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# NURSE STAFFING, LEGISLATIVE ALTERNATIVES AND HEALTH CARE POLICY

*Theresamarie Mantese, Christine Pfeiffer, and Annamarie Mantese*

## I. INTRODUCTION

In this age of trying to maximize limited personnel to undertake expanding workloads, there is a risk of a detrimental increase of mistakes, misjudgments, and harm. The health care industry is especially vulnerable to the risks associated with understaffing, as health care providers, squeezed by the rising costs of delivering health care, are pressured to find cost-saving methods. This search inevitably causes hospital administrators to consider whether reducing the number of staff will help them in meeting budgetary goals.

While nurse-staffing legislation has been enacted for nursing homes and other health care providers,<sup>1</sup> the issue of nurse staffing within hospitals is still a hotly debated topic among legislative policymakers, health care associations, and administrators. One obvious focus of this debate is whether medical providers will be more at risk of breaching a standard of care because staffing levels have been cut so low that patients do not receive the proper care and thus suffer debilitating injuries or fatal results. Over the years, there has been a vigorous dialogue in the health care community regarding the vital role nurses play in the quality of health services received by patients.

The health care community, including nursing associations, the federal government, state legislatures and other health care stakeholders, has adopted different approaches to address nurse staffing within hospitals. California was the first state to enact legislation adopting mandatory nurse-patient ratios in an effort to deal with the nurse staffing issue.<sup>2</sup> Many health care policymakers are carefully watching California's experience to determine whether it is an advantageous approach. In conjunction with state efforts, the federal government is now considering whether Medicare funding should be

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<sup>1</sup> See, e.g., DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE EXPERIENCES WITH MINIMUM NURSING STAFF RATIOS FOR NURSING FACILITIES: FINDINGS FROM THE RESEARCH TO DATE AND A CASE STUDY PROPOSAL (2003), available at <http://aspe.hhs.gov/daltcp/reports/8state.pdf>. As of February 2003, thirty-six states had laws or regulations establishing minimum nurse-to-patient ratios in nursing homes. *Id.* at ii.

<sup>2</sup> CAL. HEALTH & SAFETY CODE § 1276.4 (West 2000).

tied to a nurse staffing standard, as well as the other already existing criteria.

This article will explore the various legislative initiatives that have been initiated to address nurse staffing in hospitals within this country. First, this article will provide a summary of the California's experience after legislating mandatory nurse-staffing ratios. This article will also briefly examine the legislative efforts in other states regarding nurse-staffing issues. Then, this article will discuss recent efforts at the national level tying payment under Medicare to nurse-staffing ratios, including legislation limiting mandatory nurse overtime and other proposals, and the new data reporting requirements for hospitals under the Medicare Modernization Act.<sup>3</sup> Additionally, this article will describe quality-related accrediting standards adopted by the Joint Commission on Accreditation of Healthcare Organizations, a national accrediting agency for health care organizations.

Finally, we will discuss how health care policymakers may want to shape the debate on the volatile issue of nurse staffing within the context of recent legislative efforts. As many competing demands are being made on an already stressed health care system, administrators may legitimately question why nurse staffing should be given center focus for limited economic resources. The preliminary response to this inquiry is that health care systems are faced with a looming crisis based on a shortage of nurses to care for patients. This crisis will lead to not only a reduction in the quality of health care in the future, but also jeopardizes the current level of quality in health care that patients receive. It is within this context that this article will explore the policy considerations of nurse staffing.

## II. NURSING SHORTAGE AND PATIENT CARE

Government reports and other data compiled by health care policymakers and researchers have raised concerns about the shortage of nurses in the United States to meet the increased needs of patient care.<sup>4</sup> The national data from the Department of Health and Human

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<sup>3</sup> The full title of this Act is the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003." Pub. L. 108-173 (2003).

