California’s Minimum Nurse-to-Patient Ratios: What Is Happening? What Next?

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This presentation will...

- Discuss the history and goals of California’s minimum licensed nurse staffing mandate
- Assess the potential impact of minimum nurse staffing ratios
- Provide preliminary observations about the first few months of the ratios
- 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
- Regulations were implemented January 1, 2004
Previous staffing regulations in California

- All hospitals must staff 1 licensed nurse per 2 patients in critical care (since 1977)
  - Half must be RNs

- California Code of Regulations Title 22:
  - All hospitals have a valid patient classification system
  - Hospitals are expected to staff according to their system

- RNs and LVNs follow scope of practice regulations developed by the BRN and BVNPT
Ratio goal #1: Improve quality of care

• Most research finds that more nurses are associated with better patient outcomes
  – Some studies do not find this link
  – Studies differ in data, methods, quality

• The research does not clearly show a causal link between staffing and outcomes

• The studies do not offer an ideal ratio
Ratio goal #2: Attract more people to nursing

- California faces a major shortage of nurses
  - Between 70,000 and 120,000 new nurses are needed to meet demand in 2020

- Working conditions are believed to be poor for nurses
  - Growing numbers of licensed nurses are thought to be working outside nursing
  - Improvements in working conditions might improve recruitment and retention of nurses
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
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Studies were conducted to help CDHS

- UCSF study (funded by California HealthCare Foundation)
  - Examined literature, determined research at that time did not support a particular ratio
  - Tabulated hospital data to estimate potential effects of stakeholder proposals
  - Noted potential problems with ratios in general

- UC-Davis study (commissioned by CDHS)
  - Literature review
  - Analysis of special survey data collected by CDHS
  - Estimates of impacts of final proposed ratios
How will minimum staffing ratios affect hospitals?

- How many hospitals are affected by the proposals?
- How many nurses will be needed to meet the new requirements?
- What is the estimated cost of the proposals?
## Share of hospitals not in compliance with DHS proposal

<table>
<thead>
<tr>
<th></th>
<th>DHS survey data</th>
<th>OSHPD data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial ratios</td>
<td>Later ratios</td>
</tr>
<tr>
<td>Med-Surg</td>
<td>~20%</td>
<td>~50%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>~40%</td>
<td>~40%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>L &amp; D</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: OSHPD; Kravitz, et al.
### Estimated statewide FTE shortage from DHS survey data

<table>
<thead>
<tr>
<th></th>
<th>Initial ratios</th>
<th>Later ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>4,880</td>
<td>7,230</td>
</tr>
<tr>
<td><strong>Med-Surg</strong></td>
<td>1,030</td>
<td>2,460</td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td>490</td>
<td>490</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
<td>520</td>
<td>520</td>
</tr>
<tr>
<td><strong>L &amp; D</strong></td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Kravitz, Sauve, et al.
Cost estimates require some assumptions

- Are new hires RNs or LVNs?
- Do wages change?
- Hospitals do not reduce staffing if they are above the new minimum ratios
Predicted per-hospital cost of minimum ratio proposals

<table>
<thead>
<tr>
<th>Source of data</th>
<th>Cost of initial ratios</th>
<th>Cost per discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSHPD data</td>
<td>$57,540,000</td>
<td>$19.18</td>
</tr>
<tr>
<td>DHS survey data</td>
<td>$266,729,000</td>
<td>$88.90</td>
</tr>
</tbody>
</table>

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.
Critiques of these analyses

• SEIU commissioned study by Berliner & Kovner
  – If hospitals moved staff across shifts costs would be lower
  – If higher ratios reduce adverse events, costs could be lower (or there could be cost savings)

• Other comments
  – Cost savings could come from reduced reliance on agency and traveling nurses
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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California is not the first locale to establish ratios

- Victoria, Australia, established ratios in 2000
  - Labor agreement between Australian Nursing Federation and state government
  - 70% of hospitals are in public system
  - Government supported recruitment drive

- ANF claims ratios attracted 2,650 inactive nurses back to work

- There were not enough nurses for ratios, so patient care wards were closed
Other U.S. states are considering ratios

- Fourteen states had proposals in 2003
  - None passed

- TX, OR, KY, VA have passed laws/regulations requiring staffing plans at hospitals

- California Nurses Association spearheaded creation of new organization to push ratios nationwide: American Association of Registered Nurses
  - Five state organizations left ANA to join AARN
What is happening in California?

- Public relations battle
  - Hospital organizations want to portray ratios as onerous
  - Nursing organizations want to portray this as key to patient and worker safety

- Legal battle
  - CHA filed lawsuit on December 30, 2003
  - Claim: requiring ratios “at all times” was unreasonable due to staff breaks
  - CHA has 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
  - Alleged violations that could harm patients are investigated in 2 working days
  - Other violations are investigated in 70 days

- In first quarter:
  - 49 complaints
    - 2 citations, requiring action plan for remedy
  - 68 self-reported violations
Other incentives lead to compliance

- 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
Stakeholders are surveying members about compliance with ratios

- California Nurses Association survey of RNs in 111 hospitals
  - 68% say staffing has improved
  - 59% are generally in compliance
  - Some hospitals are severely violating the ratios

- California Healthcare Association survey of 300 hospitals
  - 89% were out of compliance at some time
  - Costs will be $422 million
Closure of Santa Teresita Hospital?

- In January 2004, Santa Teresita Hospital announced closure
  - They claimed the ratios caused the closure

- 39 acute care beds licensed in 2002, 177 long-term care beds
  - 60% occupancy rate

- Hospital had an emergency room
  - Several other major hospitals nearby
  - Only 1-2 other ERs within 5 miles
Was the hospital closure due to ratios?

- Former employees said the hospital was meeting the ratios without difficulty
- Hospital did not provide legal layoff notice to employees
- Net income in 2002: -$4,758,911
  - Equity in 2002: -$9,137,154
Reduced access to care due to ratios?

- Closures of patient care wards occurred in Victoria, Australia
- No reports of significant closures thus far in California
- Statewide, no increase in emergency room diversions
  - Exception: Santa Clara county, in January 2004
Other potential issues

- What share of licensed nurses can be LVNs?
  - Regulations say 50%

- Are hospitals eliminating other support staff to free funds for hiring nurses?
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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?
Is nurse supply rising enough?

- There is a nursing shortage now
  - More graduations of nurses is needed to end the shortage in the short-term and long-run

- Nursing schools in California do not have capacity to meet future needs
  - Waiting lists are reported at nearly all nursing programs
  - Nurse Workforce Initiative funding is in limbo and needs to be released
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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