The Illinois Department of Public Health:
        - Also make the reports available to the public;[201] and
        - Summarize the report information into a report to the Illinois Legislature and publish that report on its website.[202]
- Massachusetts requires that:
    - Acute hospitals report to the Massachusetts Department of Public Health their nurse-to-patient ratios for each intensive care unit;[203] and
    - Acute hospitals also post the reports on the acute hospital's website or as specified by the Massachusetts Health Policy Commission.[204]
- Minnesota requires that:
    - The chief nursing executive or nursing designee of every reporting hospital to develop a core staffing plan;
    - Hospitals report quarterly data for actual direct patient care hours on a per-patient and per-unit basis;[205] and
    - The plan and the hours of the hospital reports be published on the Minnesota Hospital Association's website.[206]

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[199] *Id*.
[200] *See* 210 Ill. Comp. Stat. 86/25(a) (2023), https://ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2466&ChapterID=21.
[201] *See* 210 Ill. Comp. Stat. 86/25(d).
[202] *See* 210 Ill. Comp. Stat. 86/30.
[203] *See* 958 Mass. Code Regs. 8.10(1) (2015), https://www.mass.gov/doc/958-cmr-8-patient-assignment-limits-for-registered-nurses-in-intensive-care-units-in-acute-hospitals/download#page=4.
[204] *See* 958 Mass. Code Regs. 8.10(2).
[205] *See* Minn. Stat. § 144.7055 (2023), https://www.revisor.mn.gov/statutes/cite/144.7055.
[206] *See id.*

- New Jersey requires each general hospital to post information daily, in the patient care area of each unit of the hospital, and provide the same to members of the public upon request, detailing for each unit and prevailing shift:
    - The number of registered professional nurses providing direct patient care;
    - The ratio of patients to registered professional nurses;
    - The number of licensed practical nurses providing direct patient care; and
    - The ratio of patients to licensed practical nurses.[207]

- New York requires that:
    - Each quarter,[208] hospitals report nurse staffing,[209] including the number of registered and licensed practical nurses providing direct care and the ratio of patients per registered nurse providing direct care, expressed in actual numbers and terms of total hours of nursing care per patient;[210]
    - The reports specify the methods used for determining and adjusting staffing levels and patient care needs, as well as the hospital's compliance with those methods;[211] and
    - The New York State Department of Health make the information from the reports available to the public on the department's website.[212]

- Rhode Island requires that:
    - Licensed hospitals annually submit core-staffing plans to the Rhode Island Department of Health;[213] and
    - The core-staffing plan specify for each patient care unit and each shift:
        - The number of registered nurses, licensed practical nurses, and certified nursing assistants assigned to provide direct patient care; and

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[207] *See* N.J. Rev. Stat. § 26:2H-5g (2023).
[208] *See* N.Y. Pub. Health Law § 2805-T(17)(c) (2021), https://www.nysenate.gov/legislation/laws/PBH/2805-T.
[209] *See* N.Y. Pub. Health Law § 2805-T(17)(a).
[210] *See* N.Y. Pub. Health Law § 2805-T(17)(a)(i) and (ii).
[211] *See* N.Y. Pub. Health Law § 2805-T(17)(a)(v).
[212] *See* N.Y. Pub. Health Law § 2805-T(17)(c).
[213] *See* R.I. Gen. Laws. § 23-17.17-8 (2023), http://webserver.rilin.state.ri.us/Statutes/title23/23-17.17/23-17.178.HTM.

        - The average number of patients upon which such staffing levels are based.[214]

- Vermont requires that:

    - Hospitals disclose nurse staffing levels in their Hospital Report Cards;[215]

    - As part of the requirements imposed by the Vermont Department of Health, hospitals report nurse hours by registered nurses and licensed practical nurses, a patient census, and the daily nurse hours per patient day;[216] and

    - The reports be submitted at least every 3 months.[217]

- Washington requires reporting when a hospital is out of compliance with its nurse staffing plan.[218]

Requirements Prohibiting or Limiting Mandatory Overtime

Eighteen states prohibit or limit overtime hours for nurses.[219] Overtime hours are generally considered the hours worked beyond a normally scheduled shift or more than forty hours during a week. The prohibitions typically prohibit employers from requiring nurses to work more than twelve hours per day, though some states have a higher limit (*e.g.*, Massachusetts sets a sixteen-hour limit). Common exceptions to overtime prohibitions include emergencies, surgery completion, patient care completion, and to protect the public. The prohibitions prohibit employers from taking adverse action against a nurse who refuses to work overtime hours. Some states

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[214] *See id.*

[215] While the term "Hospital Report Card" is only used unofficially (*see infra* note 216), the reports are required to include "[v]alid, reliable, and useful information on nurse staffing, including comparisons to appropriate industry benchmarks for safety. This information may include system-centered measures such as skill mix, nursing care hours per patient day, and other system-centered measures for which reliable industry benchmarks become available." Vt. Stat. Ann. tit. 18, § 9405b(a)(4) (2023), https://legislature.vermont.gov/statutes/section/18/221/09405b.

[216] *See* Nurse Staffing Data Collection Templates, available at https://www.healthvermont.gov/stats/systems/hospital-report-cards. (Click "For Vermont hospitals" and then download "Nurse Staffing Data Collection Template: FTE based (for April 2023-March 2024)" or "Nurse Staffing Data Collection Template: Hour based (for April 2023-March 2024)").

[217] *See* Hospital Report Card Reporting Manual for the Community Hospitals, page 5, available at https://www.healthvermont.gov/sites/default/files/document/HSI-stats-HRC-Manual-for-Community-Hospital-2024.pdf, and Hospital Report Card Reporting Manual for the Psychiatric Hospitals, page 3, available at https://www.healthvermont.gov/sites/default/files/document/HSI-stats-HRC-Manual-for-Psych-Hospital-2024.pdf.

[218] *See* Wash. Rev. Code § 70.41.410(7)(b)(i) (2023), https://app.leg.wa.gov/rcw/default.aspx?cite=70.41.420. This reporting requirement takes effect in 2026.

[219] *See* Morganne Skinner, *A Guide to Mandatory Overtime for Nurses*, IntelyCare, https://www.intelycare.com/career-advice/a-guide-to-mandatory-overtime-for-nurses/, and Maura Deering, *Understanding Mandatory Overtime for Nurses: Which States Enforce Mandatory Overtime?*, NurseJournal, October 3, 2023, https://nursejournal.org/resources/mandatory-overtime-for-nurses/.

explicitly allow nurses to volunteer for overtime hours, though the remaining states that establish prohibitions do not expressly forbid nurses from volunteering for an overtime shift. Lastly, the prohibitions typically prescribe a mandatory off-duty rest period (usually eight to ten hours) before returning to work after a regularly scheduled shift or an overtime shift.

- Alaska requires that:
    - Healthcare facilities cannot require a nurse to work beyond a scheduled shift[220] or to accept an assignment of overtime that would jeopardize patient or employee safety,[221] except:
        - For nurses on duty for special events held by an educational institution;[222]
        - When volunteering on an aircraft;[223]
        - Overtime incurred for completion of a medical procedure or surgery;[224]
        - Overtime incurred due to an unforeseen emergency situation;[225]
        - Overtime incurred due to an unforeseen weather condition;[226]
        - For health care facilities located in a rural community that declare a temporary nurse staffing emergency;[227] and
        - For other limited circumstances;[228]
    - If a nurse volunteers for an overtime shift, the overtime shift generally must not exceed 14 hours,[229] except a 16-hour shift is permissible from late Fridays to early Mondays if the nurse is provided with additional pay;[230] and
    - Nurses must be given at least 10 hours off duty following a shift.[231]

[220] *See* Alaska Stat. § 18.20.400(a)(1) (2023), https://www.akleg.gov/basis/statutes.asp#18.20.400.
[221] *See* Alaska Stat. § 18.20.400(a)(2).
[222] *See* Alaska Stat. § 18.20.400(c)(1).
[223] *See* Alaska Stat. § 18.20.400(c)(2).
[224] *See* Alaska Stat. § 18.20.400(c)(3)(A).
[225] *See* Alaska Stat. § 18.20.400(c)(3)(B).
[226] *See* Alaska Stat. § 18.20.400(c)(3)(C).
[227] *See* Alaska Stat. § 18.20.400(c)(3)(D).
[228] *See* Alaska Stat. § 18.20.400(c).
[229] *See* Alaska Stat. § 18.20.400(c)(5).
[230] *See* Alaska Stat. § 18.20.400(c)(7)(B).
[231] *See* Alaska Stat. § 18.20.400(b).

- California requires that:
    - Nurses cannot be assigned to work more than 12 hours during a 24-hour period, except during a health care emergency; provided that all reasonable steps have been taken to provide required staffing and continued overtime by the nurse is necessary to provide required staffing;[232]
    - Nurses cannot be terminated for refusing to work more than 72 hours during a workweek;[233]
    - If a nurse works beyond the assigned hours, the employer must not require the nurse to work more than 16 hours in a 24-hour period;[234] and
    - Nurses be allowed to volunteer to work up to 24 hours during a 24-hour period; provided that the nurse is given at least 8 hours of off-duty time at the end of those hours worked.[235]
- Connecticut requires that:
    - Hospitals cannot require nurses work beyond a predetermined scheduled work shift,[236] except overtime incurred:
        - To complete surgery;
        - To a critical care unit when no relief nurse is available;
        - During a public health emergency;
        - During an institutional emergency; or
        - If a collective bargaining agreement specifies an alternative;[237] and
    - Nurses be allowed to volunteer or agree to work overtime hours.[238]

[232] *See* California Department of Industrial Relations, Wage Order 4-2001, Section 11040, subsection 3(B)(9) (2023), https://www.dir.ca.gov/t8/11040.html.
[233] *See* California Department of Industrial Relations, Wage Order 4-2001, Section 11040, subsection 3(L).
[234] *See* California Department of Industrial Relations, Wage Order 4-2001, Section 11040, subsection 3(B)(10).
[235] *See id.*
[236] *See* Con. Gen. Stat. § 19a-490l(b) (2023), https://www.cga.ct.gov/current/pub/chap_368v.htm#sec_19a-490l.
[237] *See* Con. Gen. Stat. § 19a-490l(c).
[238] *See* Con. Gen. Stat. § 19a-490l(b).

- Illinois requires that:
    - Overtime cannot be mandated, except during an unforeseen emergent circumstance when overtime hours are required only as a last resort;[239]
    - Mandated overtime, when allowed, not be more than 4 hours beyond an agreed-to, predetermined work shift;[240]
    - Hospitals cannot generally take adverse action against a nurse who has refused to work mandated overtime;[241] and
    - Total nurse shift hours (including overtime) be limited to a maximum of 12 consecutive hours and that the nurse must be allowed at least 8 consecutive hours of off-duty time immediately following the completion of the shift.[242]
- Maine requires that:
    - Employers cannot discipline any nurse who refuses to work more than 12 consecutive hours, except in the case of an emergent circumstance or for patient safety;[243] and
    - Any nurse who is mandated to work more than 12 consecutive hours be allowed at least 10 hours of off-duty time following the worked overtime.[244]
- Maryland prohibits employers from requiring nurses to work more than the regularly scheduled hours according to the predetermined work schedule, except for:
    - Emergencies;
    - Completing a patient's treatment or procedure;
    - When there's no replacement nurse available; or
    - Other limited circumstances.[245]

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[239] *See* 210 Ill. Comp. Stat. 85/10.9(b) (2023), https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K10.9.
[240] *See id.*
[241] *See* 210 Ill. Comp. Stat. 85/10.9(d).
[242] *See* 210 Ill. Comp. Stat. 85/10.9(c).
[243] *See* Me. Stat. tit. 26, § 603(5) (2023), https://www.mainelegislature.org/legis/statutes/26/title26sec603.html.
[244] *See id.*
[245] *See* Md. Code. Ann., Lab. & Empl., § 3-421 (2023), https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gle&section=3-421&enactments=false.

- Massachusetts requires that:
    - Hospitals cannot require a nurse to work mandatory overtime, except in the case of an emergency, where the safety of the patient requires working overtime, and when there is no reasonable alternative;[246] and
    - Nurses cannot work more than 16 consecutive hours in a 24-hour period and nurses have at least 8 hours of off-duty time following those hours worked.[247]
- Minnesota prohibits hospitals from acting against a nurse for refusing to work hours longer than a normal, 12-hour work period if, in the nurse's judgment, working the excess hours would jeopardize patient safety,[248] except during an emergency[249] or in certain types of facilities.[250]
- Missouri requires that:
    - Ambulatory surgical center policies cannot mandate nurse overtime, except:
        - When an unexpected nurse staffing shortage involves a substantial risk to patient safety;[251]
        - When an unexpected nurse staffing shortage occurs during an unforeseeable emergency;[252] or
        - As agreed upon by the nurses;[253] and
    - Nurses who are required to work more than 12 consecutive hours have the option to take at least 10 hours of time off.[254]

[246] *See* Mass. Gen. Laws ch. 111, § 226(b) (2023), https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section226.
[247] *See* Mass. Gen. Laws ch. 111, § 226(f).
[248] *See* Minn. Stat. § 181.275, subd. 1 and 2 (2023), https://www.revisor.mn.gov/statutes/cite/181.275.
[249] *See* Minn. Stat. § 181.275, subd. 3.
[250] *See* Minn. Stat. § 181.275, subd. 2.
[251] *See* Mo. Code Regs. Ann. tit. 19, § 30-30.020(1)(C)(9)(A) (2018), https://www.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-30.pdf#page=4.
[252] *See* Mo. Code Regs. Ann. tit. 19, § 30-30.020(1)(C)(9)(C).
[253] *See id.*
[254] *See* Mo. Code Regs. Ann. tit. 19, § 30-30.020(1)(C)(9)(F).

- New Hampshire requires that:
    - Nurses cannot be subject to discipline for refusing to work more than 12 consecutive hours, subject to certain exceptions involving emergencies, safety, surgery, shift changes, and collective bargaining;[255] and
    - Nurses mandated to work more than 12 consecutive hours due to an exception must have 8 consecutive hours of off-duty time immediately following the worked overtime.[256]
- New Jersey requires that:
    - Employers cannot require employees to work more than a predetermined shift, not to exceed 40 hours per week, except due to an unforeseeable emergent circumstance, which are:
        - The overtime is required only as a last resort and is not used to fill vacancies resulting from chronic short staffing;
        - The employer has exhausted reasonable efforts to obtain staffing; and
        - An emergency;[257]
    - If an employer requires an employee to work overtime due to an unforeseeable emergent circumstance, the employee must be given up to an hour to arrange for the care of the employee's minor children or elderly or disabled family members;[258] and
    - Employees be allowed to voluntarily work more than 40 hours during a week.[259]

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[255] *See* N.H. Rev. Stat. Ann. § 275:67 (2023), https://www.gencourt.state.nh.us/rsa/html/XXIII/275/275-67.htm.
[256] *See id.*
[257] *See* N.J. Admin. Code § 8:43E-8.5(a) and (b) (2024), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=834b2544-13f8-4172-9125-6ada925b0b8a&nodeid=AALADEAAJAAF&nodepath=%2FROOT%2FAAL%2FAALADE%2FAALADEAAJ%2FAALADEAAJAAF&level=4&haschildren=&populated=false&title=%C2%A7+8%3A43E-8.5+Overtime+procedures&config=00JAA1YTg5OGJlYi04MTI4LTRlNjQtYTc4Yi03NTQxN2E5NmE0ZjQKAFBvZENhdGFsb2ftaXPxZTR7bRPtX1Jok9kz&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5XKV-PWC1-JWR6-S4FX-00008-00&ecomp=6gf5kkk&prid=7b346e14-e70d-44d8-83ac-1c1e94e4f804.
[258] *See* N.J. Admin. Code § 8:43E-8.5(c).
[259] *See* N.J. Admin. Code § 8:43E-8.5(a).

- New York prohibits healthcare employers from requiring a nurse to work more than that nurse's regularly scheduled work hours,[260] except for overtime incurred:
    - Due to a disaster;
    - Due to an emergency; or
    - To complete a surgery.[261]
- Oregon requires that:
    - Hospitals cannot require nurses to work:
        - Beyond the agreed-upon and prearranged shift, regardless of the length of the shift;
        - More than 48 hours in any hospital-defined work week; or
        - More than 12 hours in a 24-hour period;[262] and
    - If a nurse works 12 hours during a 24-hour period, the nurse must be provided with 10 hours of off-duty time before working again,[263] with exceptions for:
        - Emergencies;
        - Potential harm to a patient; and
        - Unforeseen events making a replacement nurse unavailable.[264]
- Pennsylvania requires that:
    - Employers cannot require a nurse to work in excess of an agreed-to, predetermined, and regularly scheduled daily work shift,[265] except for an unforeseeable emergent circumstance;[266] and
    - An employee who is required to work more than 12 consecutive hours per workday or who volunteers to work more than 12 consecutive hours shall be

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[260] *See* N.Y. Lab. Law § 167(2)(a) (2023), https://www.nysenate.gov/legislation/laws/LAB/167.
[261] *See* N.Y. Lab. Law § 167(3).
[262] *See* Or. Rev. Stat. § 441.166(3)(a) (2024), https://oregon.public.law/statutes/ors_441.166.
[263] *See* Or. Rev. Stat. § 441.166(3)(a)(D).
[264] *See* Or. Rev. Stat. § 441.166(4) and (8).
[265] *See* 43 Pa. Stat. § 932.3(a) (2023), https://govt.westlaw.com/pac/Document/N21174AC0D91811DD93BAC2ED286859A8?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).
[266] *See* 43 Pa. Stat. § 932.3(c).

entitled to at least 10 consecutive hours of off-duty time immediately after the worked overtime, though an employee may voluntarily waive this requirement for time off.[267]

- Rhode Island requires that healthcare facilities cannot require an employee to:
    - Accept work; or
    - Work overtime in excess of an agreed-to and predetermined scheduled work shift of 8, 10, or 12 hours, with 12 hours being the maximum shift,[268] except due to unforeseeable emergent circumstances.[269]
- Texas requires that:
    - Hospitals cannot require nurses to work mandatory overtime,[270] except:
        - During a disaster;
        - During an emergency; or
        - To complete surgery;[271] and
    - Nurses be allowed to voluntarily work overtime hours.[272]
- Washington requires that:
    - Healthcare facilities cannot require employees to work overtime,[273] except for:
        - Overtime incurred due to an unforeseeable emergent circumstance;
        - Prescheduled on-call time;
        - To complete patient care; or
        - If the employer has used reasonable efforts to obtain staffing;[274] and

[267] *See* 43 Pa. Stat. § 932.3(d).
[268] *See* 23 R.I. Gen. Laws § 23-17.20-3(a) and (b) (2023), https://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.20/23-17.20-3.htm.
[269] *See* 23 R.I. Gen. Laws § 23-17.20-3(d).
[270] *See* Tex. Health & Safety Code Ann. § 258.003(a) (2023), https://statutes.capitol.texas.gov/Docs/HS/htm/HS.258.htm.
[271] *See* Tex. Health & Safety Code Ann. § 258.004(a).
[272] *See* Tex. Health & Safety Code Ann. § 258.003(b).
[273] *See* Wash. Rev. Code § 49.28.140(1) (2023), https://app.leg.wa.gov/rcw/default.aspx?cite=49.28.140.
[274] *See* Wash. Rev. Code § 49.28.140(3).