<sup>4</sup> See, e.g., UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING WORKFORCE: EMERGING NURSE SHORTAGES DUE TO MULTIPLE FACTORS (2001), available at <http://www.gao.gov/archive/2001/d01944.pdf> [hereinafter NURSING SHORTAGES]; UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING WORKFORCE: RECRUITMENT AND RETENTION OF NURSES AND NURSE AIDES IS A GROWING CONCERN (2001) (Testimony of William J. Scanlon, Director, Health Care Issues),

Services on projected supply, demand, and shortages of registered nurses indicates that by 2020, the shortage of registered nurses should peak at more than one million nursing vacancies.<sup>5</sup> In a recent article in the *New England Journal of Medicine*, the author stated that “[e]ntire public health systems are at risk of collapse because of the growing shortages of nurses in the developing world.”<sup>6</sup>

Although the data correlating nurse workforce shortages with the quality of patient care may be inconclusive, some state legislatures have enacted statutes seemingly based on the premise that such a correlation exists.<sup>7</sup> That the issue of a nursing shortage should be dealt with through legislation is reasonable based on long-term planning and other policy goals. However, such legislation should be more closely evaluated to determine whether it will achieve the intended goal of improved patient care.

### III. CALIFORNIA STATUTE AND EXPERIENCE

In 1999, California enacted the first legislation in the United States to establish minimum staffing levels for registered nurses and licensed vocational nurses working in hospitals.<sup>8</sup> The California regulations, requiring California hospitals to have no more than six patients per nurse in general medical-surgical units and labor units, and one patient per nurse in the operating rooms, took effect on January 1, 2004.<sup>9</sup>

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*available at* [www.haponline.org/downloads/NrsingWrkfrceConcern.pdf](http://www.haponline.org/downloads/NrsingWrkfrceConcern.pdf) [hereinafter NURSING RECRUITMENT]; UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING WORKFORCE: MULTIPLE FACTORS CREATE NURSE RECRUITMENT AND RETENTION PROBLEMS (2001), *available at* <http://www.haponline.org/downloads/NrsingWrkfrceProblems.pdf> [hereinafter RETENTION PROBLEMS].

<sup>5</sup> DEPARTMENT OF HEALTH AND HUMAN SERVICES, PROJECTED SUPPLY, DEMAND, AND SHORTAGES OF REGISTERED NURSES: 2000-2020, at 10 (2002), *available at* [http://www.ahca.org/research/rnsupply\\_demand.pdf](http://www.ahca.org/research/rnsupply_demand.pdf); NURSING SHORTAGES, *supra* note 4, at 1-2.

<sup>6</sup> Srekanth Chagutura & Snigdha Vallabhaneni, *Aiding and Abetting – Nursing Crises at Home and Abroad*, 353 *NEW ENG. J. MED.*, 1761, 1762 (2005).

<sup>7</sup> *See infra* Part III & IV.

<sup>8</sup> CAL. HEALTH & SAFETY CODE § 1276.4 (West 2000).

<sup>9</sup> A.B. 394, Chap. 945 (Cal. 1999). These regulations were the result of an intricate collaboration over a 10-year period between the American Nurses Association California and the Association of California Nurse Leaders, who formed a partnership to build a staffing and quality database to analyze nurse-patient ratios on patient outcomes. Much has been written about this process and legislative history that ultimately resulted in the passage of the California statute. *See, e.g.*, Nancy

Nurses, hospitals, and other health care policymakers are closely watching California to determine whether legislating minimum nurse-patient ratios in hospitals has had any significant impact on the improvement of medical care provided to patients. In the first study of the effect of the California nurse-to-patient ratio statute, the authors found no significant changes in the incidence of patient falls or pressure sores (two common hospital-based adverse nursing-sensitive outcomes.<sup>10</sup>).<sup>11</sup> However, the authors cautioned that these findings were preliminary and that more data over a longer time frame needed to be analyzed.<sup>12</sup>

Thus, at best, the data is inconclusive as to the impact of legislation mandating nurse staffing levels in hospitals.

