

March 5, 2025

Senate Health and Human Services Committee
Nevada State Legislature
401 South Carson Street
Carson City, NV 89701

Sent electronically to: senhhs@sen.state.nv.us

RE: Opposition to SB182 – Mandatory Nurse Staffing Ratios in Nevada Hospitals

Dear Chair Doñate and Members of the Committee:

The Nevada Hospital Association strongly opposes SB182, the bill proposing mandatory nurse staffing ratios (MNSRs) for hospitals with 70 or more beds in Clark and Washoe counties. This legislation poses significant risks to our healthcare delivery system, burdens a variety of other healthcare providers, and, most importantly, threatens to harm access to care for Nevadans.

The Case Against Mandatory Nurse Staffing Ratios

Hospital-wide mandatory nurse staffing ratios have been considered and rejected in many states across the U.S. over the years, with only California and Oregon adopting them. However, despite two decades of MNSRs in California, the state is still projected to face severe nurse shortages. California is projected to need nearly 40,000 nurses by 2030.¹ Oregon, whose law is only a year old, recently experienced a historic nurses' strike. These examples clearly show that MNSRs are not the solution to Nevada's nursing shortage. Unlike many other states, Nevada's healthcare delivery system is fragile and underdeveloped, making the implementation of MNSRs particularly problematic.

Nursing and CNA Shortages

Nevada's nursing shortage is severe. Nevada currently ranks 46th in the nation for nurses per capita.² When Oregon passed its MNSR law, the state ranked 30th in the nation for nurses per capita.³ Oregon had far more nurses to help meet the MNSRs.

Nevada requires 3,162 additional registered nurses (RNs) and 3,284 additional licensed practical nurses (LPNs) just to reach the national average.⁴ By 2030, Nevada is projected to be one of the five states with

¹ Nurse.org. [Nursing Shortage May Be Worse by State Than Projected, New Analysis Shows](#). June 23, 2023

² Bureau of Labor Statistics. The U.S. Nursing Shortage: A State-by-State Breakdown. March 28, 2024. <https://nursejournal.org/articles/the-us-nursing-shortage-state-by-state-breakdown/>

³ Becker's Hospital Review. June 23rd, 2023. <https://www.beckershospitalreview.com/workforce/nurses-per-capita-ranked-by-state.html>

⁴ Nevada Health Workforce Research Center. [Health Workforce in Nevada: A Chartbook – 2023 Edition](#). fg. 83. pg. 98

the most pronounced nursing shortages in the nation.⁵ Additionally, 40% of Nevada's RN licenses (approximately 24,000) are held by nurses with an out-of-state address.⁶ This means our actual shortage could be far greater than anticipated because nurses with out-of-state addresses are not as likely to be working in Nevada permanently.

We are also facing a CNA shortage with 5,055 more CNAs needed to meet the national average.⁷ SB182 sets forth mandatory CNA staffing ratios. California's law does not mandate staffing ratios for CNAs. Mandating CNA staffing would only exacerbate staffing challenges for other healthcare providers who are more dependent on CNA staffing, such as nursing homes, because CNAs would leave their current jobs to work at hospitals that may pay more.

Economic Impact of SB182 on Nevada's Healthcare System

To meet the proposed mandatory staffing ratios in SB182, Nevada hospitals in the two counties would need to hire 1,498 more nurses. This would add an estimated \$188 million+ to Nevada's healthcare delivery system (not including the cost of additional CNAs). Since we have many unfilled open RN positions, it is likely we will need to use travelling nurses and contract nurses, and the estimated cost will be \$240 million+ annually (not including the cost of additional CNAs). Such a large increase in healthcare costs comes at a time when the federal government is considering significant cuts to Medicaid reimbursement, including the Private Hospital Medicaid Provider Fee programs, which would have a devastating impact on hospitals. These cuts could reduce funding for critical services and decrease patient access.

It's important to note that Nevada hospitals are already searching for nurses to fill vacant positions. As of January 1, 2025, Nevada hospitals were actively recruiting open positions for 780 RNs, 33 LPNs and 239 CNAs. If hospitals cannot fill these positions, how will they be able to fill nearly 1,500 more?

Does MNSR Improve Quality of Care?

Research and evidence on whether mandatory nurse staffing ratios translate into better patient outcomes is divided, with many studies indicating only marginal improvements, if any.

