The California Experience Following Implementation of Minimum Ratios in 1999

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This presentation will…

- Describe the process that resulted after the ratio legislation passed
- Examine the experience of the first year of implementation
- Suggest directions for future research, regulation, and legislation

AB 394 was signed in October 1999

- Department of Health Services (CDHS) required to establish minimum licensed-nurse-to-patient ratios for each type of hospital unit
  - RNs and LVNs included
- Unlicensed personnel are prohibited from performing certain tasks

Stakeholders submitted suggestions to CDHS

- California Healthcare Association (hospital group) suggested 1 nurse to 10 patients in medical-surgical
- Service Employees International Union suggested 1 nurse to 4 patients in medical-surgical
- California Nurses Association suggested 1 RN to 3 patients in medical-surgical

After much work by CDHS…

- Proposed ratios were announced in January 2002
  - Medical-surgical ratio begins at 1:6
  - Medical-surgical ratio transitions to 1:5 after one year
- Governor Davis announced a $60 million initiative to expand the supply of nurses on the same day

Predicted per-hospital cost of minimum ratio proposals

Source of data	Cost of initial ratios	Cost per discharge
OSHPD data	$57,540,000	$19.18
DHS survey data	$266,729,000	$88.90

There were approximately 3 million general acute-care discharges in 2001.
The estimates from OSHPD data are a “lower bound”.

Source: Spetz’s calculations from OSHPD data and from Kravitz, Sauve, et al.

Hospital responses to ratio legislation

- Most hospitals followed California Hospital Association opposition
- Kaiser Foundation Hospitals established agreement with SEIU that embraced SEIU proposed ratios
- Some hospitals already were staffing better than the final minimum ratios

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The legal battle

- CHA filed lawsuit on December 30, 2003
  - Claim: requiring ratios "at all times" was unreasonable due to staff breaks
  - CDHS argued that difficulty meeting this regulation was not reason to eliminate it
  - CHA lost this suit

The legal battle

- Governor S. issued emergency order to delay 1:5 medical-surgical ratio on November 4, 2004
  – California Nurses Association sued against the emergency order
  – CDHS argued that difficulty meeting this regulation was reason to eliminate it
  – CDHS lost this suit

Hospitals may request waivers

- In first quarter:
  - 60 waiver requests
    - 23 approved
    - 29 denied
    - 8 unnecessary
  - Nearly all rural hospitals that requested waivers received them

Enforcement mechanisms are weak

- CDHS cannot fine hospitals
  - Violations require submission of plan for remedy
- Medicare and Medicaid require compliance with state laws and regulations
  - These programs can audit records
  - Payments can be revoked retroactively
- California's malpractice cap ($250,000) does not apply in cases of negligence
  - Willfully violating regulations constitutes negligence

Are hospitals meeting the regulations?

- First quarter of ratios…
  - 49 complaints
    - 2 citations, requiring action plan for remedy
  - 68 self-reported violations
- Los Angeles Times reported that 15 of 28 hospitals inspected January-October 2004 did not meet ratios

Reduced access to care due to ratios?

- No reports of permanent bed closures thus far in California
- Statewide, one county may have had a permanent increase in emergency room diversions
  - An emergency room closed recently in that county

What about hospital closures?

- In January 2004, Santa Teresita Hospital announced closure
  - They claimed the ratios caused the closure
- Former employees said the hospital was meeting the ratios without difficulty
- Net income in 2002: -$4,758,911
  - Equity in 2002: -$9,137,154

Substitution of staff

- Stanford issued layoff notices to 113 nursing aides in advance of the ratios
- Reduction of EMT staff in emergency rooms

More power to the nurses

- Some CNOs are glad to have upper management forced to provide more funding for nurse staffing
- Nurses can close a unit to admissions if additional staff are not available

- What about the patients?

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Has staffing increased?

- Many hospitals were staffing at the minimum level before January 1, 2004
  - Are hospitals still using their patient classification systems?
  - Are support staff positions being eliminated?
  - Are staff simply moving shift-to-shift?
- Is staffing rising at the cost of access to care?

Are nurses changing jobs in ways that affect the quality distribution?

- School class-size reduction is analogous
  - Implemented in 1996-1997
- Demand for teachers rose
- Teachers moved from poor, difficult schools to wealthy schools
- Students in advantaged schools did better
- Students in disadvantaged schools did worse

Will there be improvements in quality of care?

- None of the studies of staffing and quality identify the “right” ratio
  - CDHS may have targeted too high or low
- Organizational culture is known to affect quality of care
  - Are ratios changing culture for the better?
- Research on the effects won’t be available for two or more years

What can we recommend to other states?

- It's too early to weigh benefits and costs of ratios because benefits cannot be measured yet
- Ratios provide a blunt instrument to change staffing
  - Other approaches might have advantages
  - Compliance with flexible regulations is a problem
- The supply of nurses must be increased
  - Even without ratios, there is a long-term shortage

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