  - Nurses who accept overtime and work more than 12 hours are offered at least 8 hours of time off.[275]

- West Virginia requires that:

  - Hospitals cannot require nurses to accept an assignment of overtime hours,[276] except:

    - During an unforeseen emergent situation that jeopardizes patient safety;[277] or

    - To complete patient care;[278]

  - Shifts generally be limited to 16 hours in a 24-hour period;[279] and

  - Nurses working more than 12 hours be given at least 8 hours of time off following those hours worked.[280]

[275] *See* Wash. Rev. Code § 49.28.140(4).
[276] *See* W. Va. Code § 21-5F-3(a) (2023), https://code.wvlegislature.gov/21-5F-3.
[277] *See* W. Va. Code § 21-5F-3(b).
[278] *See* W. Va. Code § 21-5F-3(d).
[279] *See* W. Va. Code § 21-5F-3(g).
[280] *See id.*

Chapter 4

SUCCESSFUL EFFORTS TO ADDRESS THE NURSING WORKFORCE SHORTAGE

The Resolution requests the Bureau to examine and assess successful efforts in other states to address the nursing workforce shortage.

While the Bureau acknowledges that opinions may differ on whether an effort was "successful," this chapter discusses various programs that have been publicly reported and for which a report indicates that the program increased the workforce of nurses. Since nurse shortages have occurred in the United States since at least the 1930s,[1] this chapter is not intended to address every successful effort but rather to present options that policymakers may wish to consider.

Background: The Current Nursing Workforce Situation in Hawaii

To assist policymakers in considering efforts that may be applicable to Hawaii, this chapter first summarizes Hawaii's nursing workforce and barriers to increasing that workforce.

Types of Nurses in Hawaii

There are three types of nurse licenses available in Hawaii, which are granted by the State Board of Nursing to:[2]

(1) Licensed practical nurses;

(2) Registered nurses; and

(3) Advanced practice registered nurses.

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[1] "By the 1930s, much of the nursing care in the country was provided by nurses who had trained in hospital programs . . . It was during this time that one of the first nursing shortages came about." Ellen Grover, *Nursing Shortages Past and Present*, allnurses, https://allnurses.com/nursing-shortages-past-present-t743640/ (last visited Sept. 30, 2024) and "[B]y 1936, many hospitals were reporting severe shortages of nurses." *Where Did All the Nurses Go?*, Penn Nursing, https://www.nursing.upenn.edu/nhhc/workforce-issues/where-did-all-the-nurses-go/ (last visited Sept. 30, 2024).

[2] The State Board of Nursing is the entity of the State of Hawaii, Department of Commerce and Consumer Affairs, responsible for licensing licensed practical nurses, registered nurses, and advanced practice registered nurses under chapter 457, Hawaii Revised Statutes. *See* Haw. Rev. Stat. § 457-5, https://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0457/HRS_0457-0005.htm.

A licensed practical nurse license (referenced in statute as a "license to practice nursing as a licensed practical nurse"[3]) provides the holder with the right to use the title "Licensed Practical Nurse" and the abbreviation "L.P.N."[4] Of the three nurse licenses, obtaining a licensed practical nurse license requires completion of the least rigorous curriculum,[5] which typically requires two semesters and a summer session of coursework in practical nursing and non-nursing prerequisite courses.[6] Licensed practical nurses have the narrowest scope of practice and the least authority. Licensed practical nurses must practice under the supervision of a registered nurse, advanced practice registered nurse, physician, or other authorized licensed health care provider.[7] A licensed practical nurse's scope of practice includes participating in nursing care, planning for patient care, patient surveillance and monitoring, documenting care, and implementing nursing interventions and prescribed medical regimens.[8]

A registered nurse license (referenced in statute as a "license to practice nursing as a registered nurse"[9]) provides the holder with the right to use the title "Registered Nurse" and the abbreviation "R.N."[10] A registered nurse license requires the individual to obtain either a bachelor's degree in nursing[11] or an associate degree in nursing,[12] both of which are a more rigorous curriculum than that of a licensed practical nurse.[13] Registered nurses' scope of practice includes providing nursing assessment of the health status of patients, developing comprehensive patient-centered health care plans, and teaching nursing.[14]

An advanced practice registered nurse license (officially referenced in statute as "an advanced practice registered nurse license"[15] and a "license from the board [of nursing] to practice as an advanced practice registered nurse"[16]) provides the holder with the right to use the title "Advanced Practice Registered Nurse" and the abbreviation "A.P.R.N."[17] Of the three licenses, advanced practice registered nurses have the broadest scope of practice and the most authority, which includes conducting advanced assessments; ordering and interpreting diagnostic

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[3] *See* Haw. Rev. Stat. § 457-8(e), https://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0457/HRS_0457-0008.htm.
[4] *Id.*
[5] *See* Haw. Code R. § 16-89-48, https://cca.hawaii.gov/pvl/files/2013/08/HAR-89-C.pdf#page=30.
[6] *See* PN General Information and Requirements, Hawaii Community College, https://hawaii.hawaii.edu/nursing/PN-general15-16 (last visited Dec. 10, 2024).
[7] *See* NCSBN Model Rules, The National Council of State Boards of Nursing, August 2021, 2-4, https://www.ncsbn.org/public-files/21_Model_Rules.pdf#page=5, and NCSBN Model Act, The National Council of State Boards of Nursing, August 2021, 3-6, https://www.ncsbn.org/public-files/21_Model_Act.pdf#page=6, as adopted by the Board of Nursing under Haw. Code R. § 16-89-126.
[8] *See supra* note 7.
[9] *See* Haw. Rev. Stat. § 457-7(d), https://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0457/HRS_0457-0007.htm.
[10] *See id.*
[11] Typically, a four-year course of study.
[12] Typically, a two-year course of study.
[13] *See* Haw. Code R. § 16-89-10(1) and 16-89-47(d). *See also supra* note 5.
[14] *See supra* note 7.
[15] *See* Haw. Rev. Stat. § 457-8.5(a), https://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0457/HRS_0457-0008_0005.htm.
[16] *See* Haw. Rev. Stat. § 457-8.5(d).
[17] *See id.*

procedures; establishing diagnoses; and prescribing controlled substances.[18] An advanced practice registered nurse license requires the individual to complete an accredited graduate-level education program preparing the nurse for one of the four recognized advanced practice registered nurse roles[19] (commonly called an "APRN certification"[20]), which are:

(1) Nurse practitioner ("NP");[21]

(2) Certified registered nurse anesthetist ("CRNA");

(3) Certified nurse-midwife ("CNM"); and

(4) Clinical nurse specialist ("CNS").[22]

Hawaii Workforce Supply

From April 17, 2023, to June 30, 2023, (the most recent biennial renewal period for nurse licensure in Hawaii[23]), 31,795 nurses applied to renew a licensed practical nurse license, registered nurse license, advanced practice registered nurse license, or a combination of those licenses.[24] These license holders include individuals who live in Hawaii (have a primary residential address in Hawaii) and individuals who primarily live outside Hawaii. Nurses who do not live in Hawaii appear to have a limited impact on Hawaii's nursing workforce.[25]

Of the 31,795 active nurse licenses, there were 1,658 active licensed practical nurse licenses, with 1,236 of those licensed practical nurse license holders (75%) reporting a primary residential address in Hawaii.[26] An estimated 13.9% of those licensed practical nurse license

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[18] *See supra* note 7.
[19] *See* Haw. Rev. Stat. § 457-8.5(a)(4).
[20] *See* Carrie M. Oliveira, 2023 Hawai‘i Nursing Workforce Supply Statewide Data Tables by License, Hawai‘i State Center for Nursing (2023), 14, https://www.hawaiicenterfornursing.org/wp-content/uploads/2023/09/State-Data-Tables-v.Final-1.pdf#page=11.
[21] *See infra* note 40 for information on nurse practitioners.
[22] *See* Haw. Code R. § 16-89-81(a), https://cca.hawaii.gov/pvl/files/2013/08/HAR-89-C.pdf#page=39.
[23] *See* Haw. Code R. § 16-89-27 and 16-89-87(a). *See also* Board of Nursing, https://cca.hawaii.gov/pvl/boards/nursing/.
[24] *See Survey Method, 2023 Hawaii Nursing Workforce Supply*, Hawai‘i State Center for Nursing, 4-5 (2023), https://www.hawaiicenterfornursing.org/wp-content/uploads/2023/09/2023-Supply-Survey-Method.vFinal.pdf#page=4.
[25] *See* Carrie M. Oliveira, *2023 Hawai‘i Nursing Workforce Supply Report; A Biennial Survey of Hawaii's Nurses*, Hawai‘i State Center for Nursing, 4 (2023), https://www.hawaiicenterfornursing.org/wp-content/uploads/2024/04/2023HawaiiNursingWorkforceSupply.vFinal.pdf#page=12.
[26] *See id*. at 5-6. For purposes of classifying licenses, the data classified licensees by the highest nursing license held. For example, an individual holding both a licensed practical nurse license and a registered nurse license, but not an advanced practice registered nurse license, was classified as a registered nurse. *Survey Method, 2023 Hawaii Nursing Workforce Supply*, Hawai‘i State Center for Nursing, 5 (2023), https://www.hawaiicenterfornursing.org/wp-content/uploads/2023/09/2023-Supply-Survey-Method.vFinal.pdf#page=5.

holders were not working in a nursing license-relevant role,[27] resulting in an estimated 1,065 licensed practical nurse license holders employed in a nursing license-relevant role in Hawaii.[28]

Of 31,795 active nurse licenses, there were 29,639 active registered nurse licenses, with 16,454 of those registered nurse license holders (56%) reporting a primary residential address in Hawaii.[29] An estimated 11.6% of active registered nurse license holders were not working in a nursing license-relevant role, resulting in an estimated 14,545 registered nurse license holders employed in a nursing license-relevant role in Hawaii.[30]

Of 31,795 active nurse licenses, there were 2,455 active advanced practice registered nurse licenses, with 1,444 of those advanced practice registered nurse license holders (59%) reporting a primary residential address in Hawaii.[31] An estimated 8.6% of those advanced practice registered nurse license holders were not working in a nursing license-relevant role, resulting in an estimated 1,320 advanced practice registered nurse license holders employed in a nursing license-relevant role in Hawaii.[32]

Accordingly, of the total estimated population of 16,390 licensed nurses working in a nursing license-relevant role in Hawaii, 1,065 are licensed practical nurse license holders, 14,545 are registered nurse license holders, and 1,320 are advanced practice registered nurse license holders.

Hawaii Workforce Demand

Surveys by the Healthcare Association of Hawaii, covering the period of February 2022 to June 2022, identified various filled and open nurse positions.[33] The survey results were compiled in a report that also included the compiled results from the 2019 surveys.[34] Although the surveys did not represent all of Hawaii's healthcare industry,[35] the information appears to be representative of the percentage of vacancies in various healthcare positions. It also appears that the vacancy rate for licensed practical nurses and registered nurses has increased while the vacancy rate for advanced practice registered nurses has remained the same.

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[27] *See id*. at 6.
[28] *See id*.
[29] *See* Oliveira, *supra* note 25, at 26.
[30] *See id*.
[31] *See id.* at 42.
[32] *See id*.
[33] *See Hawai'i Healthcare Workforce Initiative 2022 Report*, Healthcare Association of Hawaii, 11 (2022), https://static1.squarespace.com/static/5d703ec20712890001abe61f/t/6371dd4102fbca73ff8d0539/1668406609446/HAH_HWI2022Report-111122_LR.pdf.
[34] *See id.*
[35] *See id.* at 4.

From the responsive surveys, licensed practical nurses had a total position count of 694, of which 211 positions were open (30%).[36] Compared to the 2019 survey results, the total position count of licensed practical nurses decreased (from 713 positions), but the number and percentage of open positions increased (from 144 open positions or 20%).[37]

From the responsive surveys, registered nurses had a total position count of 7,282, of which 999 positions were open (14%).[38] Compared to the 2019 survey results, the total position count decreased (from 7,351 positions), but the number and percentage of open positions increased (from 463 open positions or 6%).[39]

While the Healthcare Association of Hawaii report did not include information about all advanced practice registered nurses (the third type of nurse license), the report did include information on advanced practice registered nurses with a nurse practitioner practice specialty.[40] Eighty-five percent of advanced practice registered nurses in Hawaii have a nurse practitioner practice specialty.[41]

From the responsive surveys, nurse practitioners had a total position count of 356, of which 54 were open positions (15%).[42] Compared to the 2019 survey results, the total position count of nurse practitioners increased (from 310 positions) along with the number of open positions (from 47 open positions) but the percentage of open positions remained the same (15%).[43]

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[36] *See id.*
[37] *See id.*
[38] *See id.* at 13.
[39] *See id.*
[40] *See supra* notes 21 and 22. Additionally, as described in the Hawaii Journal of Health & Social Welfare:

> NPs [Nurse Practitioners] are advanced practice registered nurses (APRNs) who are licensed, independent practitioners. They provide primary and specialty care in all practice settings, including ambulatory, acute, and long-term care. In Hawai`i, NPs have full scope of practice authority (they assess, diagnose, and treat patients, including prescribing both controlled and uncontrolled drugs). Practicing NPs have more than six years of academic and clinical preparation that includes graduate education, national board certification, and state APRN licensure in their specialty area of NP training. This training prepares NPs to offer a high level of quality care to their patients. (citations omitted)

Laura Reichhardt & Joanne R. Loos, *Spotlight on Nursing Filling the Gap in the Primary Care Shortage: Issues and Solutions for Hawai`i's Healthy Future*, 78 Haw. J. of Health & Social Welfare 11, 349 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6847999/pdf/hjhsw7811_0349.pdf.
[41] *See* Carrie M. Oliveira, *Statewide Data Tables by License: 2023 Hawai`i Nursing Workforce Supply*, Hawai`i State Center for Nursing (2023), 14, https://www.hawaiicenterfornursing.org/wp-content/uploads/2023/09/State-Data-Tables-v.Final-1.pdf#page=11. Indicating that out of the 1,320 advance practice registered nurses, 970 have a nurse practitioner certification alone and 155 have multiple certifications with one of the certifications being a nurse practitioner certification. (970 + 155) / 1,320 = 0.85227.
[42] *Supra note* 33, at 20.
[43] *Id.*

Hawaii Supply of New Nurses

There appear to be three sources of nurses from which to draw to increase Hawaii's nursing workforce: (1) nurses who permanently relocate to Hawaii for employment, (2) travel nurses temporarily assigned to Hawaii, and (3) new graduates of nursing programs.[44] Given the nationwide nursing shortage and the higher cost of hiring travel nurses, the most sustainable means to address a nursing shortage would appear to be through increasing the number of new graduates of nursing programs.

For the 2021-2022 academic year, there were eight schools of nursing with a physical campus located in Hawaii. The academic degrees that each school offered were as follows:[45]

School Name	Academic Degree Offered					
	Licensed Practical Nurse Certificate (LPN Cert.)	**Associate Degree in Nursing (ADN)**	**Baccalaureate Degree in Nursing (BSN)**	**Master's Degree in Nursing (MSN)**	**Doctor of Nursing Practice (DNP)**	**Doctor of Philosophy on Nursing (PhD)**
Chaminade University			✓		✓	
Hawaii Community College	✓	✓				
Hawaii Pacific University			✓	✓	✓	
Kapiolani Community College	✓	✓				
Kauai Community College		✓				
University of Hawaii at Hilo			✓		✓	
University of Hawaii at Manoa			✓	✓	✓	✓
University of Hawaii Maui College	✓	✓				

[44] *See* Carrie M. Oliveira, *Hawaii State Nurse Education Capacity Report, Academic Year 2021-2022*, Hawai‘i State Center for Nursing, 15 (2023) https://www.hawaiicenterfornursing.org/wp-content/uploads/2023/12/2021-2022-Education-Capacity-Statewide-Report-v.Final-1.pdf#page=17.
[45] *Id.* at 12.

For the 2021-2022 academic year, the eight schools collectively graduated 483 pre-licensed program graduates, comprised of 32 licensed practical nurses (who then generally would have been expected to obtain a licensed practical nurse license), 139 individuals with an associate degree in nursing (who then generally would have been expected to obtain a registered nurse license), 264 individuals with a baccalaureate degree in nursing (who then generally would have been expected to obtain a registered nurse license[46]), and 48 individuals with a graduate degree in nursing (who then generally would have been expected to obtain an advanced practice registered nurse license).[47]

In addition to the pre-license graduates mentioned in the previous paragraph, the applicable schools of the eight institutions mentioned above collectively graduated 111 post-license graduates (individuals who had previously obtained a nurse license), comprised of 54 registered nurses who previously had an associate degree and graduated from a baccalaureate degree program in nursing,[48] 30 individuals who graduated from a master's degree program in nursing (who then generally would have been expected to obtain an advanced practice registered nurse license), 25 individuals who graduated with a doctor of nursing practice degree, and 2 individuals who graduated with a doctor of philosophy (PhD) in nursing degree.[49]

Unfortunately, these graduates are not sufficient in number to meet the entire demand for new nurses in Hawaii,[50] and nursing schools in Hawaii cannot simply increase enrollment.[51] The most significant issue limiting nursing school educational capacity is an insufficient number of clinical training sites, followed by difficulty filling clinical faculty positions; difficulty filling full-time faculty positions; insufficient funding, faculty, or other resources for program maintenance or development; insufficient number of preceptors for clinical training experiences; insufficient resources (*e.g.*, faculty, facilities, etc.) to provide simulated clinical experiences; and a lack of funding for new teaching faculty or raises.[52]

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[46] A registered nurse license may be obtained following completion of either a two-year associate degree program in nursing or a more rigorous four-year baccalaureate degree program in nursing. Registered nurses who have completed the more rigorous four-year baccalaureate degree program in nursing generally experience increased career and employment opportunities and higher pay compared to registered nurses who have only completed a two-year associate degree program in nursing. *ADN vs BSN: Which is Right for You?*, American Nurses Enterprise, February 9, 2024, https://www.nursingworld.org/content-hub/resources/becoming-a-nurse/adn-vs-bsn/.

[47] *See id.* at 16.

[48] *See supra* note 46.

[49] *See id.* at 19.

[50] *See id.* at 8 ("[Nursing schools in Hawaii] are unable to keep pace with the anticipated increase in employment demand for nurses.").

[51] *See* Dean Ontai, *No Room For New Nurses at UH*, Manoa Now (March 5, 2004, updated September 29, 2016), https://www.manoanow.org/no-room-for-new-nurses-at-uh/article_6bb45191-3e4d-5f2a-9af4-963a23fa01a3.html. ("[A] restricting factor [to increasing nursing school capacity] is the limited number of clinical spaces available in hospitals for students to learn in workplace settings.").

[52] *See* Oliveira, *supra* note 44, at 9 and 24.