The *Journal of Nursing Administration* published research conducted by a faculty member at the University of Nevada, Reno's Orvis School of Nursing who examined the impact of California's nurse-to-patient ratios on patient-level outcomes based on a comprehensive literature review. The research concluded:

... we explored the impact the ratios had on patient-level outcomes and found that significant and widespread improvements in patient

⁵ Nurse.org. Using data from the Bureau of Labor Statistics, U.S. Census, and Univ. Of Virginia Center for Public Service. [Nursing Shortage May Be Worse by State Than Projected, New Analysis Shows](#). June 23, 2023

⁶ Nevada State Board of Nursing.

⁷ Nevada Health Workforce Research Center. [Health Workforce in Nevada: A Chartbook – 2023 Edition](#). fig. 83. pg. 99

*outcomes **have not been substantiated**. The broad and long-term impact of the nurse-to-patient regulation remains unclear. (Emphasis added)⁸*

Given the overwhelming financial burden implementation of SB182 would have on our healthcare system, particularly with looming Medicaid cuts, now is not the time to implement an unproven policy that could drain millions from our system without guaranteeing significant quality improvements for our patients.

Lack of Access

All health care providers, especially nursing homes, have difficulty recruiting nurses and CNAs. The inability of post-acute providers to adequately staff their facilities causes a bottleneck at our hospitals.

Hospitals cannot discharge medically cleared patients from the hospital because of a lack of post-acute care options. This problem will worsen with MNSRs as hospitals will be driven to hire nurses from other healthcare facilities to meet the mandated ratios, causing further under-staffing at post-acute facilities. As a result, medically cleared patients will be housed in hospitals longer, occupying beds that will be subject to the MNSRs, increasing costs, and reducing the availability of hospital beds for patients who actually require acute care.

Behavioral health providers also have difficulty recruiting and retaining nurses and CNAs. As more behavioral health nurses join the ranks of hospitals, Nevadans will have greater difficulty accessing behavioral health services.

Emergency Departments (EDs) will see an even greater number of behavioral health patients because they will not be able to access services in the community. This will further clog EDs, and patients needing emergency care will not be able to access it timely because the MNSR will count the behavioral health patients who may remain in the ED for hours upon hours, assigning the ED nurses to their care instead of the patients who actually need emergency care.

Unintended Consequences of MNSRs in Nevada

SB182 fails to account for the dynamic and unpredictable nature of healthcare. Nurse staffing in hospitals is influenced by multiple factors, including nurse call-offs, departures, the acuity of patients, and patient surges. Unfortunately, MNSRs impose rigid, one-size-fits-all ratios that do not account for patient acuity or the specific needs of each unit and will further burden our already fragile healthcare delivery system.

For instance, Nevada's emergency departments already face high volumes of patients seeking care for conditions that would typically be managed by primary care providers or behavioral health providers.

⁸ Serratt T. California's nurse-to-patient ratios, part 3: eight years later, what do we know about patient level outcomes? J Nurse Adm. 2013

These patients, often covered by Medicaid, have lower nursing needs than other patients, but under MNSRs, they will receive care at the same level simply because they chose to enter the ED rather than going to a provider in the community or elsewhere, diverting resources from patients in critical need. In fact, emergency departments will be forced to go on diversion if they reach their staffing cap as a result of non-emergency care patients, resulting in ambulances bypassing the hospital and potentially delaying care for trauma victims or patients requiring urgent attention.

Hospitals have limited options for compliance

Hospitals in Nevada will face significant challenges and difficult decisions in complying with the new law. Their options are few:

- **Recruit more nurses:** With Nevada's nursing shortage, it will be exceedingly difficult to recruit enough nurses to meet the mandated ratios. Already, Nevada hospitals have 780 RN, 33 LPN and 239 CNA positions they can't fill.
- **Hire traveling nurses:** While this option could help fill staffing gaps, it significantly raises healthcare costs. Additionally, the nursing shortage is a nationwide issue so even recruiting traveling nurses can be problematic, especially in a state that is not part of the Nurse Licensure Compact.
- **Recruit from other providers:** Hospitals will be forced to recruit nurses and CNAs from other healthcare facilities in the state, public health offices, clinics, and other places that need nurses and CNAs. This will force these other facilities to also search for nursing staff.
- **Close beds:** Hospitals can eliminate the need for more nurses by closing beds. With a constantly growing population, this will adversely affect the state's bed supply and patient access. Nevada hospitals estimate the potential closure of 956 beds daily if additional nurses cannot be recruited.
- **Close services:** Some services, such as maternity services, require a lot of staff when they are busy. They often have too many idle staff when things are slow. The bill requires one nurse to one patient for women in active labor and one nurse for four patients (over each 12-hour shift) when the mother is not in active labor. Mothers and babies are counted as separate patients. Twins or triplets really throw the ratio off. Of course, hospitals never know how many deliveries they will have on a given day. Many mothers arrive unexpectedly at the hospital and have never received prenatal care. Other mothers remain in active labor for hours. Hospitals maintaining maternity units will have to over-staff or turn mothers away when they become full. Overstaffing can be unnecessarily costly for a hospital that is financially struggling.
- **Divert ambulances:** The Emergency Room MNSRs will also be difficult to achieve. Fixed ratios do not account for fluctuating patient acuity or emergency situations. Once again, a hospital never knows when a car accident, shooting, or other event involving multiple injuries will occur. Because of Nevada's poor access to primary care and behavioral healthcare services, EDs are often used by people for primary care and law enforcement for behavioral healthcare holding