#### IV. OTHER STATE STATUTES

While California has been the first state to enact a minimum nurse-to-patient ratio statute, other states have enacted statutes requiring the compilation of data to determine if there is any relationship between nurse staffing and patient outcomes.<sup>13</sup> These states have proceeded very cautiously to first establish regulatory bodies to gather and analyze

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Donaldson et al., *Leveraging Nurse-Related Dashboard Benchmarks to Expedite Performance Improvement and Document Excellence*, 35 J. NURSING ADMIN. 163 (2005); Nancy Donaldson et al., *Nurse staffing in California hospitals 1998-2000: Findings from the California Nursing Outcomes Coalition Database Project*, 2 POL'Y, POL., & NURSING PRACTICE 19 (2001). Before the enactment of A.B. 394, hospitals in California were required to set staffing requirements on certain units (nurseries, neonatal intensive care, adult intensive care and coronary care) based on legislatively prescribed specifications. CAL. CODE REGS. tit. 22, § 70217 (2005). This legislation was insufficient to address the changing health care environment where “[m]ajor redesign of acute –care-delivery systems ... had resulted in reduced RN-to-patient ratios and increased demands on direct care RNs because of decentralization of ancillary services” was occurring concomitantly with “increased patient acuity and reduced length of stay associated with episodes of acute care [which] resulted in a markedly more complex, severely ill hospitalized patient population requiring more intensive nursing care.” Nancy Donaldson et al., *Impact of California’s Licensed Nurse-Patient Ratios on Unit-Level Nurse Staffing and Patient Outcomes*, 6 POL'Y, POL., & NURSING PRACTICE 198, 199 (2005)[hereinafter Donaldson, *Nurse-Patient Ratios*].

<sup>10</sup> MARK. W. STANTON, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HOSPITAL NURSE STAFFING AND QUALITY OF CARE 2 (2004).

<sup>11</sup> Donaldson, *Nurse-Patient Ratios*, *supra* note 9, at 209.

<sup>12</sup> *Id.* at 207.

<sup>13</sup> See, e.g., CONN. GEN. STAT. ANN. § 19A-89 (West 2003) and Florida (FLA. STAT. ANN. § 408.05 (West 2005).

the data to justify the enactment of a statutory mandate requiring hospitals to adopt nurse-to-patient ratios or other nurse staffing arrangements.<sup>14</sup> Below is a summary of the categories in which state legislatures have explored different types of statutory or regulatory initiatives to resolve concern about nurse staffing. One can conclude from the conservative legislative approaches to the issue of nurse staffing that state governments remain skeptical as to whether statutorily enforced nurse-patient ratios or nurse staffing standards will result in the improvement of patient care.

### A. Data Gathering Regulations

Some states, such as Delaware, have enacted legislation that requires health care facilities to develop nurse-staffing plans.<sup>15</sup> Those states that have considered the issue of minimum nurse-staffing standards have proceeded cautiously in enacting legislation. Unlike California, where legislation was passed that adopted a nurse ratio standard before regulations were developed, other states have enacted legislation that would require a health care committee to conduct studies on nurse staffing.<sup>16</sup> Under these circumstances, the preliminary steps before a final implementation of nurse staffing requirements would include the gathering of quality-related data and collaboration between legislative committees and health care stakeholders to determine whether the data supports a relationship between nurse staffing and patient outcomes.

Connecticut has enacted a prototypical regulatory statute designed to analyze nurse staffing levels and patient outcomes. The statute provides:

The Department of Public Health shall: (1) Develop a single, uniform method for collecting and analyzing standardized data concerning the linkage between nurse staffing levels and the quality of acute care, long-term care and home care, including patient outcomes; (2) conduct an ongoing study of the relationship between nurse staffing patterns in hospitals and the quality of health care, including patient outcomes; (3) obtain relevant licensure and demographic data that may be available from other

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<sup>14</sup> *Id.*

<sup>15</sup> DEL. CODE ANN. TIT. 16, § 1162 (2002).