Hawaii's limitation on expanding education capacity can be summarized by a comment from Laura Reichhardt, Director of the Hawaii State Center for Nursing,[53] during a meeting of the Working Group to Study the Feasibility and Impact of the State Adopting the Nurse Licensure Compact Pursuant to the Senate Concurrent Resolution 112, Session Laws Hawai'i 2023:

> [I]n terms of our local community, we have far more Hawai'i state residents who have completed all of their pre-nursing requirements, but there are not enough nursing educational spots in our state. We have a problem that we cannot expand our nursing educational programs enough, because we don't have enough faculty and because we don't have enough clinical sites. If we could offer education to all qualified applicants, it is likely that . . . [w]e could meet the nursing workforce demand for nursing graduates. However, you never want 100% of your workforce to be new grads, because a mixture of skill and experience contributes to patient safety. Because we continue to need experienced nurses, and our state has a shortage of nurses based on demand, that requires that we still recruit from out-of-state until we have matched demand with the current workforce plus inflow from new nursing graduates.[54]

Hawaii Legislative Efforts

Hawaii Healthcare Preceptor Tax Credit

One problem associated with a lack of clinical placement sites is a shortage of nurse preceptors, i.e., individuals currently employed as nurses who train or oversee nursing students in hospitals and other healthcare facilities. In 2018, the Hawaii State Legislature established a healthcare preceptor tax credit to encourage individuals to become preceptors who provide professional instruction, training, and supervision to students and residents seeking careers as primary care physicians and advanced practice registered nurses throughout Hawaii, with the intention of building capacity for clinical education at in-state academic programs that are nationally accredited for the training of primary care physicians, advanced practice registered nurses, and pharmacy professionals.[55] The law allows for a $1,000 tax credit for each volunteer-based supervised clinical training rotation supervised by the taxpayer, up to a maximum of $5,000 per taxpayer per taxable year.[56] The law considers 80 hours of supervisory time per year as one rotation.[57] Eligible advanced practice registered nurses, medical doctors, doctors of

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[53] For a discussion of the Hawaii State Center for Nursing, s*ee infra* notes 61 to 69.
[54] *Report on the Feasibility and Impact of the State Adopting the Nurse Licensure Compact*, University of Hawai'i System Report, 63 (2023), https://www.hawaii.edu/govrel/docs/reports/2024/scr112-slh2023_2024_nursing-licensure-compact_report.pdf.
[55] *See* Act 43, 2018 Haw. Sess. Laws 137, https://www.capitol.hawaii.gov/slh/Years/SLH2018/SLH2018_Act43.pdf.
[56] *See* Haw. Rev. Stat. § 235-110.25 (2023), https://www.capitol.hawaii.gov/hrscurrent/Vol04_Ch0201-0257/HRS0235/HRS_0235-0110_0002_0005.htm.
[57] *See id.*

osteopathy, and registered pharmacists may claim the tax credit. Of the total tax credits claimed, the credits claimed by advanced practice registered nurses were as follows:[58]

Tax Year	Number of Eligible Rotations	Total Credit	Percentage of Tax Credits Allocated to Advanced Practice Registered Nurses per Year
2019	61	$61,000	16%
2020	62	$62,000	16%
2021	75	$75,000	13%
2022	116	$116,000	18%
2023	155	$155,000	23%

While the number of advanced practice registered nurses who claimed the tax credit or performed more than one eligible rotation is unclear, the Preceptor Credit Assurance Committee[59] reported that for the 2023 taxable year, it certified a total of tax credit claims from 310 preceptors (which also included medical doctors, doctors of osteopathy, and registered pharmacists) for a total of 676 credits ($676,000).[60]

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[58] *See* Laura Reichhardt & Kelley Withy, *2023 Summary of Hawaii Preceptor Tax Credit Program*, 4 (2024), https://preceptortaxcredit.hawaii.edu/wp-content/uploads/2024/06/PCAC-Annual-report-2023-v7_clean2_FINAL.pdf#page=4.

[59] The Preceptor Credit Assurance Committee was established within the Hawaii State Department of Health to develop and implement a plan for certifying healthcare preceptor tax credits. Haw. Rev. Stat. **§** 321-2.7, https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0002_0007.htm. A separate law also requires the Preceptor Credit Assurance Committee to certify and verify healthcare preceptor tax credit claims. Haw. Rev. Stat. **§** 235-110.25, https://www.capitol.hawaii.gov/hrscurrent/Vol04_Ch0201-0257/HRS0235/HRS_0235-0110_0002_0005.htm. *See also* Preceptor Credit Assurance Committee, https://preceptortaxcredit.hawaii.edu/pcac/.

[60] *See supra* note 58*,* at l.
Similarly, Colorado, Georgia, Maryland, and South Carolina have tax credit programs for nurse preceptors. *See* Colo. Rev. Stat. § 39-22-538 (2023), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=16dcc0f0-b4b6-4b38-94a7-96b1a994e326&nodeid=ABPAACAACAABAAGACE&nodepath=%2FROOT%2FABP%2FABPAAC%2FABPAACAAC%2FABPAACAACAAB%2FABPAACAACAABAAG%2FABPAACAACAABAAGACE&level=6&haschildren=&populated=false&title=39-22-538.+Credit+for+health-care+preceptors+working+in+health+professional+shortage+areas+-+legislative+declaration+-+definitions.&config=014FJAAyNGJkY2Y4Zi1mNjgyLTRkN2YtYmE4OS03NTYzNzYzOTg0OGEKAFBvZENhdGFsb2d592qv2Kywlf8caKqYROP5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A65N7-BV53-GXF6-84MJ-00008-00&ecomp=6gf59kk&prid=fa8707d6-eb5e-4a12-8080-98a15dd71517; Ga. Code Ann. § 48-7-29.22 (2023), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=de4d11b6-edf4-4349-b97e-922480097c8d&nodeid=ABWAALAADACA&nodepath=%2FROOT%2FABW%2FABWAAL%2FABWAALAAD%2FABWAALAADACA&level=4&haschildren=&populated=false&title=48-7-29.22.+%5BRepealed+effective+December+31%2C+2026%5D+Tax+credits+for+certain+medical+preceptor+rotations.&config=00JAA1MDBlYzczZi1lYjFlLTQxMTgtYWE3OS02YTgyOGM2NWJlMDYKAFBvZENhdGFsb2feed0oM9qoQOMCSJFX5qkd&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A686X-DV33-GXF6-80RK-00008-00&ecomp=6gf59kk&prid=1d0efa14-812a-4aa2-adcf-8797b41c03de; Md. Code Ann., Tax-Gen § 10-739 (2023),

Hawaii Center for Nursing

In 2003, the Legislature established the Center for Nursing to address the inadequate supply of registered nurses in the State.[61] The functions of the Center for Nursing are to:

(1) Collect and analyze data and prepare and disseminate written reports and recommendations regarding the current and future status and trends of the nursing workforce;

(2) Conduct research on best practices and quality outcomes;

(3) Develop a plan for implementing strategies to recruit and retain nurses; and

(4) Research, analyze, and report data related to the retention of the nursing workforce.[62]

During the 2022-2023 fiscal year, the Center for Nursing conducted nursing workforce research, offered the Evidence-Based Practice and Nursing Professional Development Programs, led the development of plans to recruit and retain nurses, and led other nursing workforce initiatives.[63] Evidence-based practice programs or initiatives included a two-day workshop for nursing school faculty on evidence-based practice in healthcare and educational settings.[64] Following the workshop, the Hawai‘i Academic & Clinical Nurse Educator Workgroup was developed to discuss methods to best support nurses in transitioning their evidence-based practice knowledge and skills from academia to practice.[65] The workgroup also focused on developing a strategy to ensure that nursing leadership understood the knowledge and skills that new graduates

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https://mgaleg.maryland.gov/mgawebsite/laws/StatuteText?article=gtg&section=10-739&enactments=true; and S.C. Code Ann. § 12-6-3800 (2023), https://www.scstatehouse.gov/code/t12c006.php.
Washington State also has the Student Nurse Preceptor program under Wash. Admin. Code § 246-840-533 (2023), https://apps.leg.wa.gov/WAC/default.aspx?dispo=true&cite=246-840-533. *See also Student Nurse Preceptor*, Washington State Board of Nursing, https://nursing.wa.gov/education/student-nurse-preceptor (last visited Sept. 30, 2024). However, we were unable to locate any data on whether the program has been successful.
Instead of a tax credit, Virginia has a program that makes payments directly to the preceptor. *See Virginia Nurse Preceptor Incentive Program (NPIP) Eligibility Guidelines*, Virginia Department of Health Office of Health Equity (2024), https://www.vdh.virginia.gov/content/uploads/sites/76/2024/02/Nurse-Preceptor-Guidelines-Updated-2024-Feb_-002.pdf.

[61] *See* Act 198, 2003 Haw. Sess. Laws 451, https://www.capitol.hawaii.gov/slh/Years/SLH2003/SLH2003_Act198.pdf, codified as Haw. Rev. Stat. § 304-1404 (2023), et seq., https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-1404.htm.

[62] *See* Haw. Rev. Stat. § 304-1406 (2023), https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-1406.htm.

[63] Additional information about the functions, activities, and accomplishments of the Center for Nursing, including efforts to address the nursing workforce shortage, are available in the *Hawaii State Center for Nursing FY 2022-2023 Annual Report*, Hawaii State Center For Nursing (2023), https://www.hawaiicenterfornursing.org/wp-content/uploads/2024/03/HSCFN-Web-Updated_03252024.pdf.

[64] *See id.* at 12.

[65] *See id.*

have when entering the workforce.[66] Nursing professional development programs or initiatives included offering continuing education for nurses on the following subjects:

(1) Nurse wellbeing;

(2) Recruitment and retention in long-term care;

(3) Trends in oncology care;

(4) Suicide prevention;

(5) Strategies to support youth mental health; and

(6) New graduate nursing workforce in Hawaii.[67]

Additionally, the Hawaii State Center for Nursing leads the coordination of the Hawaii Clinical Placement Collaborative, a program to maximize the matching of nursing school students with hospitals offering suitable clinical placements.[68] The Hawaii Clinical Placement Collaborative uses the Centralized Clinical Placement System, the same software designed to ease California's nursing shortage.[69]

Hawaii Nursing Scholars Program

In 2005, the Legislature established the Nursing Scholars Program to award scholarship grants to eligible nursing students who agree to teach nursing in Hawaii after graduation.[70] The program has reported awarding only two scholarships of $8,928 each.[71] It appears that both scholarship recipients continued to teach nursing for many years following their graduation. After the 2017 repeal of the reporting requirement,[72] the University of Hawaii has not published

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[66] *See id.*
[67] *See id.* at 13-15.
[68] *See* The Hawaii Clinical Placement Collaborative, https://hawaiihcpc.com/about/ (last visited Sept. 30, 2024).
[69] *See id.*
[70] *See* Haw. Rev. Stat. § 304A-3302(d)(5)(B) (2023), https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-3302.htm. *See generally*, Act 116, 2005 Haw. Sess. Laws 305, https://www.capitol.hawaii.gov/slh/Years/SLH2005/SLH2005_Act116.pdf, codified as Haw. Rev. Stat. § 304A-3301, et. seq., https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0304A/HRS_0304A-3301.htm.
[71] *See Annual Report on Nursing Scholars Program*, University of Hawaii System (2008), https://library.lrb.hawaii.gov/cgi-bin/koha/opac-retrieve-file.pl?id=bb188eeff07a0899abbe63f588a8db8a.
[72] *See* Act 14, section 3, 2017 Haw. Sess. Laws 58, https://www.capitol.hawaii.gov/slh/Years/SLH2017/SLH2017_Act14.pdf. Among other things, Act 14 repealed Haw. Rev. Stat. § 304A-3305 (2016), which stated "The University of Hawaii shall publish a report by September 1, 2006, and every year thereafter. The report shall include information regarding the operation of the program, including: (1) The total number of students receiving nursing scholarship grants; . . . ." Testimony in support of the repeal by the University of Hawaii System stated, "The School of Nursing and Dental Hygiene has had no additional information to provide since the last report submitted in 2009 and thereby feels this reporting requirement to be obsolete." Hearing on House Bill No. 850, H.D. 2 (Haw. 2017), before the Senate Committee on Ways and Means, March 29, 2017, written testimony by the University of Hawaii System,

subsequent public reports on the program. The last report issued in 2016 states that, "[s]ince being enacted in 2005, the Nursing Scholars Program only received one year of funding in 2006. The School of Nursing and Dental Hygiene has no additional information to report since the 2009 report."[73]

Recent Efforts to Increase Nursing School Capacity

Act 74, Session Laws of Hawaii 2023[74] increased from ten students to thirty students annually, the enrollment of the Certified Nurse Aide to Practical Nurse Bridge Program at the University of Hawaii Maui College,[75] a program to educate and train certified nurse aids to become licensed practical nurses. In 2024, the Legislature appropriated additional funds to expand the program from 30 to 50 students.[76]

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https://www.capitol.hawaii.gov/sessions/Session2017/Testimony/HB850_HD2_TESTIMONY_WAM_03-29-17_.PDF.

[73] *Annual Report on Nursing Scholars Program HRS 304A-3305 (Act 116, SLH 2005)*, University of Hawaii System (2016), https://library.lrb.hawaii.gov/cgi-bin/koha/opac-retrieve-file.pl?id=22d10c23590021e79617a67551bce8ee. Annual reports for 2005 to 2015 are available at https://library.lrb.hawaii.gov/cgi-bin/koha/opac-detail.pl?biblionumber=34809.
Like Hawaii's Nursing Scholars Program, the Illinois Nurse Educator Scholarship Program awards scholarships to students who commit to teaching. *See* 110 Ill. Com. Stat. 967/15-5 et. seq., https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=011009670HArt%2E+15&ActID=2813&ChapterID=18&SeqStart=1100000&SeqEnd=1800000. Similarly, the Texas Nursing Faculty Loan Repayment Assistance Program, Maryland Nurse Support Program II, and New York Nursing Faculty Loan Forgiveness Incentive Program provide loan forgiveness and other incentives for individuals with a nursing degree who teach. *See* 19 Tex. Admin. Code § 23.186 et. seq. (2023), https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=19&pt=1&ch=23&rl=186; *About Nurse Support Program II (NSP II)*, The Maryland Nurse Support Program (2024), https://nursesupport.maryland.gov/Pages/about-nsp-ii.aspx; and *NYS Nursing Faculty Loan Forgiveness (NFLF) Incentive Program*, Higher Education Services Corporation (2024), https://www.hesc.ny.gov/find-aid-you-need/new-york-state-loan-forgiveness-programs/nys-nursing-faculty-loan-forgiveness/.

[74] *See* Act 74, 2023 Haw. Sess. Laws 174, https://www.capitol.hawaii.gov/slh/Years/SLH2023/SLH2023_Act74.pdf

[75] *See Report to the Thirty-Third Legislature State of Hawai'i 2024, Pursuant to Section 321-1.5, Hawai'i Revised Statutes, Requiring the Department of Health to Submit an Annual Report on Recommended Primary Health Care Incentives, Strategies, And Implementation*, State of Hawai'i Department of Health Health Resources Administration Family Health Services Division (2023), https://health.hawaii.gov/opppd/files/2024/03/15_2024-Primary-Care-Office-Legislative-Report.pdf. Other annual reports are available at https://library.lrb.hawaii.gov/cgi-bin/koha/opac-detail.pl?biblionumber=29894.

[76] *See* Act 89, §§ 6 and 7, 2024 Haw. Sess. Laws 221, https://www.capitol.hawaii.gov/sessions/session2024/bills/GM1190_.PDF.

Hawaii Health Corps Program and Related Loan Repayment Programs

In 2012, the Legislature established the Hawaii Health Corps Program[77] to encourage nurse practitioners and other individuals to serve in areas with a shortage of healthcare providers.[78] As part of that program, the Legislature also established the Hawaii Rural Health Care Provider Loan Repayment Program to provide loan repayments to eligible nurse practitioners and other health care providers who agree to serve five consecutive years in a county having a shortage of health care providers.[79] The program is administered by the University of Hawaii John A. Burns School of Medicine and the University of Hawaii at Manoa School of Nursing and Dental Hygiene[80] and does not have a reporting requirement. The University of Hawaii has not issued any reports on the program. However, according to information provided by the University of Hawaii John A. Burns School of Medicine, the Hawaii Rural Health Care Provider Loan Repayment Program has never received any funding.[81]

Hawaii also has loan repayment programs that are not statutorily created. The Hawaii State Loan Repayment Program was established by the State of Hawaii in 2012[82] and is funded by a federal grant.[83] Participants include nurse practitioners, registered nurses, dentists, and physicians,[84] but not licensed nurse practitioners since participants in this program are required to have completed training in an accredited graduate training program.[85] Participants must agree to work for two years at a site that provides discounts for low-income individuals, among other requirements.[86] According to information provided by the University of Hawaii John A. Burns, the Hawaii State Loan Repayment Program is currently funding loan repayments for twenty-six registered nurses for about $530,000 per year total and seven advanced practice registered nurses for about $200,000 per year total.[87]

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[77] *See* Act 187, 2012 Haw. Sess. Laws 697, https://www.capitol.hawaii.gov/slh/Years/SLH2012/SLH2012_Act187.pdf.
[78] *See* Haw. Rev. Stat. § 309H-2 (2023), https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0309H/HRS_0309H-0002.htm.
[79] *See* Haw. Rev. Stat. § 309H-3 (2023), https://www.capitol.hawaii.gov/hrscurrent/Vol05_Ch0261-0319/HRS0309H/HRS_0309H-0003.htm.
[80] *See* Haw. Rev. Stat. § 309H-2 (2023).
[81] E-mail from Kelly W. Withy, Dir. Hawaii/Pacific Basin Area Health Education Center, University of Hawaii John A. Burns School of Medicine, to Devin Choy, Research Attorney, Legislative Reference Bureau (Dec. 9, 2024, 12:32 PST) (on file with author).
[82] *See Grants to States for Loan Repayment*, TAGGS, https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=H5646787&arg_ProgOfficeCode=71 (last visited Dec. 9, 2024), click "View Award Abstract" ("The Hawaii State Loan Repayment Program was established in 2012").
[83] "The Hawaii State Loan Repayment Program (HSLRP) is funded by a federal grant to pay off educational loans for primary care and behavioral health providers who care for patients at non-profit organizations in designated Health Professional Shortage Areas of Hawaii.", *See* Hawaii State Loan Repayment Program, https://ahec.hawaii.edu/ahecsite-forhealthcareprofessionals/ahecsite-loanrepayment/ahecsite-hawaiistateloanrepayment.html (last visited Dec. 10, 2024).
[84] *See id.*
[85] *See id.*
[86] *See id.*
[87] *See supra* note 81.

Additionally, the Hawaii Executive branch and the Healthcare Association of Hawaii established the Hawaii Health Education Loan Repayment Program (known as HELP) in 2023.[88] The program was initially funded by a $30,000,000 appropriation that year.[89] Participants in the Hawaii Health Education Loan Repayment Program must agree to provide clinical care and at least 30% of the participant's patient care claims must be from public insurance.[90] According to information provided by the University of Hawaii John A. Burns School of Medicine, the Hawaii Health Education Loan Repayment Program is funding loan repayments for ninety advanced practice registered nurses for about $3,570,000 per year total and ninety-six registered nurses for about $1,860,000 per year total.[91]

Expediting the Process for Out-of-State Nurse Employment

In recent years, the Legislature has taken steps to expedite the process for out-of-state nurses to work in Hawaii. As discussed below, these improvements include expanding the eligibility of the temporary permits to work as a nurse, requiring that temporary permits be issued within ten days, expanding the temporary permit duration, and exempting nurses traveling to accompany patients who are temporarily in Hawaii.

Generally, employment as a nurse in Hawaii requires a license issued by the Board of Nursing.[92] However, an individual may temporarily practice as a licensed practical nurse or registered nurse under a temporary permit, also issued by the Board of Nursing. Until mid-2022, the issuance of temporary permits was limited to nurses licensed in another state, which excluded

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[88] *See* Gov. Green Announces $30M in Loan Repayment for Healthcare Professionals Who Serve Hawai`i, September 9, 2023, https://governor.hawaii.gov/featured/office-of-the-governor-news-release-gov-green-announces-30m-in-loan-repayment-for-healthcare-professionals-who-serve-hawaii/ (last visited Dec. 10, 2024).