centers. These patients have a lower nursing need than most other patients in the emergency room, but because of the MNSR, primary care and behavioral health patients will receive the same nurse ratio as other patients in the ED. Hospitals will be forced to staff at heightened ratios because the state has poor primary care and behavioral healthcare. Bottlenecks will occur in emergency rooms. Inpatient units will be forced to “shut their units” down once they reach their maximum nurse-to-patient ratio. Patients will have to remain in the ED until a properly staffed room becomes available. This blocks additional patients from entering the emergency room because of the staffing ratios for the ED.

- EDs cannot close their doors. Patients walking into ED waiting rooms must be screened and stabilized under EMTALA. Some need to be in beds with monitors, but they cannot be placed in those beds because of MNSR. Time is of the essence in EDs, and the staffing ratios will put patients at risk.
- When the ED is full, hospitals will have to make the decision to go on diversion, which means ambulances are directed to bypass the hospital and go elsewhere. This could be especially tragic if our trauma centers are full and there is a multiple-person accident or incident where a high level of care is needed. Patients should not be forced to travel across town to a lower level of care when they need lifesaving emergency services quickly.
- EMS is also adversely affected. They will see increased Ambulance Patient Offload Times (APOT), which holds an ambulance at the ED. This prevents the ambulance and crew from responding to calls for help.

Technical and Service Staffing Committees

SB182 also mandates that certain hospitals create technical and service staffing committees. The legislative requirements for these committees are unnecessary and will only add to the administrative burden without improving patient care. These committees may create confusion, inefficiency, and bureaucracy that would divert resources away from the immediate needs of the patients.

Real-Life Scenarios and the “One-Size-Fits-All” Problem

MNSRs fail to account for the unique and unpredictable nature of hospital care. Consider the following scenarios:

1. You are scheduled for a life-saving surgery to remove a tumor. On the morning of the surgery, you receive a call saying it’s canceled because a nurse called in sick, and the hospital cannot meet staffing requirements in the post-operative surgical unit. Your surgery cannot be rescheduled for several weeks, and your tumor grows.
2. You are scheduled to be induced for labor, but a mother expecting twins arrives unexpectedly in active labor. Other mothers arrive at the hospital in active labor. Because there are not enough

nurses, you are sent home.

3. You experience a heart attack or stroke. The ambulance takes you to the nearest trauma center. However, the trauma center has gone on diversion because it is short of just one nurse, and you are diverted to another hospital. Time is of the essence, and your care is delayed.

These are real situations that could have life-altering consequences for patients. MNSRs will limit hospitals' ability to respond to dynamic, unpredictable needs.

Conclusion

SB182, while well-intentioned, will do more harm than good to Nevada's fragile healthcare delivery system. The bill fails to address the many challenges we face. Before considering such a drastic measure, we must address the fundamental issues facing our healthcare system by:

- expanding nursing schools and graduating more nurses;
- working to surpass the national average number of nurses per capita;
- filling all hospital open nursing positions;
- staffing all post-acute facilities' beds;
- moving all medically cleared patients out of hospitals timely;
- ensuring that Medicaid patients have access to primary care services and providing adequate behavioral health services in the community so that EDs are not forced to delay service to critically ill patients because behavioral health patients cannot be safely discharged;
- improving the guardianship process so that patients can be discharged from hospitals timely; and
- enacting The Nurse Licensure Compact to ensure nurses can work in our state without having to apply for a separate license like the other 41 nurse licensure compact states and two U.S. territories.

Until these foundational issues are addressed, MNSRs will do more harm than good. If you are concerned about rising healthcare costs and access to healthcare, we urge you to **vote "No" on SB182**.

Regards,



Patrick Kelly
President & CEO
Nevada Hospital Association