<sup>16</sup> FLA. STAT. ANN. § 408.05 (West 2005).

state agencies and make the data collected under this subsection available to the public in a standardized format; and (4) collaborate with hospitals and the nursing profession with respect to the collection of standardized data concerning patient care outcomes at such hospitals and make such data available to the public in a report card format.<sup>17</sup>

Similarly, CONN. GEN. STAT. ANN. § 19a-89a (West 2003), provides that the Connecticut Department of Health in consultation with the State Board of Examiners for Nursing, shall establish a database on nursing personnel to assist the Department, the Board, and other state agencies in planning for nurse staffing patterns and practices. Thus, states such as Connecticut, seem to be moving methodically in the data gathering and analyzing process prior to concluding whether, from a policy standpoint, nurse staffing requirements are the appropriate means for increasing the quality of patient care

In addition, the Connecticut legislature has enacted a separate statutory provision prohibiting overtime for nurses working in hospitals.<sup>18</sup> Thus, Connecticut has adopted both a mandatory limit on nurse overtime as well as a statute requiring data analysis to determine whether nurse-staffing ratios will increase the quality of patient outcomes.<sup>19</sup> Connecticut is unique in that its legislature has correlated nurses working excessive hours with patient outcomes, a cause and effect relationship which has been established in various studies.<sup>20</sup> Yet, the Connecticut legislature presumably is not certain as to the policy logic behind mandating nurse-patient ratios.

Other states, such as Florida, have created a data collection body.<sup>21</sup> In Florida, this entity is the State Center for Health Statistics.<sup>22</sup>

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<sup>17</sup> CONN. GEN. STAT. ANN. § 19a-89d (West 2003).

<sup>18</sup> CONN. GEN. STAT. ANN. § 19a-490l (West 2004).

<sup>19</sup> CONN. GEN. STAT. ANN. § 19a-89d (West 2003); CONN. GEN. STAT. ANN. § 19a-490l (West 2004).

<sup>20</sup> See, e.g., INSTITUTE OF MEDICINE, COMMITTEE ON THE WORK ENVIRONMENT FOR NURSES AND PATIENT SAFETY, KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES (Ann Page ed., 2003) [hereinafter IOM]; Ann E. Rogers et al., *The Working Hours of Hospital Staff Nurses and Patient Safety*, 23 HEALTH AFFAIRS 202 (2004).

<sup>21</sup> FLA. STAT. ANN. § 408.05 (West 2005) (data collection committee established).

<sup>22</sup> *Id.*

Again, the legislative focus is on creating a comprehensive health information system that provides statistical information to health care policymakers.<sup>23</sup> This data is supposed to be compiled and summarized as a tool for legislators to determine whether mandatory nurse ratios are a valid means to achieve better quality patient care. The Florida legislation also provides that the data and statistics compiled by the State Center for Health Statistics must be made available to consumers to enable them to compare the quality of health care services in medical facilities.<sup>24</sup>

Indeed, the Florida statute is based on the perception that there is a relationship between performance, outcome, and charges for services.<sup>25</sup> It is noteworthy that the charge to patients (or to a patient's insurance company) may have an effect on, but is not a direct measure of, nurse-patient ratios; i.e., many factors go into the computation of a patient's cost for treatment – not just the cost of nurse staffing.<sup>26</sup> Thus, states, including Florida, Kentucky, Rhode Island, New Jersey, Oregon, and Missouri,<sup>27</sup> are at the analytical stage in which they are not yet committed to correlating better patient care to nurse staffing, without considering patient charges.

## B. Mandatory Limitation On Nurse Overtime

States such as Connecticut, *supra*, and West Virginia, have approached the issue of relationships between patient outcomes and nursing care by following the federal legislative example limiting nurse overtime.<sup>28</sup> In

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<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> FLA. STAT. ANN. § 408.05(2)(g) (West 2005).