[89] It appears that the funding for the Hawaii Health Education Loan Repayment Program was originally intended to supplement the federal funding for the Hawaii State Loan Repayment Program. The budget worksheets for House Bill 382, HD 1 SD3, CD1 (2023) (which later became Act 164, 2023 Haw. Sess. Laws 499) state "HAWAII STATE LOAN REPAYMENT PROGRAM (FY24: 10,000,000; FY25: 20,000,000)" and "HAWAII STATE LOAN REPAYMENT PROGRAM (FY24: 10,000,000; FY25: 20,000,000)", Legislative Budget System Budget Comparison Worksheet, 589, https://www.capitol.hawaii.gov/sessions/session2023/worksheets/HB300%20HD1%20SD1%20CD1%20Worksheets.pdf#page=589. However, it seems that instead of allocating the $30,000,000 for the Hawaii State Loan Repayment Program, the Executive branch and the Healthcare Association of Hawaii created the Hawaii Health Education Loan Repayment Program. *See supra note* 88. ("HELP builds on the decade-old, federally funded Hawai‘i State Loan Repayment Program by reaching a larger group of healthcare professionals.")

[90] *See Healthcare Education Loan Repayment Program*, John A. Burns School of Medicine, https://ahec.hawaii.edu/ahecsite-forhealthcareprofessionals/loan-repayment-help.html (last visited Dec. 9, 2024). "Public insurance" means Medicare Fee-For-Service, Medicare Advantage, Medicaid Fee-For-Service, QUEST Integration (Med-QUEST), Veterans Administration, and TRICARE. *Id.*
Similar or related loan payment or loan forgiveness programs in other jurisdictions for nurses who work in an area with a shortage of medical care include the Nurses Across New York Loan Repayment Program (officially the Nurse Loan Repayment Program) and the Iowa Mental Health Professional Loan Repayment Program. *See* N.Y. Pub. Health Law § 2807-AA (2023), https://www.nysenate.gov/legislation/laws/PBH/2807-AA, and Iowa Code § 256.225 (2023), https://www.legis.iowa.gov/docs/code/256.225.pdf.

[91] *See supra* note 81.

[92] *See supra notes* 2 to 22.

nurses licensed in a territory of the United States or a foreign country.[93] This forced individuals licensed as a licensed practical nurse or registered nurse in a territory of the United States or a foreign country to wait for licensure from the Board of Nursing before beginning employment as a nurse in Hawaii, a process that typically takes 45-60 working days (up to 90 calendar days).[94] In 2022, the Legislature broadened the scope of temporary permits to include licensed practical nurses and registered nurses licensed in a territory of the United States or foreign country,[95] which allowed those individuals to begin their employment in Hawaii sooner.

During the 2024 legislative session, the Legislature again expanded the temporary permit process to include licensed practical nurses and registered nurses who hold a multistate license, instead of nurses who only hold a license in a particular state, territory, or county.[96] The Legislature also required that temporary permits be issued within ten days of application[97] and increased the maximum duration of temporary permits from three months[98] to six months.[99] Additionally, the Legislature established a Hawaii nursing license exemption for nurses licensed in another state, a territory, or another country who accompany patients visiting Hawaii for less than two weeks.[100]

Additionally, beginning July 1, 2025, the maximum duration of a temporary permit will increase from six months to one year, and the license application process for out-of-state licensed practical nurses and registered nurses will be further streamlined by allowing those individuals to submit a single application for both a temporary permit and appropriate nurse license.[101]

Public testimony expressed support for the 2024 changes made by the Legislature. One testifier stated that "[t]he temporary permit process is instrumental for recruiting nurses from outside of Hawai‘i as well as bringing in travel nurses to maintain 24/7 care in the state at a time in which Hawai‘i is short of the number of nurses needed."[102] Other submissions of written testimony commented on the reduction in wait time between the submission of an application for

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[93] *See* Act 203, 2022 Haw. Sess. Laws 457, https://www.capitol.hawaii.gov/slh/Years/SLH2022/SLH2022_Act203.pdf. *See also* 2021 versions of Haw. Rev. Stat. §§ 457-7(b)(2) and 457-8(b)(2) (2021), https://www.capitol.hawaii.gov/hrsarchive/hrs2021/Vol10_Ch0436-0474/HRS0457/HRS_0457-0007.htm and https://www.capitol.hawaii.gov/hrsarchive/hrs2021/Vol10_Ch0436-0474/HRS0457/HRS_0457-0008.htm (which both state "[p]ending verification of a valid, unencumbered license *from another state*, a temporary permit may be issued for employment with a Hawaii employer" (emphasis added)).

[94] *See* Hearing on Senate Bill No. 63, S.D. 2, H.D. 2 (Haw. 2024), before the House Committee on Finance, March 30, 2024, written testimony by Hawaii State Center for Nursing, https://www.capitol.hawaii.gov/sessions/session2023/Testimony/SB63_HD2_TESTIMONY_FIN_03-30-23_.PDF#page=6.

[95] *See* Act 203, *supra* note 93.

[96] *See* Act 95, 2024 Haw. Sess. Laws 246, https://www.capitol.hawaii.gov/sessions/session2024/bills/GM1196_.PDF.

[97] *See id.*

[98] *See* Haw. Code. R. § 16-89-22 (2018).

[99] *See supra* note 96.

[100] *See id.*

[101] *See supra* note 96.

[102] *See supra* note 94.

a temporary permit and the issuance of the permit, which would allow nurses licensed outside of Hawaii to begin their employment sooner.[103]

Nurse Licensure Compact

In 2023, the Legislature adopted a concurrent resolution[104] requesting the Hawaii State Center for Nursing[105] to convene a working group to study the feasibility of Hawaii adopting the Nurse Licensure Compact. The Nurse Licensure Compact is an agreement among states to allow nurses licensed in one state and who meet uniform license requirements[106] to practice in another compact state without obtaining an additional license.[107] Forty-two states or territories have enacted the Nurse Licensure Compact.[108]

The working group published its report in December 2023.[109] The report stated that the "working group could not conclude if the [Nurse Licensure Compact] will resolve the state's current nursing workforce shortages"[110] and "[t]here is no conclusive data that describes increases in the nursing workforce due to the [Nurse Licensure Compact], but rather that it facilitates states' access to a larger pool of nurses."[111] The report further noted that the "data do suggest that there would be some risk of losing nurses to out-of-state practice."[112] Also, the report states that in one of the working group meetings, it was pointed out that "[i]t is not the intention of the [Nurse Licensure Compact] to resolve nursing workforce shortages. Rather it was designed to remove licensing as a barrier to employment for nurses who already intend to work in another jurisdiction."[113]

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[103] *See* Hearing on Senate Bill No. 63, S.D. 2, H.D. 2 (Haw. 2024), before the House Committee on Finance, March 30, 2024, written testimony by Hawaii Pacific Health, https://www.capitol.hawaii.gov/sessions/session2023/Testimony/SB63_HD2_TESTIMONY_FIN_03-30-23_.PDF#page=16.
[104] *See* S. Con. Res. 112 (Haw. 2023), https://www.capitol.hawaii.gov/sessions/session2023/bills/SCR112_.pdf.
[105] *See supra* note 61.
[106] *See Uniform Licensure Requirements for a Multistate License*, NCSBN (2024), https://www.nursecompact.com/files/2023_NLC_ULRs.pdf.
[107] *See, e.g.*, House Bill No. 2415, H.D. 2, S.D. 2 (Haw. 2024), https://www.capitol.hawaii.gov/sessions/session2024/bills/HB2415_SD2_.htm.
[108] *See 42 states have enacted the NLC,* NLC Nurse Licensure Compact, https://www.nursecompact.com/files/NLC_Map.pdf. While the title of the document appears to solely address states, the map and information indicate that the count of forty-two consists of forty states, Guam, and the Virgin Islands of the United States.
[109] *See supra* note 54. The report was published as a "University of Hawaii System Report." It appears that since S. Con. Res. 112 (Haw. 2023) requested the Hawaii State Center for Nursing (which is a part of the University of Hawaii at Manoa, Nancy Atmospera-Walch School of Nursing) to convene the working group, the Hawaii State Center for Nursing was the primary author and therefore published the report it its capacity as an entity of the University of Hawaii System.
[110] *See id.* at vi.
[111] *Id.*
[112] *Id.* at 56.
[113] *Id.* at 55.

The Working Group did not specifically recommend to the Legislature whether or not Hawaii should adopt the Nurse Licensure Compact. However, the group made numerous recommendations for improvement if the Nurse Licensure Compact were to be adopted.[114]

The Working Group also made recommendations seemingly unrelated to the Nurse Licensure Compact that would help to address Hawaii's nursing shortage if adopted:

- "Supporting public and private nursing education expansion enables local residents to become nurses in Hawaii, which will increase the local workforce and improve local recruitment opportunities."[115]

- "[Since the h]igh cost of living and housing shortages further challenge nursing retention[, c]ontinued efforts to impact these issues will have benefits to the nursing workforce retention."[116]

The 2024 Legislature did not adopt any House or Senate Bill enacting the Nurse Licensure Compact.

Efforts in Other States to Address Nursing Workforce Shortages

This section discusses the various legislative efforts in other states to address nurse workforce shortages for which a subsequent report or other document indicated that the workforce grew following the effort or the effort helped people obtain a nursing degree. For information about proposed legislative initiatives in other states and efforts that may have been successful but for which the Bureau is not aware of an assessment or follow-up report evaluating that success, a reader may wish to review the Evaluation of the [Texas] Nursing Shortage Reduction Program, Appendix C.[117] Appendix C was prepared by staff of the Texas Higher Education Coordinating Board and summarizes legislative efforts made in states other than Texas to address shortages of initial licensure nurses, categorized by the following subjects: didactic faculty (faculty primarily focused on teaching), clinical faculty/preceptors and training sites, students, educational pathways and partnerships, workforce planning, and evaluation and investment. Additionally, Appendix D of the same document summarizes state funding strategy proposals for the efforts in Appendix C along with providing some commentary.[118]

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[114] Some recommendations included making conforming amendments to Hawaii law, preventing the Nurse Licensure Compact from superseding existing state labor laws, implementing a delayed effective date, developing a funding method, addressing whether continuing competency for nurses would be required for practice in Hawaii, development of a method to address any delays in nurse investigations due to expansion of the registry of nurses, and allowing the Hawaii State Center for Nursing to retain nursing workforce research duties. *See id.* at viii-ix.
[115] *Id.* at ix.
[116] *Id.* The Working Group's recommendations appeared under the subject heading "Priorities, not related to the [Nurse Licensure Compact]."
[117] *See infra* note 157.
[118] *See id*.

Centers for Medicare and Medicaid Services Graduate Nurse Education Demonstration

The Affordable Care Act of 2010 established the temporary Graduate Nurse Education (GNE) Demonstration to test whether payments to hospitals and other healthcare entities to provide clinical education would increase the number of advanced practice registered nurse student graduates.[119] The Affordable Care Act appropriated $50,000,000 per fiscal year, for fiscal years 2012 to 2015, with the authority to expend appropriated funds in subsequent years.[120] The demonstration selected five lead hospitals, one in each of the following states: North Carolina, Pennsylvania, Texas, Illinois, and Arizona.[121] The five lead hospitals then partnered with schools of nursing, other hospitals, and other healthcare entities to form networks for the program.[122]

Each lead hospital administered the project for its respective network, including distributing payments. Payments by the Centers for Medicare and Medicaid Services were based on the number of additional students educated due to participating in the program and covered "reasonable costs attributable to providing qualified clinical education to [advanced practice registered nurse] students enrolled as a result of the demonstration project[,]"[123] such as:

- Salaries for staff in lead hospitals to administer the project;
- Costs incurred by schools of nursing for materials, salaries for non-didactic (i.e., administrative or clinical) faculty, and coordination of clinical preceptorships for additional advanced practice registered nurse students that the hospitals and their partnering entities educated as a result of their participation in the project;[124]
- Costs associated with executing partnership agreements with clinical education sites;[125] and
- Precepting payments for the clinical education of additional advanced practice registered nurse students.[126]
- Payments to the clinical education sites, which then decided how to disburse those payments.[127] The clinical education sites disbursed the funds by providing bonuses

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[119] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5509, 124 Stat. 119, 674-676 (2010), https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf#page=556.
[120] *See id.* at § 5509(d), 124 Stat. at 675.
[121] *See* Brandon Hesgrove et al., *The Graduate Nurse Education Demonstration Project: Final Evaluation Report*, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation 4 (2019), https://www.cms.gov/priorities/innovation/files/reports/gne-final-eval-rpt.pdf.
[122] *See id.* at 12.
[123] *Id.* at 16.
[124] *See id.* at 16-17.
[125] *See id.*
[126] *See id.*
[127] *See id*. at 38.

> to staff, subsidizing staff education through conferences and training, and giving a portion of the precepting payment directly to the preceptor as a bonus.[128] In a few instances, preceptors declined the payments and asked that the funds be used to support patient care.[129]

The demonstration began before the 2012-2013 academic year and closed out during the 2018-2019 academic year.[130]

According to the final report, the project resulted in an overall increase in the number of advanced practice registered nurse graduates.[131] The demonstration project increased clinical placements, which saw a corresponding increase in enrollment for participating schools of nursing.[132] The total cost of the demonstration project was $176,377,494 and increased the total number of advanced practice registered nurse graduates by an estimated 3,739. The total estimated cost per advanced practice registered nurse graduate was $47,172.[133]

The evaluation process of the Graduate Nurse Education Demonstration Project included, among other things, conducting interviews and focus groups, issuing surveys, and analyzing survey responses and other data.[134] Discussions with preceptors included asking if the availability of payments would affect their willingness to provide clinical education, and many preceptors reported that they were not motivated by payments.[135] Rather, preceptors were motivated by a willingness to give back to the profession, teach the next generation of advanced practice registered nurses, and continue their own education.[136] Conversely, representatives for the clinical education sites were highly motivated by the payments.[137] Since precepting typically reduces a preceptor's productivity,[138] many clinical education sites participating in the Graduate Nurse Education Demonstration Project used the precepting payment to compensate for this loss in productivity,[139]

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[128] *See id.*
[129] *See id.*
[130] *See id.* at 23.
[131] *See id.* at 79.
[132] *See id.* at 7-8.
[133] *See id.* at 79.
[134] *See id.* at 5.
[135] *See id.* at 56. The report did not include information on the payment or bonus amounts. *See also supra* note 128.
[136] *See id.* at 56-57.
[137] *See id.* at 57.
[138] "[M]any preceptors in health care facilities have difficulties due to their excessive workload, because they have to train new nurses and attend to patients at the same time." Kyung Jin Hong & Hyo-Jeong Yoon, *Effect of Nurses' Preceptorship Experience in Educating New Graduate Nurses and Preceptor Training Courses on Clinical Teaching Behavior*, 18(3) Int'l J. Env't Rsch. Pub. Health 975 (2021), https://doi.org/10.3390/ijerph18030975.
[139] *See supra note* 121 at 57. The report states:

> In contrast, other stakeholders agreed that the clinical education sites, not individual preceptors, were driven by precepting payments. The sites used the precepting payments to offset the negative impact that precepting APRN students had on the site's productivity level. Preceptors we spoke with noted that by taking on an APRN student, their productivity decreased. Sites also noticed a decrease in their staff's productivity due to precepting APRN and physician students. To offset this productivity loss, many sites used the precepting payments as compensation for the preceptor's time. This allowed the site to take on more students without affecting the quality of care or their financial bottom line. Sites also ultimately decided if and how many of their staff would precept students each semester. Because of the time and resources needed to educate

presumably by scheduling additional staff, though the report does not provide specific information on how clinical education sites compensated for the loss in productivity.

Song-Brown Health Care Workforce Training Program (California)[140]

In 1973, California established the then-entitled Song-Brown Family Physician Training program to train physicians to provide high-quality primary care.[141] The scope of the program expanded over the years, and registered nurse programs were added in 2005.[142] Currently, the Song-Brown Health Care Workforce Training program ("Song-Brown program") encompasses programs for primary care residency, family nurse practitioners, physician assistants, registered nurses, and midwifery, with the goal "to increase the number of students and residents receiving quality primary care education and training in areas of unmet need throughout California."[143] State funding totaled $27,400,000 for the 2023-2024 fiscal year.[144]

Among other things, the Song-Brown program provides grants to California programs that train registered nurses.[145] Grant amounts are $15,000 per student per year for a two-year service period with a maximum of thirty students per program that trains registered nurses.[146] The maximum annual reward per program that trains registered nurses is $900,000 ($15,000 per student-year x 30 students x 2 years = $900,000).[147]

Separately, to encourage registered nurse training programs to expand their training capacity, the Song-Brown program also provides grants of $30,000 to registered nurse training programs that permanently expand their training capacity by an additional student slot and fill that slot.[148] The $30,000 grant has a ten-student slot maximum with a total maximum award of $600,000 per registered nurse training program.[149]

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students clinically in professional health care programs, sites were more inclined to accept students whose schools paid for them to precept.

[140] Cal. Health & Safety Code § 128200 et seq. (2023), https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=3.&chapter=4.&article=1.

[141] *See Graduate Medical Education Funding in California The Song-Brown Program*, California Health Care Foundation (2019), https://www.chcf.org/wp-content/uploads/2019/02/GMEFundingCASongBrown.pdf.

[142] *See id.*

[143] *Id.*

[144] *See Song-Brown Registered Nurse Education Program, Grant Guide For Fiscal year 2023-2024*, Department of Health Care Access and Information, 4, https://hcai.ca.gov/wp-content/uploads/2023/10/2023-24-RN-Grant-Guide.pdf.

[145] *See id* at 3.

[146] *See id* at 4.

[147] *See id.*

[148] *See id*.