<sup>26</sup> Additional costs factored into patient hospital charges may include: labor costs (other than labor costs for nurse staffing), operating costs for routine, ancillary and special care services, and other miscellaneous costs (such as utilities, pharmaceuticals, food, medical education, capital costs, and malpractice insurance). 48 Fed. Reg. 39,752, 39,761-39,762 (1983).

<sup>27</sup> FLA. STAT. ANN. § 408.05 (West 2005); KY. REV. STAT. § 160 (West 2001); R.I. GEN. LAWS § 23-17.17-8 (2005); N.J. STAT. ANN. §§ 26:2H-5f, 5g (West 2005); OR. REV. STAT. § 441.162 (2003); MO. REV. STAT. § 197.29 (2000).

<sup>28</sup> Federal legislation introduced in 2005 prohibits health care facilities from requiring nurses to work more than the nurse's scheduled work shift, 12 hours in a 24-hour period, or 80 hours in a consecutive 14 day period unless there is a declared state of emergency and the provider has "made reasonable efforts to fill the immediate staffing needs ... through alternative means" and the duration of the work does not exceed the period of state of emergency. S. 351, 109th Cong. § 3(a) (2005). See *infra* Part V.



West Virginia, the legislature found the following policy factors to be determinative in addressing and limiting mandatory nurse overtime:

- (1) It is essential that qualified registered nurses and other licensed health care workers providing direct patient care be available to meet the needs of patients;
- (2) Quality patient care is jeopardized by nurses that work unnecessarily long hours in hospitals;
- (3) Health care workers, especially nurses, are leaving their profession because of workplace stresses, long work hours and depreciation of their essential role in the delivery of quality, direct patient care;
- (4) It is necessary to safeguard the efficiency, health and general well-being of health care workers in hospitals, as well as the health and general well-being of the persons who use their services;
- (5) It is further necessary that health care workers be aware of their rights, duties and remedies with regard to hours worked and patient safety; and
- (6) Hospitals should provide adequate safe nursing staffing without the use of mandatory overtime.<sup>29</sup>

Seemingly, states like West Virginia, have concluded that there is a relationship between nurse overtime and patient safety. However, these states prefer to leave the decision regarding nurse-to-patient ratios to hospitals, and instead, have enacted legislation limiting the amount of mandatory overtime required of nurses. In other words, in such states, limiting nurse overtime rather than arbitrarily requiring a certain number of nurses to be assigned based on the number of patients on a hospital unit seems to be preferable because such laws are less intrusive for hospital administrators. As discussed below, these policy considerations are important for the type of statutes that would ultimately control future health care relative to nursing care.

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<sup>29</sup> W.VA. CODE § 21-5F-1 (West 2004).

## V. FEDERAL LEGISLATION

On the federal level, there have been two bills introduced in Congress to address nurse-staffing issues.<sup>30</sup> The first bill, titled the “Registered Nurse Safe Staffing Act of 2003,” was introduced in the U.S. Senate by Senator Bill Inouye in 2003.<sup>31</sup> The Inouye bill ultimately languished in committee. If it had been enacted, the legislation would have required hospitals receiving payment for services from Medicare to implement staffing plans to ensure minimum nurse staffing levels for patient safety.<sup>32</sup>

The second bill, titled the “Safe Nursing and Patient Care Act of 2005,” was introduced in the U.S. Senate by Senator Ted Kennedy<sup>33</sup> along with an identical companion bill introduced in the U.S. House of Representatives by Representative Fortney Stark (“Kennedy-Stark bill”).<sup>34</sup> This bill addresses the nursing shortage and quality of care issue by proposing to limit the number of mandatory overtime hours nurses can work in hospitals that receive payment from the Medicare program.<sup>35</sup>

Congressional findings in the Kennedy-Stark bill include citations to studies recognizing the dangers of mandatory overtime for nurses:

A November 2003 Institute of Medicine report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*,<sup>36</sup> concluded that limiting the number of hours worked per day and consecutive days of work by nursing staff ... is a fundamental safety precaution ... .