[149] *See id.*

The program supported 385 registered nurse training slots for 2019-2021 (the latest period for which publicly accessible data is available).[150] According to the Program Director for one university, "[a]ll of the student recipients are from underrepresented groups and would struggle to continue their education without the Song-Brown assistance."[151]

The Professional Nursing Shortage Reduction Program (Texas)

In 2001, Texas established the Professional Nursing Shortage Reduction Program by adopting the Nursing Shortage Reduction Act of 2001.[152] Section 2(b) of the Nursing Shortage Reduction Act of 2001 stated the purpose of the Act as follows:

> It is the purpose of this Act to establish a program to increase the ability of professional nursing educational programs to prepare the registered nurses Texas needs [sic], to encourage persons to enter the nursing profession or to teach in a nursing program, and to establish a nursing workforce data center to address issues of supply and demand in nursing.[153]

While the requirements of the Professional Nursing Shortage Reduction Program have been refined throughout the years, the general framework involves awarding grants to public and private college and university nursing schools to increase their number of nurse graduates.[154]

Grant money may only be used for enrolling additional nursing students, nursing faculty enhancement, encouraging innovation in the recruitment and retention of students, effectively using resources, sharing resources between programs, and using preceptors or part-time faculty to provide clinical instruction to address the need for qualified faculty to accommodate increased student enrollment in the professional nursing program.[155]

According to one analysis, the program has been "highly effective."[156] Throughout the 2007 to 2018 period of study, the number of nursing graduates per year increased nearly every

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[150] *See Song-Brown Healthcare Workforce Training Program*, Department of Health Care Access and Information, https://hcai.ca.gov/wp-content/uploads/2021/06/Registered-Nurse-Outcome-Flyer-HCAI-2022.pdf.
[151] *Id.*
[152] 2001 Tex. Gen. Laws 5284, https://lrl.texas.gov/scanned/sessionLaws/77-0/SB_572_CH_1489.pdf.
[153] *Id.*
[154] *See* Tex. Educ. Code Ann. § 61.9622, https://statutes.capitol.texas.gov/Docs/ED/htm/ED.61.htm#61.9622 and *Nursing Shortage Reduction Program*, Texas Higher Education Coordinating Board, https://www.highered.texas.gov/our-work/supporting-our-institutions/institutional-grant-opportunities/nursing-shortage-reduction-program/. *See also* Texas Higher Education Coordinating Board Rules, 19 Tex. Admin. Code §22.501 et seq. https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=19&pt=1&ch=22&sch=S&rl=Y.
[155] *See* Tex. Educ. Code Ann. § 61.9623(a)(1), https://statutes.capitol.texas.gov/Docs/ED/htm/ED.61.htm#61.9623.
[156] *The Nursing Shortage Reduction Program*, Texas Nurses Association, 2 (2022-2023), https://cdn.ymaws.com/www.texasnurses.org/resource/resmgr/docs/gac/2022/Nursing_Shortage_Reduction_P.pdf ("Recent analysis of the program by [the Texas Higher Education Coordinating Board] using Texas Center for Nursing Workforce Studies data shows the [Nursing Shortage Reduction Program] has been highly effective and has room to grow.")

year, despite inconsistent amounts of funding over the years. Texas nurse graduates increased from 8,467 in 2007 to 20,045 in 2018, and pre-registered nurse licensure student admissions increased from 10,856 for the 2008-2009 academic year to 16,284 for the 2017-2018 academic year.[157]

The most common uses of grant money by the nursing schools have been to retain faculty nurses (24.1% of funds), for nursing faculty education (20.6% of funds), and for preceptors (19.2% of funds).[158]

The Nursing and Allied Health Initiative (Massachusetts)

In 2005, Massachusetts formed what later became the Nursing and Allied Health Initiative through a collaboration of private and public entities to address the root causes of the nursing shortage: limited faculty, insufficient clinical education capacity, and inadequate laboratory teaching facilities.[159]

In the subsequent years, the Massachusetts legislature funded the initiative, which then, according to a 2012 report, developed or helped to develop various programs, including:

- The Nursing Workforce Development Framework, a framework for the progression of newly licensed and incumbent nurses to further and advance their education and job levels as the demographics of the patient population change.

- Nurse of the Future Nursing Core Competencies, a framework developed by the schools and practice partners to ensure that nursing program curricula reflect contemporary demands.

- The purchase of simulation manikins to support clinical education.

- Use of the Centralized Clinical Placement System,[160] the web-based software tool to maximize the number of nursing students placed in clinical nursing education.

- Welcome Back Center, a program to help nurses trained in foreign countries obtain a Massachusetts nursing license.

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[157] *See Evaluation of the Nursing Shortage Reduction Program*, Texas Higher Education Coordinating Board, 7-8 (2020) https://reportcenter.highered.texas.gov/meeting/advisory-committee-supporting-documents/evaluation-of-nursing-shortage-reduction-program-report-october-2020/. This evaluation did not mention whether the increases in graduates and enrollment may also be attributable to other factors.
[158] *See id.* at 12.
[159] *See Nursing and Allied Health Workforce Development, A Strategic Workforce Plan for Massachusetts' Healthcare Sector*, Massachusetts Department of Higher Education, 5 (2012), https://www.mass.edu/strategic/documents/AAC13-15NursingandAlliedHealthWorkforceDevelopmentPlan_asamendedbyAACCommitteewithreport.pdf.
[160] *See also supra* note 69.

- Scholarships for clinical nurses who enroll in master's or doctoral nursing programs and commit to teach for at least one year upon graduation.

- Education Redesign Grants for schools to implement necessary core competencies into their curriculum and practice, develop curricula centered on gerontology, and implement pilot models for the progression of licensed practice nurses to obtain a bachelor of science in nursing degree and for individuals with an associate degree in nursing to obtain a bachelor of science in nursing degree and a master of science in nursing degree.[161]

While recent reports on the results of the various programs are not readily available, the Nursing and Allied Health Initiative website touts, in large letters "Big News: 62% increase in BSN graduates in MA from 2010 to 2015!"[162]

Bridge to Professional Practice Program (Connecticut)

The Bridge to Professional Practice Program in Connecticut was developed during the coronavirus disease 2019 (COVID-19) pandemic to provide senior-level baccalaureate nursing students with hours of clinical experience required for their nursing degrees while reducing hospital nursing workforce shortages.

In late 2020, Connecticut hospitals faced workforce staffing issues, particularly due to a strained nursing workforce[163] and shortage of travel nurses.[164] Meanwhile, schools and healthcare facilities had suspended clinical placements[165] due to uncertainties about COVID-19 and a shortage of personal protective equipment.[166] The suspension of clinical placements prevented nursing students from completing enough clinical hours required for a degree[167] and to qualify for the National Council Licensure Examination (NCLEX).[168] A delayed nursing degree would have

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[161] *See id.* at 5-9.
[162] *About the Nursing & Allied Health Initiative*, Massachusetts Department of Higher Education, https://www.mass.edu/nahi/about/about.asp (last visited Sept. 30, 2024). *See also Academic Progression Making Great Progress*, Massachusetts Action Coalition, https://www.mass.edu/nahi/documents/AcademicProgression-UpdatefromRWJFGrantreport-Final.pdf.
[163] *See* Mary Cleary, et. al., *Reshaping the Future: An Innovative Academic-Practice Collaboration for COVID-19 Vaccinations and Testing*, 46(2) Nursing Admin., 167-176 (2022), https://journals.lww.com/naqjournal/fulltext/2022/04000/reshaping_the_future__an_innovative.9.aspx.
[164] *See* Mary E. Dietmann, et. al., *How the Practice/Academic Partnership Model Helped One State During COVID-19*, Leader to Leader, 8-9 (Fall 2021), https://digitalcommons.sacredheart.edu/cgi/viewcontent.cgi?article=1301&context=nurs_fac.
[165] Clinical placements in healthcare facilities allow nursing students to gain real-world experience and complete the clinical hours required for a nursing degree. *See* Brian Koonz, *Commitment and Innovation Guide Nursing Students, Faculty In Pandemic*, Quinnipiac Magazine, August 24, 2022, https://www.qu.edu/magazine/commitment-and-innovation-guide--nursing-students-faculty-in-pandemic/.
[166] *See* Cleary, et al., *supra* note 163, at 168.
[167] *See id.*
[168] *See supra* note 165.

the further effect of disrupting the hospitals that had planned to employ those students following an expected graduation date.[169]

In response to these issues, the nursing schools and hospitals partnered to develop the Bridge to Professional Practice Program to allow nursing students entering their final semester to complete clinical hours.[170] The program began in December 2020, a nonclinical time of the school year between the fall and spring semesters.[171] More than 330 students in three cohorts participated.[172]

The nursing schools recruited and hired clinical faculty members to oversee the students, and the hospital system funded payments for the clinical faculty members.[173] The program "provided the healthcare institutions with well-needed extra hands during the crisis"[174] and helped to "ensure adequate staffing."[175] As part of the program, students also assisted in greeting, screening, and vaccinating patients, resulting in a savings of over $144,000 that the hospitals would have spent on staff to fulfill those roles.[176] Clinical faculty members were on-call when the students were at the hospitals and were also required to regularly visit each student with the student's preceptor.[177] The program assigned students to preceptors for the twelve-hour day or evening shifts.[178] While the program did not pay individuals for precepting, those individuals could use the experience toward career advancement in the health care system.[179]

Evaluations of the Bridge to Professional Practice Program were generally positive. One study on the program stated, "[t]he health care system benefited as this program provided much need assistance at the bedside."[180] In surveys, preceptors reported that the experience was helpful to their workload, professionally beneficial, and had minimal impact on their stress levels.[181] Student surveys expressed positive experiences and agreement with the statements that the "experience prepared me [to practice nursing,]" the "program aided in my ability to prioritize the healthcare needs of patients," and "[after my experience with the program,] I am satisfied in choosing nursing as my career."[182] However, surveys of nurse managers indicated that the "students did not greatly enhance the unit staffing from the managers' perspective."[183] Specifically,

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[169] *See* Judith Hahn, et. al., *An Innovative Academic/Practice Partnership to Support Nursing Workforce Needs and Student Clinical Education*, 53(2) J. of Nursing Admin., 88-95, 88 (2023), https://journals.lww.com/jonajournal/fulltext/2023/02000/an_innovative_academic_practice_partnership_to.5.aspx
[170] *See id.* at 89.
[171] *See* Dietmann, et al., *supra* note 164, at 9.
[172] *See* Hahn, et al., *supra note* 169, at 90.
[173] *See id.* at 89.
[174] *Id.* at 93.
[175] Cleary, et al., *supra* note 163, at 170.
[176] *See id.* at 172.
[177] *See* Hahn, et al., *supra* note 169, at 89.
[178] *See id.* at 90.
[179] *See id.*
[180] Audrey Beauvais, et al., *Educating Nursing Students Through the Pandemic: The Essentials of Collaboration*, 7 SAGE Open Nursing 1-6, 5 (2021), available at https://journals.sagepub.com/doi/epub/10.1177/23779608211062678.
[181] *See* Hahn, et al., *supra* note 169, at 91.
[182] *Id.* at 91.
[183] *Id.* at 94.

following the conclusion of the program, thirty-two nurse managers were sent a set of six survey questions to evaluate various outcomes of the program.[184] One of the survey questions was "How helpful was a student in unit staffing?" and the nurse managers could answer on a 1-5 scale.[185] Nine nurse managers responded to the survey questions and the average numerical response to that question was a 3.4 with 3 meaning "unsure" and 4 meaning "somewhat."[186]

[184] *See id.* at 92.
[185] *See id.*
[186] *See id.*

Chapter 5

CONCLUSION AND CONSIDERATIONS

There appears to be a consensus among healthcare associations, nurse advocacy groups, and academic researchers that, in any particular healthcare setting, nurses who are assigned to fewer patients have better patient outcomes and experience preferrable employment conditions compared to nurses who are assigned to more patients in the same healthcare setting.[1] There are multiple approaches to achieving these results, each with some evidentiary support.

Many states use mandated nurse staffing ratios in at least some healthcare settings. While state-mandated ratios appear to have had a positive effect on patient outcomes and job satisfaction for nurses, there is no definitive evidence that they have *eliminated* a state's nursing workforce shortage. Notably, more than two decades after California became the first state to legislatively implement mandatory nurse-to-patient ratios, the state continues to experience a nursing workforce shortfall. However, there does appear to be some evidence that state-mandated nurse-to-patient ratios have had some effect on at least *reducing* a nursing workforce shortage.[2]

Alternatives to mandated nurse staffing ratios, such as allowing or requiring hospitals to establish their own nurse-to-patient ratios, requiring hospitals to have a sufficient number of nurses on duty, requiring nurse staffing levels to be publicly reported, and limiting or prohibiting mandatory overtime hours can, in some circumstances, improve nurse staffing levels, working conditions, and retention. However, it similarly has not been definitively established that any of these alternatives have eliminated a state's nursing workforce shortage.[3] Nevertheless, as with state-mandated ratios, there does appear to be evidence that these initiatives can at least reduce a state's nursing workforce shortage. Moreover, there is no clear evidence that any single approach is the most effective in reducing a state's nursing workforce shortage or that there is a consensus among the states for a particular set of approaches.[4]

Accordingly, the Bureau suggests implementing a combination of the approaches mentioned in this report to reduce Hawaii's nursing workforce shortage, but makes no specific recommendations regarding the most effective or advisable approach.

Similarly, the Bureau also suggests adopting a multi-faceted approach toward increasing the number of nurse graduates. Other states have successfully increased their number of nurse graduates with programs to support nurse preceptors, incentivize nursing schools to increase enrollment, provide nursing students with more opportunities for clinical placements, and incentivize nurses to work in areas with nursing shortages.[5] While there is also no evidence that

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[1] *See* Chapter 2, section entitled Evaluating Outcomes: The Efficacy of State-Mandated Nurse Staffing Ratios.
[2] *See id.,* Sections entitled Staffing Committees: An Alternative Approach to Mandated Staffing Ratios and subsequent sections.
[3] *See id.*
[4] *See* Chapter 3, Introduction section and included table.
[5] *See* Chapter 4, sections under Efforts in Other States to Address Nursing Workforce Shortages.

these programs alone have eliminated any states' nursing workforce shortage, it does appear that each program had a positive impact on increasing the respective state's nursing workforce.[6]

In addition to implementing programs based upon successful efforts in other states, the Bureau suggests funding existing Hawaii programs that have never been funded or have not been recently funded, including the Nursing Scholars Program and Hawaii Rural Health Care Provider Loan Repayment Program,[7] and establishing reporting requirements relating to these programs. Given that there has been no recent funding for or recent data available on these programs, the Bureau is unable to comment on their effectiveness. Sufficient funding and reporting requirements should help to inform future legislatures on the effectiveness of these existing programs, including whether the programs should be retained, modified, or eliminated.

Lastly, the Bureau suggests seriously considering recommendations made by the various nursing and other healthcare entities throughout the State. These entities have years or decades of first-hand experience with nursing, including nursing workforce, and health care issues in Hawaii, in contrast to the few months the Bureau has had to study these issues.

[6] *See id.*
[7] *See id.*

HOUSE OF REPRESENTATIVES
THIRTY-SECOND LEGISLATURE, 2024
STATE OF HAWAII

H.C.R. NO. 187 H.D. 1 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO CONDUCT A STUDY ON BEST PRACTICES FOR NURSE STAFFING IN HEALTH CARE FACILITIES.

WHEREAS, the State is facing a persistent health care staffing shortage, which has been exacerbated by the challenges posed by the coronavirus disease 2019 pandemic; and

WHEREAS, as a result of this ongoing shortage, the staff-to-patient ratio has greatly increased, leading to working conditions becoming increasingly unpredictable and unsafe and increasing the rate of burnout among health care professionals; and

WHEREAS, research has shown that improved staff-to-patient ratios greatly improve patient safety and outcomes; and

WHEREAS, identifying best practices in labor standards for health care facilities will help inform lawmakers on how to improve working conditions for health care professionals and increase recruitment and retention; now, therefore,

BE IT RESOLVED by the House of Representatives of the Thirty-second Legislature of the State of Hawaii, Regular Session of 2024, the Senate concurring, that the Legislative Reference Bureau is requested to conduct a study on best practices for nurse staffing in health care facilities which shall assess and discuss:

(1) Existing nursing staffing standards and regulations in other states; and

(2) A literature review of best practices for staffing and workforce development, along with successful efforts

in other states to address the nursing workforce shortage; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to submit a report of its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2025; and

BE IT FURTHER RESOLVED that a certified copy of this Concurrent Resolution be transmitted to the Director of the Legislative Reference Bureau.

Appendix B

	State-Mandated Nurse Staffing Standards		Facility-Determined Nurse Staffing Standards		Reporting Requirements	Prohibits Mandatory Overtime
	General	Ratios	Staffing Committees	Other		
Alabama	☑					
Alaska	☑					☑
Arizona	☑	☑				
Arkansas	☑	☑				
California		☑				
Colorado	☑		☑			
Connecticut	☑		☑			☑
Delaware		☑				
District of Columbia	☑	☑				
Florida		☑				
Georgia		☑				
Hawaii	☑					
Idaho						
Illinois	☑	☑	☑		☑	☑
Indiana		☑				
Iowa		☑				
Kansas	☑					

	State-Mandated Nurse Staffing Standards		Facility-Determined Nurse Staffing Standards		Reporting Requirements	Prohibits Mandatory Overtime
	General	Ratios	Staffing Committees	Other		
Kentucky	☑			☑ [1]		
Louisiana						
Maine						☑
Maryland		☑				☑
Massachusetts		☑			☑	☑
Michigan	☑					
Minnesota	☑			☑ [2]	☑	☑
Mississippi	☑					
Missouri	☑					☑
Montana	☑					
Nebraska	☑					
Nevada	☑		☑			
New Hampshire	☑					☑
New Jersey	☑				☑	☑
New Mexico	☑					
New York		☑	☑		☑	☑
North Carolina	☑					
North Dakota	☑					

[1] Hospitals are required to have a staffing plan, but the law does not specify who should create the plan.
[2] A Chief Nursing Executive or nursing designee determines the staffing plan.

	State-Mandated Nurse Staffing Standards		Facility-Determined Nurse Staffing Standards		Reporting Requirements	Prohibits Mandatory Overtime
	General	Ratios	Staffing Committees	Other		
Ohio	☑ [3]		☑			
Oklahoma	☑					☑
Oregon			☑			
Pennsylvania	☑	☑				☑
Rhode Island	☑					☑
South Carolina	☑					
South Dakota	☑					
Tennessee	☑					
Texas	☑		☑			☑
Utah		☑				
Vermont	☑				☑	
Virginia	☑					
Washington	☑	☑	☑		☑	☑
West Virginia	☑	☑				☑
Wisconsin		☑				
Wyoming	☑					

[3] Requires "sufficient" and "appropriate" staffing but requires staffing needs to be determined based on patient acuity.

Appendix C

Charlotte A. Carter-Yamauchi
Director

Shawn K. Nakama
First Assistant

Research 808-587-0666
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Fax 808-587-0681

LEGISLATIVE REFERENCE BUREAU
State of Hawaii
State Capitol, Room 446
415 S. Beretania Street
Honolulu, Hawaii 96813

May 22, 2024

Dear

Subject: House Concurrent Resolution 187, H.D. 1, S.D. 1 (2024), Requesting the Legislative Reference Bureau to Conduct a Study on the Best Practices for Nurse Staffing in Health Care Facilities

I am writing to offer your entity an opportunity to bring to our attention any information that should be considered by the Legislative Reference Bureau in response to House Concurrent Resolution 187, H.D. 1, S.D. 1 (2024), a copy of which is attached for your convenience.

The concurrent resolution requests the Legislative Reference Bureau to study best practices for nurse staffing in health care facilities and to submit a report to the Hawaii State Legislature no later than December 26, 2024, that assesses and discusses:

(1) Existing nursing staffing standards and regulations in other states; and

(2) A literature review of best practices for staffing and workforce development, along with successful efforts in other states to address the nursing workforce shortage.

We ask that any information you bring to our attention be publicly available, directly responsive to the specific request made by the concurrent resolution, reasonable in volume, and if applicable, supported by data or empirical evidence or other documentation that supports the information. We also request that you submit your response by June 30, 2024.

If the responses are not voluminous and subject to other publication restrictions, we hope to include them as an appendix to our report. Accordingly, if any information is available online, you may share the website address instead of providing the entire document.

You may mail or deliver your response to the above address or email If you have any questions, please contact Devin Choy or Valerie Grey by phone at 808-587-0666.

The Bureau appreciates your cooperation and looks forward to receiving your input on this matter.

Very truly yours,

Charlotte A. Carter-Yamauchi
Director

Enc.

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Legislative Reference Bureau
State of Hawaii
State Capitol, Room 446
415 S. Beretania Street
Honolulu, Hawaii 96813

June 28, 2024

Subject: Hawaii Government Employee Association's Response to Legislative Reference Bureau's Request for Response in Re: House Concurrent Resolution 187, H.D.1, S.D.1 (2024)

To whom it may concern,

The Hawaii Government Employees Association welcomes this opportunity to discuss a long-standing concern and respectfully encourages this legislature to take prompt and decisive action to remedy it.

Legally-mandated and enforceable nurse-to-patient ratios, known colloquially as "safe staffing" and "safe staffing ratios", ensure that there are enough staff to keep both staff and patients safe, and provide an environment of care that ensures continued positive patient and staff outcomes.

One state on the West Coast of the United States, California, has a adopted a "nurse-to-patient ratio" or "safe staffing" statute[1]. That statute is known colloquially as A.B. 394[2].

A.B. 394 is a safe staffing law that has multiple provisions designed to remedy unsafe staffing and achieve safe staffing in acute-care facilities. The safe staffing standards therein are based on individual patient acuity, of which the Registered Professional Nurse ("RPN") ratios are the minimum.

[1] https://leginfo.legislature.gov/faces/billNavClient.xhtml?bill_id=199920000AB394
[2] Id.

A.B. 394 requires the following nurse-to-patient ratios in the following settings to achieve safe staffing:

- 1:1 - Operating Room Trauma Patient in ER;
- 1:2 - Intensive/Critical Care, Neonatal Intensive Care, Post-Anesthesia Recovery, Labor & Delivery, and ICU Patient in ER;
- 1:3 – Step Down;
- 1:4 – Antepartum, Post-Partum Couplets, Pediatrics, Emergency Room, Telemetry, and Other Specialty Care;
- 1:5 - Medical/Surgical; and
- 1:6 – Postpartum Women Only and Psychiatric[3].

A.B. 394 has the following effects:

- Mandates Minimum, Specific, Numerical Ratios; and
- Requires a Patient Classification System – Additional RNs Added Based on Patient Acuity and Need; and
- Regulates Unlicensed Staff; and
- Restricts Unsafe "Floating" or Nursing Staff; and
- Applies At All Times; and
- Prohibits Averaging; and
- Bars Cuts in In Ancillary Staff as a Result of Nurse-To-Patient Ratios[4].

[3] Id.
[4] Id.

There is much we can learn California's experience. A.B. 394 has been subject of exhaustive studies into its effects on health & safety and patient outcomes. **The effects of A.B. 394 have been clear and wide reaching - Despite claims otherwise, safe staffing has *saved* money and lives.**

"Safe staffing" saves lives. Hospitals that have nurse-to-patient ratios at 1:8 experience five (5) additional deaths per 1,000 patients than those that staff using a safe staffing nurse-to-patient ratio of 1:4[5]. The odds of patient death increase by 7% for each additional patient the nurse must take on at one time[6]. Outcomes are better for patients when staffing levels meet those established by A.B. 394 in California, including an increase in lives saved, shorter hospital stays, and general improvement in quality care[7]. Studies by independent physicians support these findings; for example, a study by Dr. Linda Aiken, PhD, RN, FAAN, estimates that there would have been 4,370 fewer in-hospital deaths in a two (2) year period among Medicare patients if New York State hospitals implemented "safe staffing" during the time of the study[8]. These were *preventable* deaths – preventable in that, but for legally-mandated and enforceable "safe staffing", many or all of those 4,370 people likely would have survived their treatment if "safe staffing" had been maintained[9].

"Safe staffing" ratios are not prohibitively expensive and they do not result in clinic and/or hospital closures, nor layoffs of non-nursing staff. For example, after ratios were implemented via A.B. 394 in California, hospital income actually rose dramatically from

[5] Journal of American Medical Association 2002.
[6] Id.
[7] Health Services Research 2010.
[8] Medical Care 2021.
[9] Id.

approximately $12.5 Billion Dollars to more than approximately $20.6 Billion Dollars[10]. Some hospital managers reported that being required to comply with a safe staffing ratios mandate actually made it *easier* to secure funding for hospitals[11]. Increased nurse staffing is a more cost-effective tactic improve patient care when compared to other interventions[12]. Ancillary staff remain vital to healthcare – California hospitals did not decide to cut non-nursing jobs as a result of "safe staffing" ration in their efforts to cut costs.

There is a substantial cost to high employee turnover in hospitals, and "safe staffing" has reduced employee turnover in hospitals[13]. High turnover is present where nurse-to-patient ratios are high, which increases the cost of care[14]. Turnover is expensive – the average cost to replace an RPN ranged from $82,000 to $88,000 as of 2008[15]. That cost has inevitably increased since 2008. "Safe staffing" has reduced turnover, and therefore the costs associated with it.

There is a substantial cost to patient readmission to hospitals, and "safe staffing" may also reduce expensive patient readmission to hospitals, therefore reducing costs. Nurse understaffing in hospital ICUs increases the risk of infections like pneumonia, which not only lead to injury and death, but also cost the hospital significant amounts of money. Hospital-acquired pressure ulcers alone have been estimated to cost $8.5. Billion Dollars per year[16]. If New York State hospitals had had "safe staffing" in the two-year period prior to the pandemic,

[10] Research Shows Safe Staffing Saves Lives | New York State Nurses Association (nysna.org)
[11] California Health Care Foundation.
[12] Nursing Administration Quarterly 2011.
[13] Id.
[14] Id.
[15] The Journal of Nursing Administration 2008.
[16] Agency for Healthcare Quality and Research Pub. No. 04-0029 2004.

they would have saved $720 Million Dollars because of avoided days of hospital care from shorter lengths of stay and fewer readmissions from better nurse staffing[17]. Doing nothing to manage one of the many factors that play a role in readmission – unsafe staffing ratios – does nothing to manage or reduce this cost. "Safe staffing" may reduce readmission, and therefore the costs associated with it.

There is a substantial cost to liability acquired when there are adverse outcomes for patients, and "safe staffing" has reduced adverse outcomes for patients. Length of stay, urinary tract infections, cases of upper gastrointestinal bleeding all increased due to unsafe staffing ratios[18]. Rates of hospital-acquired pneumonia and shock cardiac arrest, as well as failure to rescues also climbed due to unsafe staffing[19]. For patients to hospitals with sepsis, each additional patient per nurse is associated with 12% higher odds of in-hospital mortality, 7% odds of 60-day mortality [and] 7% higher odds of 60-day readmission[20]. Adverse outcomes for patients inevitably result in increases in potential and actual legal liability, and therefore more resources being utilized to fund litigation and settlements. This, of course, increases the cost of care rather reducing it.

These statistics also seem to substantiate an anecdotal "truth" that has been observed patients and caregivers alike – **both patient and RPN outcomes improve when RPNs have more face-to-face time with each patient.** A key part of care is mental aspect of care which is notably reduced and otherwise devalued in environments where nurse-to-patient ratios are lower.

[17] Medical Care 2021.
[18] New England Journal of Medicine 346 (22) 1715-22.
[19] Id.
[20] American Journal of Infection Control 2020.

There is simply less time to devote to ensuring that kupuna are comfortable and on their way to recovery when nurse-to-patient ratios are so high that impersonal treatment becomes guaranteed. When you are treated like a number, you feel like a number. This cannot improve patient outcomes.

Finally, Employers can pass on the cost-savings resulting from "nurse-to-patient ratios" and "safe staffing" to consumers and the electorate. Given that there is a substantial cost to readmission and liability acquired when there are adverse outcomes for patients, and "safe staffing" has reduced adverse outcomes for patients, it follows that this substantial cost can be turned into cost *savings* if low "nurse-to-patient ratios" and "safe staffing" are imposed and enforced. This cost savings can be conceivably passed on to patients, where applicable, resulting in cost savings on crucial care for consumers and the electorate that relies on care provided by and at government-funded and run facilities.

In short, safe staffing both saves lives and reduces adverse outcomes more generally, and are cost effective for the facilities that are required to comply with a safe staffing ratio mandate. Thus, not only is it the right thing to do – it's also a net benefit to those who are required to comply, those who administer the care, and those who are placed in their care. Everyone benefits from low "nurse-to-patient ratios" and "safe staffing".

Accordingly, HGEA thanks the Legislative Reference Bureau for this opportunity to discuss a long-standing concern, and respectfully encourages this legislature to take prompt and decisive action to remedy it.

Aloha,

JESSE SLIVA
Advocacy Manager

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, M.D., M.G.A., M.P.H.
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

In reply, please refer to
file: 24-001491

STATE OF HAWAI'I
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KAPOLEI, HAWAII 96707

July 10, 2024

Charlotte A. Carter-Yamauchi
Director
Legislative Reference Bureau
415 S. Beretania Street
Honolulu, Hawaii 96813

RE: House Concurrent Resolution 187, H.D. 1, S.D. 1 (2024) Best Practices for Nurse Staffing in Health Care Facilities

Dear Mrs. Carter-Yamauchi,

The Department of Health has received your letter, dated May 22, 2024, regarding House Concurrent Resolution 187, H.D.1, S.D.1 (2024). The Department appreciates the opportunity to give input on this measure.

Currently in Hawaii, only the facility types of Adult Residential Care Homes (ARCH), Expanded Adult Residential Care Homes (E-ARCH), and dialysis facilities have required staffing ratios. ARCHs and E-ARCHs have a current staff to resident (patient) ratio of one to five (1:5) or one to two point five (1:2.5). The staff requirement is for Nurse Aides, and Registered Nurse licensure is not required. The ratio may be higher in facilities with a fire suppression safety system (sprinklers) throughout the entire facility. CMS has recently finalized minimum staffing standards for nursing homes (https://public-inspection.federalregister.gov/2024-08273.pdf).

Dialysis centers in Hawaii are required to have a ratio of one to eight (1:8) for nurses and one to four (1:4) for patient care technicians, based on federal recommendations. One study on dialysis center staffing ratios in four states was unable to find a meaningful effect of staffing ratios on quality of care, including hospitalization and death.

Hawaii does not have required hospital nurse staffing ratios. Currently only two (2) states, California and Massachusetts, have hospital nurse staffing ratios in State law. California: AB 394 passed in 1999 and requires ratios varying from one to one (1:1) to one to six (1:6) depending on the type of care/unit. Massachusetts: 958 CMR 8.00 passed in 2015 requires a one to one (1:1) ratio in the ICU, and nurses may take a second patient in the ICU based on their clinical judgement; no staffing ratio exists for other hospital units.

The Department of Health supports nurse staffing levels that are appropriate to safely meet patients' nursing needs.

Sincerely,

JUSTIN LAM, R.N.
Acting Chief
Office of Health Care Assurance

c: Kenneth S. Fink, MD, MGA, MPH
Director of Health

Deborah K. Morikawa
Deputy Director, Health Resources Administration

References:

https://worldpopulationreview.com/state-rankings/nurse-patient-ratios-by-state
https://www.mass.gov/doc/final-icu-nurse-staffing-regulation/download
https://www.cga.ct.gov/2004/rpt/2004-R-0212.htm
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9007864/
https://health.hawaii.gov/opppd/files/2015/06/11-100.1.pdf

From: Paige Heckathorn Choy
To: Devin Choy
Subject: Information re: HCR 187
Date: Thursday, June 27, 2024 3:22:51 PM
Attachments: image001.png
image002.png
image003.png
image004.png
Copy of Literature Review_Nurse Staffing.xlsx
HCR 187 Lit Review.zip
HCR 187_SNF minimum nurse staffing final rule.pptx

Hi Devin: I am trying not to bombard your inbox with information but wanted to provide an overview of how we're looking at this issue.

First, I want to point your attention to the attached literature review, which was completed by a former direct care RN that we have at HAH working on various quality measures. You can review her work, along with the studies and other materials she used for her review.

In her research and in her experience, she has found that there is evidence that staffing standards do contribute to improved outcomes for patients and help with the retention of nurses. However, rigid ratios and standards enshrined in law do not reflect general best practices and will not keep up with evolving technology and guidance.

Most nursing specialties provide guidance on ideal staffing standards that take patient acuity, the experience and type of clinicians available, and other factors into account when recommending certain staffing standards. The levels of staffing needed will change vastly based on those and many other factors. Requiring all hospitals—including rural hospitals—to meet arbitrary standards in law not only risks telling clinicians how to practice but also could be incredibly costly.

We have seen in many states that these ratios result in millions of dollars in penalties that do not go into bolstering the workforce—instead, they are often used only to increase pay for nurses, which should more properly be negotiated in a collective bargaining agreement. Further, we know that no state who has implemented nurse staffing ratios has seen an improvement in their nurse workforce shortage. For example, California—which has had nurse staffing ratios in place for decades—has tens of thousands of open RN positions with no solution in sight.

While we understand that there is a focus on providing high quality of care, we would note that Hawaii consistently ranks very high on quality measures and in the overall health of the population. **The greatest concern for healthcare providers is that current and persistent nursing workforce shortage.**

You can see, below, data that we published in 2022 through our Healthcare Workforce Initiative Demand Survey. You can find the full report here. As you can see—there were nearly 1,000 vacant RN positions. There was also a need for more than 500 nurse case and care managers, and just over 450 certified nurse assistants needed to serve our acute and post-acute care sectors.

Profession	2022 Average Difficult to Fill Rating*	Average Turnover Rate	Filled Positions	Open Positions	Total Positions	Percent Open	2019 Open Positions	Total Positions	Percent Open
Nursing									
NP by Specialty	2.1	20%	302	54	356	15%	47	310	15%
RN by Specialty	2.0	18%	6,283	999	7,282	14%	463	7,351	6%
Licensed Practical Nurse	1.8	22%	483	211	694	30%	144	713	20%
Nurse Care Manager	2.0	30%	241	44	285	15%	16	148	11%
Nurse Case Manager	2.4	17%	217	31	248	13%	44	553	8%

*Difficult to Fill Rating scale: 1 – Very difficult 2 – Moderately difficult (can be filled within 6–12 months) 3 – Normal (can be filled within 6 months) 4 – Oversupply

Profession	2022 Average Difficult to Fill Rating*	Average Turnover Rate	Filled Positions	Open Positions	Total Positions	Percent Open	2019 Open Positions	Total Positions	Percent Open
Patient Care									
Medical Assistant	1.9	19%	1,266	278	1,544	18%	106	1,064	10%
Nursing Assistant	2.4	46%	1,315	286	1,601	18%	118	1,424	8%
Certified Nurse Aide	2.1	26%	2,132	458	2,590	18%	299	2,581	12%
Personal Care Assistant	2.3	43%	251	181	432	42%	35	406	9%

We have undertaken several initiatives to improve the nursing workforce in the state. We were part of the Good Jobs Initiative in the state, helping to pioneer innovative high school and community college programs to get more people into nursing positions. We are also grateful that the legislature passed HB 1827, which provides state funding to continue these programs. We are also proud that Hawaii remains one of the healthiest states in the nation, despite these challenges.

However, there is a worldwide shortage of nurses, and the demand for RNs will get even worse in the next 3-5 years if a recently finalized rule from CMS goes into effect. I've attached another document outlining this rule, which will create minimum nurse staffing ratios in nursing homes.

Our analysis found that this would cost upwards of $7 million additionally each year to effectuate and would reduce the number of long-term care beds available in the state by around 200. Nationally, the requirements in this bill would require 100,000 new nurses (77,000 CNAs and 24,000 RNs) and would cost $6.5 billion a year. There is no additional funding to effectuate these minimum nurse staffing ratios, which will likely result in more nursing home closures in the state. (We already lost Wahiawa's nursing home during the pandemic, and we have heard from members that they will have to reduce services, close beds, or close entirely—the entirety of those results are in the attached presentation.

		CNA HPRD		Total Nurse Staffing HPRD	
Island	Avg. Daily Census	Average Daily Census Reduction	% of Days	Average Daily Census Reduction	% of Days
Big Island	580	-70	-12%	-25	-4%
Kauai	223	-32	-14%	-15	-7%
Maui	381	-13	-4%	-2	0%
Oahu	2,008	-78	-4%	-19	-1%
Total	3,192	-194	-6%	-61	-2%

The reduction in the total number of beds that will be available, by island and overall, if the minimum nurse staffing ratios go into effect in nursing homes.

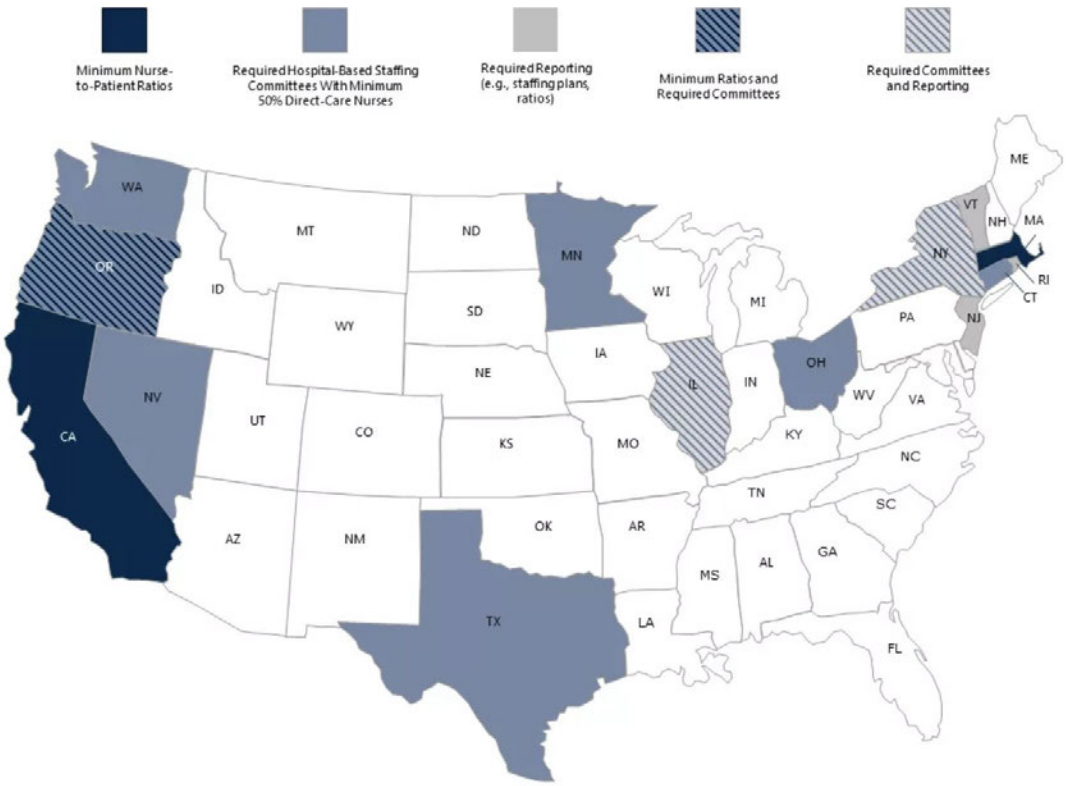
We understand that a few states have passed legislation regarding minimum nurse staffing ratios. We have heard from our counterparts that some of these pieces of legislation are more reflective of actual hospital practices and constraints, including the lack of nursing workforce and the narrow operating margins of non-profit hospitals. (Of note, all hospitals in Hawaii are non-profit.)

According to Chartis and the American Nursing Association (ANA), there are three main types of laws and regulations that institute a safe staffing standard in hospitals. Those are:

1. Mandated ratios, which are inflexible numbers set in statute. California, Massachusetts, and Oregon passed laws with this type of rigid ratio-setting made permanent in law. *The legislation introduced in the Hawaii State Legislature reflects this inflexible approach and would put Hawaii in a small minority of states regarding how they address nurse staffing levels in hospitals.*

2. Staffing committees. Nine states have passed legislation requiring hospital-based staffing committees that would be made up of at least 50% direct care nurses.

3. Disclosure/reporting requirements. Five states have laws require hospitals to report their staffing plans to the state every year or two years. Information includes ratios used by specialty/floor/clinician, how the hospital sets ratios, and any applicable quality measure



Source: https://www.chartis.com/insights/growing-number-laws-seek-address-hospital-staffing-concerns-core-problem-persists?utm_source=linkedin&utm_medium=social&utm_campaign=linkedin-newsletter&utm_term=staffing-newsletter-2-20

We would suggest that any report consider workable solutions to any nurse staffing shortages, including supporting more workforce development and training programs. Specifically, funding would be necessary to cover the workforce development program costs, and any additional costs to hospitals and other settings for hiring more workers. We do believe that there would be tens of millions needed to effectuate any strict ratio requirements.

We are happy to speak more in depth about this matter in a follow-up meeting.

If you are interested in speaking with subject matter experts, I would recommend the following individuals:

Julie Kathman
Program Manager, HAH

Julie Chicoine
Director, Compliance, Privacy, Risk Management & Govt. Relations
Adventist Health Castle

Juanita Lauti
VP and Chief Human Resource Officer
HHSC Corporate

Amy Thomas
HPH System Chief Nurse Executive

Dr. Shilpa Patel
SVP, HPH System Chief Quality Officer

Paige Heckathorn Choy
Associate Vice President, Government Affairs
Healthcare Association of Hawaii

Citation (APA)	Purpose	Patient/Unit/Facility Population	Theoretic/Conceptual Framework	Sample	Design	Measurement	Results/Conclusions
Delgado, S. A., Blake, N. T., Brown, T., Clark, L., Needleman, J., & Cassidy, L. (2024). Diverse perspectives on unit-level nurse staffing ratios in medical–surgical units: A Delphi policy analysis. *Nursing Outlook* , *72* (4), 102184.	Examines perspectives on unit-level nurse-to-patient ratio policy in adult medical–surgical units.	Med-Surg	none identified	28 enrolled panelists including direct care nurses, clinical leaders, executive nurse leaders, non-clinical leaders, faculty and providers	Delphi policy analysis	Survey in three rounds including Likert, rank order and open-ended questions. Results of each round informed the composition of successive rounds	1. Survey completion - Round 1: 21; Rounds 2 & 3: 22 2. Unit-level staffing ratios could increase staffing levels, shorten LOS, reduce nurse turnover, improve current state of patients, not increase hospital closure, worsen work environments, 3. On units staffed above policy minimum, decreased staffing could be an unitended consequence. A mitigation for this would be including a requirement for staffing based on patient acuity. 4. No consensus on impact to costs, innovation, increases in travel nurses, decreases in support staff, increasing floating to other units and mandatory overtime. 5. Consider unit-level ratio policies to lessen discord between those who support patient-level ratio and those who oppose it.
Jennifer Dillon, M. P. A. (2020). Registered nurse staffing, workload, and nursing care left undone, and their relationships to patient safety in hemodialysis units. Nephrology Nursing Journal, 47(2), 133-142.	The purpose of this study was to examine the complex interrelationships among RN staffing, RN workload, nursing care left undone, and patient safety outcomes including patient shift change safety and overall patient safety ratings.	Hemodialysis	The Nursing Organizations and Outcomes Model	104 hemodialysis direct care nurses	Cross-sectional correlational	2 subscales of the hospital Survey on Ptient Safety Culture: 1)Handoff and transitions scale 2) Patient Safety Grade, RN staffing, Workload subscale of the Individual workload perception scale, and Nursing Care left undone.	High patient-to-RN staffing, high RN workloads, and nursing care left undone are key contributors to unsafe patient shift change periods and lower overall safety ratings in hemodialysis facilities. Findings from this study indicate that these patient safety outcomes can be enhanced by ensuring adequate RN staffing and reasonable workloads as well as redesigning responsibilities so nurses have time to complete necessary and important care activities. By ensuring that RNs have the human resources and time that allow them to provide quality patient care, hemodialysis providers will enhance patient safety in their dialysis facilities.
Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. Health Services Insights. 2020;13. doi:10.1177/1178632920934785	The purpose of this article is to present a guide to determine presence of adequate and appropriate nurse staffing at the facility level. It references current federal and state nurse staffing requirements and describes 5 basic steps for determining staffing levels	Nursing homes	none identified	not a study	Guide for determining sufficient staffing in nursing homes	n/a	This article cites 15 studies from 2002-2018 that illustrate the impact of improved staffing (including some describing ratios) on reduction in pressure injury, restrain use, infections, weight loss, dehydration and mortality rates. It proposes a 5-step guide: (1) determine the collective resident acuity and care needs, (2) determine the actual nurse staffing levels, (3) identify appropriate nurse staffing levels to meet residents care needs, (4) examine evidence regarding the adequacy of staffing, and (5) identify gaps between the actual staffing and the appropriate nursing staffing levels based on resident acuity.
Shin, S., Park, J. H., & Bae, S. H. (2018). Nurse staffing and nurse outcomes: A systematic review and meta-analysis. Nursing outlook, 66(3), 273-282.	The purpose of this review was to systematically assess empirical studies on the relationship between nurse staffing and nurse outcomes through meta-analysis.	Hospitals	2 of 13 included studies used a theoretical model/framework	13 studies (US and international)	Systematic review/Meta-analysis	Data were presented in a pooled odds ratio, random effects meta-regression model was applied, and heterogeneity of the effects were tested using I-squared statistic which describes variation across studies caused by heterogeneity vs. chance.	Higher nurse-to-patient ratios are related to negative nurse outcomes: burnout, job dissatisfaction, intent to leave. No patient outcomes were studied.
Jun, J., Ojemeni, M. M., Kalamani, R., Tong, J., & Crecelius, M. L. (2021). Relationship between nurse burnout, patient and organizational outcomes: Systematic review. International journal of nursing studies, 119, 103933.	The purpose of this review is to systematically and critically appraise the current literature to examine the associations between nurse burnout and patient and hospital organizational outcomes.	Hospitals	none identified	20 studies (US and international)	Systematic review	Maslach Burnout Inventory, Maslach Burnout Inventory-Human Service Survey, Safety Attitudes Questionnaire, Pennsylvania Health Care cost containment Council, NWI-R=Nurse Work Index-Revised, job satisfaction, Hospital survey of patient safety culture, nurse-assesed quality of care, Taylor Monifest Anxiety Scale, HCAHPS, hospital quality questionnaire by patients, etc.	Burnout, especially emotional exhaustion of nurses, is negatively associated with the quality and safety of care, patient satisfaction, nurses' organizational commitment, and productivity.
Griffiths, P., Saville, C., Ball, J., Jones, J., Pattison, N., Monks, T., & Safer Nursing Care Study Group. (2020). Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion. International journal of nursing studies, 103, 103487.	Pupose of this scoping review was to provide an overview of the major approaches to assessing nurse staffing requirements and identify recent evidence in order to address unanswered questions including the accuracy and effectiveness of tools.	Hospitals	none identified	37 sources	Scoping review	Approaches for determining nurse staffing requirements:Professional judgement (Telford), Benchmarking approaches, nurse-patient ratios (volume-based), patient classification, timed-task, regression-based;Approaches for utilizing tools for staffing: Prospective employment (how many staff should a unit employ), concurrent deployment (how many staff should be used on a particular shift), and Retrospective review (was number of staff appropriate for patient needs and financial benchmarks)	Recent years continue to see reports of new staffing tools and systems. Important sources of variability are neglected in published reports. Benefits are associated with increased staffing levels but the costs and benefits of using a tool, as opposed to simply increasing staffing, remain unknown.

Lasater, K. B., Aiken, L. H., Sloane, D., French, R., Martin, B., Alexander, M., & McHugh, M. D. (2021). Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study. BMJ open, 11(12), e052899.	To evaluate variation in Illinois hospital nurse staffing ratios and to determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals.	Med-Surg	none identified	210, 493 Medicare patients, 65 years and older, who were hospitalised in a study hospital. 1391 registered nurses employed in direct patient care on A medical–surgical unit in a study hospital.	Cross-sectional analysis	Primary outcomes were 30-day mortality and length of stay. Deaths avoided and cost savings to hospitals were predicted based on results from regression estimates if hospitals were to have staffed at a 4:1 ratio during the study period. Cost savings were computed from reductions in lengths of stay using cost-to-charge ratios.	Patient-to-nurse staffing ratios on medical-surgical units ranged from 4.2 to 7.6 (mean=5.4; SD=0.7). After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by 16% for each additional patient in the average nurse's workload (95% CI 1.04 to 1.28; p=0.006). The odds of staying in the hospital a day longer at all intervals increased by 5% for each additional patient in the nurse's workload (95% CI 1.00 to 1.09, p=0.041). If study hospitals staffed at a 4:1 ratio during the 1-year study period, more than 1595 deaths would have been avoided and hospitals would have collectively saved over $117 million.
Dall'Ora, C., Saville, C., Rubbo, B., Turner, L., Jones, J., & Griffiths, P. (2022). Nurse staffing levels and patient outcomes: a systematic review of longitudinal studies. International Journal of Nursing Studies, 134, 104311.	To identify and assess the evidence for an association between nurse staffing levels, including the composition of the nursing team, and patient outcomes in acute care settings from longitudinal studies.	Hospitals (US and international)	none identified	27 studies	Systematic review	Due to operationalization of staffing measures in different ways, direct comparisons between studies was difficult. Additionally, study bias was a risk and likely underestimated the effect of higher RN staffing.	Overall, findings are consistent with beneficial effect on preventing patient death and potentially improving patient outcomes. This review also evaluated the impact of other staff (CNA, LPN, etc) on outcomes but the evidence is not sufficient to support substitution of RNs by other grades of staff.
Lasater, Karen B. PhD, RN*,†; Aiken, Linda H. PhD, RN, FAAN*,†; Sloane, Douglas M. PhD*; French, Rachel BSN, RN*,†; Anusiewicz, Colleen V. PhD, RN*,†; Martin, Brendan PhD‡; Reneau, Kyrani MS‡; Alexander, Maryann PhD, RN, FAAN‡; McHugh, Matthew D. PhD, RN, FAAN*,†. Is Hospital Nurse Staffing Legislation in the Public's Interest?: An Observational Study in New York State. Medical Care 59(5):p 444-450, May 2021. | DOI: 10.1097/MLR.0000000000001519	Examine variation in patient to nurse staffing in NY hospitals and association with adverse outcomes (LOS, mortality, avoidable costs)	NY hospitals, med-surg	none identified	417,861 patients in 116 acute care general hospitals	cross-sectional analysis	Patient-to-nurse staffing, in-hospital mortality, LOS, 30-day readmission, estimated costs using Medicare cost-to-charge ratios.	Staffing ratios ranged from 4.3 to 10.5 patients per nurse with average 6.3. Each additional patient per nurse was associated with higher odds of in-patient mortality, longer LOS, higher odds of 30-day readmission. With a 4:1 ratio, an estimated 4370 lives could be saved and $720,000 saved over 2 years.

From: Rosalee Agas Yuu
To: Irbresearch
Cc: Alex Miller; Carol Philips
Subject: House Concurrent Resolution 187, H.D. 1, S.D. 1 (2024)
Date: Sunday, June 23, 2024 1:00:13 PM
Attachments: Reference List--Safe Staffing.pdf

Dear Charlotte,

I have attached a Reference List that should help as you review the information related to best practices for nurse staffing in health care facilities. We appreciate the opportunity to provide you with information that may assist you and the Legislative Reference Bureau during this process.

As you know the nurses at Kapi'olani Medical Center for Women and Children felt the need to bring attention to this matter and walked a strike picket line for 7 days in January. 5 months later, we are still in negotiations to bargain language that would provide safe staffing for our patients who are also a big part of the community we live in. Queens Medical Center (which includes Queens at Punchbowl and Queens West), Wilcox Medical Center in Kauai and Kulana Malama (a long term care facility) are also in negotiations and there are also concerns regarding the staffing issues in these facilities. As we reached out and talked to more nurses, this staffing concern is most definitely a statewide issue as well as a nationwide problem, so the Hawai'i Nurses' Association would like to offer assistance if you need more information or need to survey our members for a fair representation of bedside nurses from various areas like long term facilities, dialysis centers, and acute care hospitals in the state of Hawaii.

Again thank you for the opportunity to share this information with you. I believe other entities will be sharing on our behalf with a phone call or email prior to June 30 deadline. If there is anything else we can assist you with, please do not hesitate to reach out.

Sincerely,

Rosalee Agas-Yuu
President
Hawai'i Nurses' Association
OPEIU, Local 50
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References

Aiken, L.H., et al (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, 288 (16), 1987-1993.

Aiken, L.H., et al (2010). Implications of the California Nurse Staffing Mandate for Other States. *Health Services Research*, 45 (4), 904-921.

Carthon, J.M.B. (2012). Nurse Staffing and Postsurgical Outcomes in Black Adults. *Journal of the American Geriatrics Society*, 60 (6), 1078-1084.

Cho, E., et al (2015). Effects of nurse staffing, work environments, and education on patient mortality: An observational study. *International Journal of Nursing Studies*, 52 (2), 535-542.

Diya, L., et al (2012). The relationship between in-hospital mortality, readmission into the intensive care nursing unit and/or operating theatre and nurse staffing levels. *The Journal of Advanced Nursing*, 68 (5), 1073-1081.

Driscoll, A., et al (2017). The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: a systematic review and meta-analysis. *European Journal of Cardiovascular Nursing*, 17 (1), 6-22.

Fontenot, H.B., et al (2022). Impact of the COVID-19 Pandemic on the Hawai‘i Nursing Workforce: A Cross-sectional Survey. *Hawaii Journal of Health and Social Welfare*, 81 (5), 119-126.

Harless, D.W. & Mark, B.A. (2010). Nurse Staffing and Quality of Care With Direct Measurement of Inpatient Staffing. *Medical Care*, 48 (7), 659-663.

Lasater, K., et al (2021). Is Hospital Nurse Staffing Legislation in the Public's Interest?: An Observational Study in New York State. *Medical Care* 0 (0), 1-7.

McHugh, M.D., et al (2013). Hospitals With Higher Nurse Staffing Had Lower Odds Of Readmissions Penalties Than Hospitals With Lower Staffing. *Health Affairs*, 32 (10), 1740-1747.

McHugh, M.D., et al (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *The Lancet*, 397 (10288), 1905-1913.

National Council of State Boards of Nursing (2023). Number of Nurses in U.S. and by Jurisdiction. *https://www.ncsbn.org/nursing-regulation/national-nursing-database/licensure-statistics.page*

Needleman, J., et al (2011). Nurse Staffing and Inpatient Hospital Mortality. *The New England Journal of Medicine*, 364 (11), 1037-1045.

Nicely, K.L.W., et al (2013). Lower Mortality for Abdominal Aortic Aneurysm Repair in High-Volume Hospitals Is Contingent upon Nurse Staffing. *Health Services Research*, 48 (3), 972-991.

Robertson, M. (2022). RN pay for all 50 states adjusted by cost of living. *Becker's Hospital Review*. https://www.beckershospitalreview.com/compensation-issues/rn-pay-for-all-50-states-adjusted-by-cost-of-living.html

State of Hawai‘i Department of Business, Economic Development, and Tourism. Occupational & Employment Wages (2022). https://files.hawaii.gov/dbedt/economic/data_reports/DLIR/OEWS-2022-Publication.pdf

Twibell, R. et al (2012). Why New Nurses Don't Stay and What the Evidence Says We Can Do About It. *American Nurses Today*, 7 (6).

Aiken, L. H., Sloane, D. M., Ball, J., Bruyneel, L., Rafferty, A. M., & Griffiths, P. (2021). Patient satisfaction with hospital care and nurses in England: An observational study. *BMJ Open*, *8*(1), e019189. https://doi.org/10.1136/bmjopen-2017-019189

Aiken, L. H., Sloane, D. M., McHugh, M. D., Pogue, C. A., & Lasater, K. B. (2023). A repeated cross-sectional study of nurses immediately before and during the COVID-19 pandemic: Implications for action. *Nursing Outlook*, *71*(1), 101903. https://doi.org/10.1016/j.outlook.2022.11.007

Al Mutair, A., Amr, A., Ambani, Z., Salman, K. A., & Schwebius, D. (2020). Nursing Surge Capacity Strategies for Management of Critically Ill Adults with COVID-19. *Nursing Reports*, *10*(1), Article 1. https://doi.org/10.3390/nursrep10010004

AWHONN Nurse Staffing Task Force. (2022). *Standards for Professional Registered Nurse Staffing for Perinatal Units, Staffing Standards Executive Summary.* Association of Women, Health Obstetric and Neonatal Nurses. https://www.awhonn.org/education/staffing-exec-summary/

AWHONN Nurse Staffing Task Force. (2022). *Standards for Professional Registered Nurse Staffing for Perinatal Units.* Association of Women, Health Obstetric and Neonatal Nurses.

Bae, S.-H. (2012). Nurse Overtime, Working Conditions, and the Presence of Mandatory Nurse Overtime Regulations. *Workplace Health & Safety*, *60*(5), 205–214. http://dx.doi.org.eres.library.manoa.hawaii.edu/10.3928/21650799-20120426-01

Bae, S.-H. (2013). Presence of Nurse Mandatory Overtime Regulations and Nurse And Patient Outcomes. *Nursing Economic$*, *31*(2), 59–89.

Bae, S.-H., Brewer, C. S., & Kovner, C. T. (2012). State mandatory overtime regulations and newly licensed nurses' mandatory and voluntary overtime and total work hours. *Nursing Outlook*, *60*(2), 60–71. https://doi.org/10.1016/j.outlook.2011.06.006

Bae, S.-H., & Yoon, J. (2014a). Impact of States' Nurse Work Hour Regulations on Overtime Practices and Work Hours among Registered Nurses. *Health Services Research*, *49*(5), 1638–1658. https://doi.org/10.1111/1475-6773.12179

Bae, S.-H., & Yoon, J. (2014b). Impact of States' Nurse Work Hour Regulations on Overtime Practices and Work Hours among Registered Nurses. *Health Services Research*, *49*(5), 1638–1658. https://doi.org/10.1111/1475-6773.12179

Bartmess, M., Myers, C. R., & Thomas, S. P. (2021). Nurse staffing legislation: Empirical evidence and policy analysis. *Nursing Forum*, *56*(3), 660–675. https://doi.org/10.1111/nuf.12594

Buerhaus, P. I. (2009). Avoiding mandatory hospital nurse staffing ratios: An economic commentary. *Nursing Outlook*, *57*(2), 107–112. https://doi.org/10.1016/j.outlook.2008.09.009

Crisis Standards of Care: A Toolkit for Indicators and Triggers (p. 18338). (2013). National Academies Press. https://doi.org/10.17226/18338

Delgado, S. A., Blake, N. T., Brown, T., Clark, L., Needleman, J., & Cassidy, L. (2024). Diverse perspectives on unit-level nurse staffing ratios in medical–surgical units: A Delphi policy analysis. *Nursing Outlook*, *72*(4), 102184. https://doi.org/10.1016/j.outlook.2024.102184

Delgado, S., Good, V., Barden, C., & Cassidy, L. (Eds.). (2024). *AACN Standards for Appropriate Staffing in Adult Critical Care*. American Association of Critical-Care Nurses.

Dierkes, A., Do, D., Morin, H., Rochman, M., Sloane, D., & McHugh, M. (2022). The impact of California's staffing mandate and the economic recession on registered nurse staffing levels: A

longitudinal analysis. *Nursing Outlook*, *70*(2), 219–227. https://doi.org/10.1016/j.outlook.2021.09.007

Duffield, C., Twigg, D., Roche, M., Williams, A., & Wise, S. (2019). Uncovering the Disconnect Between Nursing Workforce Policy Intentions, Implementation, and Outcomes: Lessons Learned From the Addition of a Nursing Assistant Role. *Policy, Politics, & Nursing Practice*, *20*(4), 228–238. https://doi.org/10.1177/1527154419877571

French, R., Aiken, L. H., Fitzpatrick Rosenbaum, K. E., & Lasater, K. B. (2022). Conditions of Nursing Practice in Hospitals and Nursing Homes Before COVID-19: Implications for Policy Action. *Journal of Nursing Regulation*, *13*(1), 45–53. https://doi.org/10.1016/S2155-8256(22)00033-3

Griffiths, P., Maruotti, A., Recio Saucedo, A., Redfern, O. C., Ball, J. E., Briggs, J., Dall'Ora, C., Schmidt, P. E., & Smith, G. B. (2019). Nurse staffing, nursing assistants and hospital mortality: Retrospective longitudinal cohort study. *BMJ Quality & Safety*, *28*(8), 609–617. https://doi.org/10.1136/bmjqs-2018-008043

Han, X., Pittman, P., & Barnow, B. (2021). Alternative Approaches to Ensuring Adequate Nurse Staffing. *Medical Care*, *59*(10 Suppl 5), S463–S470. https://doi.org/10.1097/MLR.0000000000001614

Joaquin, J. R. (2019). Mandating Nurse-to-Patient Ratios. [Letter]. *Journal of Nursing*, *119*(5). https://doi.org/10.1097/01.NAJ.0000557893.90618.ae

Lasater, K. B., Aiken, L. H., Sloane, D. M., French, R., Anusiewicz, C. V., Martin, B., Reneau, K., Alexander, M., & McHugh, M. D. (2021). Is Hospital Nurse Staffing Legislation in the Public's Interest?: An Observational Study in New York State. *Medical Care*, *59*(5), 444–450. https://doi.org/10.1097/MLR.0000000000001519

Leigh, J. P., Markis, C. A., Iosif, A.-M., & Romano, P. S. (2015). California's nurse-to-patient ratio law and occupational injury. *International Archives of Occupational and Environmental Health*, *88*(4), 477–484. https://doi.org/10.1007/s00420-014-0977-y

Mandatory Overtime and Its Impact on Nurses and CNAs. (2021, July 26). DarrasLaw. https://www.longtermdisabilitylawyer.com/2021/07/mandatory-overtime-impacts-nurse-cna-performance/

Map: The states that ban mandatory nurse overtime (and one more that could soon). (n.d.). Retrieved September 3, 2021, from https://www.advisory.com/Daily-Briefing/2018/06/19/nurse-overtime

Mark, B. A., Harless, D. W., Spetz, J., Reiter, K. L., & Pink, G. H. (2013). California's Minimum Nurse Staffing Legislation: Results from a Natural Experiment. *Health Services Research*, *48*(2pt1), 435–454. https://doi.org/10.1111/j.1475-6773.2012.01465.x

Mueller, C., Bowers, B., Burger, S. G., & Cortes, T. A. (2016). Policy brief: Registered nurse staffing requirements in nursing homes. *Nursing Outlook*, *64*(5), 507–509. https://doi.org/10.1016/j.outlook.2016.07.001

Needleman, J., Liu, J., Shang, J., Larson, E. L., & Stone, P. W. (2020). Association of registered nurse and nursing support staffing with inpatient hospital mortality. *BMJ Quality & Safety*, *29*(1), 10–18. https://doi.org/10.1136/bmjqs-2018-009219

Needleman, J., & Shekelle, P. G. (2019). More ward nursing staff improves inpatient outcomes, but how much is enough? *BMJ Quality & Safety*, *28*(8), 603–605. https://doi.org/10.1136/bmjqs-2018-009266

Needleman, J. (2024). Achieving safe staffing in hospitals. Nursing Economic$, 42(4), 203-205. https://DOI.ORG/10.62116/NEC.2024.42.4.203

Nurse Staffing Task Force. (2024). *Nurse Staffing Task Force Imperatives, Recommendations, and Actions*. American Association of Critical-Care Nurses and American Nurses Association. https://www.nursingworld.org/~499b62/contentassets/568122c62ddc44bea03b11a71f240a50/nurse-staffing-task-force-imperatives-recommendations--actions.pdf

Partners for Nurse Staffing Think Tank. (2022). *Nurse Staffing Think Tank: Priority Topics and Recommendations.* *https://www.nursingworld.org/~49940b/globalassets/practiceandpolicy/nurse-staffing/nurse-staffing-think-tank-recommendation.pdf*

Trepanier, S., Schlegel, S., Salisbury, C., & Moore, A. (2023). Implementing a virtual team model in the acute care setting. *Nursing Administration Quarterly, 47*(3), 249–256. https://doi.org/10.1097/NAQ.0000000000000584

Raja, C. (2023). How do hospitals respond to input regulation? Evidence from the California nurse staffing mandate. *Journal of Health Economics*, *92*, 102826. https://doi.org/10.1016/j.jhealeco.2023.102826

Scott, L. D. (November 6, 2023) [Letter from Linda D. Scott, President, American Academy of Nursing to Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 2003].

Serratt, T. (2013a). California's Nurse-to-Patient Ratios, Part 1: 8 Years Later, What Do We Know About Nurse-Level Outcome? *JONA: The Journal of Nursing Administration*, *43*(9), 475–480. https://doi.org/10.1097/NNA.0b013e3182a23d6f

Serratt, T. (2013b). California's Nurse-to-Patient Ratios, Part 2: 8 Years Later, What Do We Know About Hospital Level Outcomes? *JONA: The Journal of Nursing Administration*, *43*(10), 549–553. https://doi.org/10.1097/NNA.0b013e3182a3e906

Serratt, T. (2013c). California's Nurse-to-Patient Ratios, Part 3: Eight Years Later, What Do We Know About Patient Level Outcomes? *JONA: The Journal of Nursing Administration*, *43*(11), 581–585. https://doi.org/10.1097/01.NNA.0000434505.69428.eb

Serratt, T., Spetz, J., & Harrington, C. (2012). Are Staffing Changes in California's Hospitals Sensitive to Individual Hospital Characteristics? *Nursing Economic$*, *30*(6), 339–346.

Shekelle, P. G. (2013). Nurse–Patient Ratios as a Patient Safety Strategy: A Systematic Review. *Annals of Internal Medicine*, *158*(5_Part_2), 404. https://doi.org/10.7326/0003-4819-158-5-201303051-00007

Shin, S., Park, J.-H., & Bae, S.-H. (2018). Nurse staffing and nurse outcomes: A systematic review and meta-analysis. *Nursing Outlook*, *66*(3), 273–282. https://doi.org/10.1016/j.outlook.2017.12.002

Shin, S., Park, J.-H., & Bae, S.-H. (2019). Nurse staffing and hospital-acquired conditions: A systematic review. *Journal of Clinical Nursing*, *28*(23–24), 4264–4275. https://doi.org/10.1111/jocn.15046

Son, Y.-J., Lee, E. K., & Ko, Y. (2019). Association of Working Hours and Patient Safety Competencies with Adverse Nurse Outcomes: A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, *16*(21), 4083. https://doi.org/10.3390/ijerph16214083

Spetz, J. (2020). Nurse Staffing Ratios: Policy Options. In *Policy & Politics in Nursing and Health Care,* (8th ed., p. 8). Elsevier. https://evolve.elsevier.com/cs/product/9780323554985?role=student

Spetz, J., Harless, D. W., Herrera, C.-N., & Mark, B. A. (2013). Using Minimum Nurse Staffing Regulations to Measure the Relationship Between Nursing and Hospital Quality of Care. *Medical Care Research and Review*, *70*(4), 380–399. https://doi.org/10.1177/1077558713475715

VA Nurses' Overtime Lawsuit to Move Forward. (n.d.). Retrieved September 3, 2021, from https://oce-ovid-com.eres.library.manoa.hawaii.edu/article/00000446-201602000-00005/PDF

Wheatley, MS, RN, CENP, C. (2018). Coordinated Approaches to Strengthen State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke. *Preventing Chronic Disease*, *15*, 170493. https://doi.org/10.5888/pcd15.170493

Wilson, B. L., & Butler, R. J. (2021). Identifying optimal labor and delivery nurse staffing: The case of cesarean births and nursing hours. *Nursing Outlook*, *69*(1), 84–95. https://doi.org/10.1016/j.outlook.2020.07.003

Nancy Atmospera-Walch School of Nursing
Office of the Dean

UNIVERSITY of HAWAIʻI® MĀNOA

June 26, 2024

Charlotte A. Carter-Yamauchi
Director
Legislative Reference Bureau
State of Hawaiʻi
State Capitol, Room 446
415 S. Beretania Street
Honolulu, HI 96813

via

Dear Ms. Carter-Yamauchi,

Thank you for the opportunity for the Nancy Atmospera-Walch School of Nursing to provide information in response to **House Concurrent Resolution (HCR) 187, H.D. 1, S.D. 1 (2024)**, to study best practices for nurse staffing. We have found that two states have mandated staffing requirements, one state has staffing ratio for intensive care units (ICU), and other states are considering legislation regarding staffing. The attached document highlights these states' policies and literature findings.

If you have any questions about our response to your request, please feel free to contact me at
or

Sincerely,

Clementina D. Ceria-Ulep

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Nurse Staffing Ratios

As of now (June 2024), only two states (California and Oregon) have mandated staffing requirements throughout the state. Massachusetts has a staffing ratio for the Intensive Care Unit (ICU), but with some exceptions. Other states are considering legislation regarding staffing, but have not passed anything as of yet. The literature on the subject offers some insights as to important factors to keep in mind. The following is a summary of what we found, with sources cited throughout. *Please note that some of this information is a direct copy/paste from the source(s). Please consider this a starting point. Please do not publish or cite this document and instead cite the original sources, if needed.*

Existing Policies

- Massachusetts: 1 patient per nurse in the ICU; "Exceptions may be made as long as nurses follow an acuity tool to determine that a patient is stable enough to be paired" (Davidson, 2023).
- California: Unit staffing ratio; "patients' severity of illness must be documented using an acuity tool," (Davidson, 2023). Table 1 specifies the ratios required in the state of California, by non-Kaiser hospitals and Kaiser.

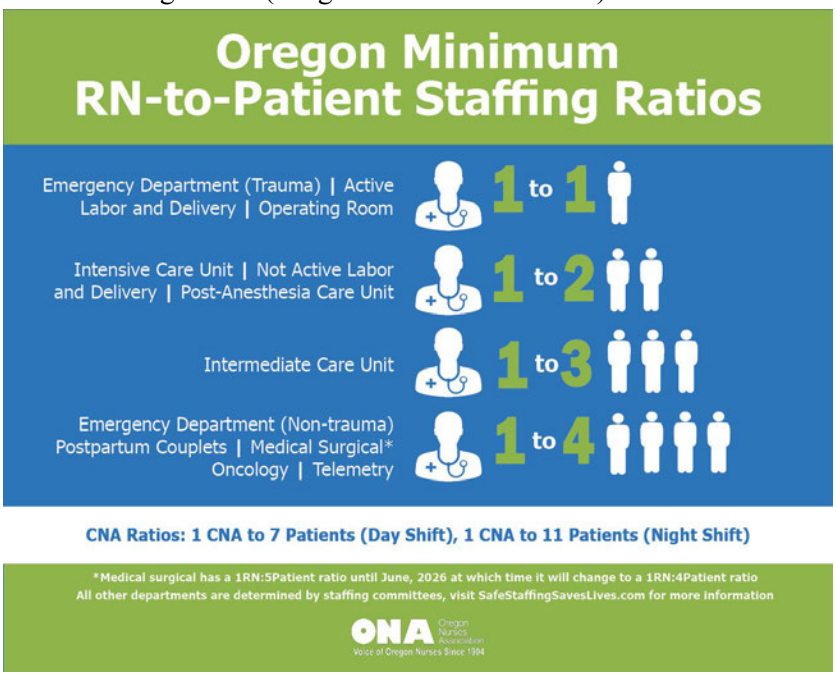
Table 1. California Nurse Staffing Ratios, Non-Kaiser and Kaiser (UNA/UHCP, 2008)

Hospital Unit	California Department of Health Services (for Non-Kaiser Hospitals)	UNAC-Kaiser Ratios
Critical Care/ICU	1:2	1:2
Neonatal ICU	1:2	1:2
Intermediate Care/Continuing Care Nursery	1:6	1:4
Perinatal Services		
Labor & Delivery	1:2	1:2
Postpartum	1:8 (4 couplets)	1:6 (3 couplets)
Well-Baby Nursery	1:8	1:6
Postanesthesia (PACU)	1:2	1:2
Emergency Department		
Trauma	1:1	1:1
Critical Care	1:2	1:2
Visits	1:4	1:3
Operating Room	1:1	1:1
Pediatrics	1:4	1:3
Stepdown	1:3	1:3
Telemetry	1:4	1:3

Medical/Surgical	1:5	1:4

- Oregon: The law (HB 2697) mandates first-in-the-nation nurse-to-patient ratios for various acute care settings, establishing these ratios as minimum staffing requirements that facilities cannot exceed without consequences. Deviations from the ratios are allowed only through innovative care models approved every two years by the committee. (More information on HB2697 available here.) These ratios are detailed in Figure 1.

Figure 1. Oregon Nurse Staffing Ratios (Oregon Nurses Association)



- Washington: Signed into law a safe staffing bill (ESSB 5236). Requires hospitals to consider hospital staffing and to have hospital staffing committees. Previously stated as “nurse staffing” and “nurse staffing committees,” the new bill “amends existing laws related to uninterrupted meal and rest breaks for acute care hospital employees (2019) and a prohibition on mandatory overtime for health care facility employees (2002).” (Washington State Hospital Association, 2023). Note: This bill is a compromise in regard to staffing, and there is no statewide nurse-to-patient ratio.
- Connecticut: “The state legislature's public health committee said it was open to "exploring" mandatory staffing ratios, although officials with the Connecticut Hospital Association openly oppose them,” (Gooch & Kayser, 2023).
- https://www.trustednursestaffing.com/nurse-patient-ratios-by-state/ - rundown of state by state and their mandates (Trusted Nurse Staffing, 2024).
- Washington ESSB 5236 - Safe Staffing bill https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Passed%20Legislature/5236-S2.PL.pdf#page=1

- Oregon HB2697
  https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/HB2697
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2697/Enrolled

From the Literature:

- This is a controversial topic (Griffiths & Dall'Ora, 2022; Kerfoot & Buerhause, 2022; as cited in Delgado et al., 2024)
- Hospitals and unions tend to be split on whether mandated staffing ratios will resolve issues. Nationwide, hospital associations have expressed concerns that a one-size-fits-all figure would drive up operating costs, worsening the situation at financially struggling hospitals and leading to service cuts and closures. Meanwhile, unions like the MNA cite research suggesting staffing ratios lead to higher care quality. (Kayser, 2023)
- Delgado et al. (2024):
  - "unit-level ratio policy could contribute to increased staffing levels, shorter LOS, and reduced nurse attrition (p. 5).
  - Unit-level ratio policy would improve the current state of patients.
  - Decreased staffing in med-surg units currently staffed above the minimum could occur as an unintended consequence (suggestion to add an element to policy design that would staff based on patient acuity, increase staffing when there is a higher demand for patient care - as is done in California)
  - Policy-associated staffing levels would improve nurse satisfaction, however, mechanisms to achieve policy adherence, such as mandatory overtime, could mitigate this impact (p. 6)
  - Disagreements on impacts of short- and long-term costs
  - Health care teams: California's ratio policy was associated with higher unlicensed assistive personnel staffing, even though the policy's requirements applied only to licensed personnel (Han et al, 2021, as cited in Delgado et al., 2024, p. 6)
  - Big takeaway: Flexibility of unit-level ratios may offer more benefits than other policies, such as patient-level ratios.
- Laseter et al. (2024):
  - This study evaluated the effects of replacing RNs with lower-wage staff. It found that reducing the number of RNs (and replacing them with lower-wage staff, such as nurse's aides or LPNs) in order to keep nursing personnel hours the same, patients were negatively affected.
  - A 10 percentage-point reduction in RNs was associated with 7% higher odds of in-hospital death, 1% higher odds of readmission, 2% increase in expected days, and lower patient satisfaction. We estimate a 10 percentage-point reduction in RNs would result in 10,947 avoidable deaths annually and 5207 avoidable readmissions, which translates into roughly $68.5 million in additional Medicare costs. Hospitals would forgo nearly $3 billion in cost savings annually because of patients requiring longer stays.
  - Big Takeaway: Reducing the proportion of RNs in hospitals, even when total nursing personnel hours are kept the same, is likely to result in significant avoidable patient deaths, readmissions, longer lengths of stay, and decreased patient satisfaction, in

addition to excess Medicare costs and forgone cost savings to hospitals. Estimates represent only a 10 percentage-point dilution in skill mix; however, the team nursing model includes much larger reductions of 40–50 percentage-points—the human and economic consequences of which could be substantial.

References

Davidson, A. (2023). Nurse-to-Patient Staffing Ratio Laws and Regulations by State. *NurseJournal*. Retrieved from: https://nursejournal.org/articles/nurse-to-patient-staffing-ratio-laws-by-state/. Accessed June 20, 2024.

Delgado, S. A., Blake, N. T., Brown, T., Clark, L., Needleman, J., & Cassidy, L. (2024). Diverse perspectives on unit-level nurse staffing ratios in medical–surgical units: A Delphi policy analysis. Nursing Outlook, 72(4), 102184. https://doi.org/10.1016/j.outlook.2024.102184.

Gooch, K., & Kayser, A. (2023). 4 states slide nurse-staffing mandates on the table. *Becker's Hospital Review.* Retrieved from: https://www.beckershospitalreview.com/workforce/3-states-slide-nurse-staffing-mandates-on-the-table.html. Accessed June 29, 2024.

Lasater, K. B., Muir, K. J., Sloane, D. M., McHugh, M. D., & Aiken, L. H. (2024). Alternative models of nurse staffing may be dangerous in high-stakes hospital care. *Medical Care, 62*(7), 434-440. https://journals.lww.com/lww-medicalcare/fulltext/2024/07000/alternative_models_of_nurse_staffing_may_be.2.aspx?context=latestarticles.

Oregon Nurses Association (2023). Safe Staffing Saves Lives: Amended Bill Overview. Retrieved from: https://www.oregonrn.org/page/SafeStaffing-AmendedBill. Accessed on June 20, 2024.

Trusted Nurse Staffing (2024). 2024 Nursing Ratios: Which States Have Nurse-Patient Ratios and Why They're Important. Retrieved from: https://www.trustednursestaffing.com/nurse-patient-ratios-by-state/. Accessed on June 20, 2024.

United Nurse Associations of California, & Union of Health Care Professionals (UNA/UHCP). 2008. California Nurse-to-Patient Ratios. Retrieved from: https://unacuhcp.org/california-nurse-to-patient-ratios/. Accessed on June 20, 2024.

Washington State Hospital Association (2023): https://www.wsha.org/articles/new-requirements-for-hospital-staffing-2023-sb-5236/