A study published in the July/August 2004 Health Affairs Journal, *The Working Hours of Hospital Staff Nurses and Patient Safety*,<sup>37</sup> found that nurses who worked shifts of

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<sup>30</sup> S. 991, 108th Cong. (2003). Representative Lois Capps introduced an identical companion bill in the House of Representatives. H.R. 3656, 108th Cong. (2003); S. 351, 109th Cong. (2005).

<sup>31</sup> S. 991, 108th Cong. (2003).

<sup>32</sup> *Id.*

<sup>33</sup> S. 351, 109th Cong. (2005).

<sup>34</sup> H.R. 791, 109th Cong. (2005).

<sup>35</sup> *Id.*

<sup>36</sup> IOM, *supra* note 20.

<sup>37</sup> Ann E. Rogers et al., *The Working Hours of Hospital Staff Nurses and Patient Safety*, 23 HEALTH AFFAIRS 202 (2004).

twelve and a half hours or more were three times more likely to commit errors than nurses who worked standard shifts of eight and a half hours or less ... .<sup>38</sup>

The Kennedy-Stark bill, if enacted, will prohibit a provider of Medicare funded services<sup>39</sup> from requiring a nurse to work more than 12 hours in a 24-hour period or 80 hours in a consecutive 14-day period with an exception for a declared state of emergency.<sup>40</sup> Additionally, the proposed bill provides a complaint procedure for nurses to report violations of the Act<sup>41</sup> and anti-discrimination/anti-retaliation provisions for nurses who report violations.<sup>42</sup>

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<sup>38</sup> S. 351, 109th Cong. § 2.

<sup>39</sup> "Provider of services" is defined in the bill as a hospital; psychiatric hospital; hospital outpatient department; critical access hospital; ambulatory surgical center; home health agency; rehabilitation agency; clinic, including rural health clinics, or a federally qualified health center. *Id.* at § 3.

<sup>40</sup> *Id.* at § 3(a). Under the bill, if a declared state of emergency has occurred, the provider may require a nurse to work in excess of the 12 hours in a 24-hour period or 80 hours in a consecutive 14-day period if:

- (i) the provider has made reasonable efforts to fill [its] immediate staffing needs ... through alternative means; and
- (ii) the duration of the work requirement does not extend past the earlier of: (I) the date on which the declared state of emergency ends; or (II) the date on which the provider's direct role in responding to the medical needs resulting from the declared state of emergency ends.

*Id.*

<sup>41</sup> The Secretary of the Department of Health and Human Services, under the proposed bill, is charged with investigating complaints. If the Secretary determines that a provider has violated the Act, the Secretary may seek civil monetary penalties of up to \$10,000 against the provider for each knowing violation of the Act. *Id.*

<sup>42</sup> Under the bill, a Provider of Services, "shall not penalize, discriminate, or retaliate in any manner with respect to any aspect of employment, including discharge, promotion, compensation, or terms, conditions, or privileges of employment, against a nurse who refuses to work mandatory overtime or who in good faith, individually or in conjunction with another person or persons—

- (i) reports a violation or suspected violation of this subsection to a public regulatory agency, a private accreditation body, or the management personnel of the provider of services;
- (ii) initiates, cooperates, or otherwise participates in an investigation or proceeding brought by a regulatory agency or private accreditation body concerning matters covered by this subsection; or
- (iii) informs or discusses with other employees, with representatives of those employees, or with representatives of associations of health

## VI. MEDICARE MODERNIZATION ACT AND HOSPITAL QUALITY DATA

In late 2003, Congress passed, and President Bush signed into law, H.R.1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“Medicare Modernization Act”).<sup>43</sup> The Medicare Modernization Act includes a new provision tying the annual payment rate for hospitals to the submission of hospital quality data.<sup>44</sup>

Under this new provision, hospitals that receive Medicare payment under the inpatient prospective payment system must submit data regarding designated quality indicators to avoid a payment reduction of 0.4 percentage points in each of the fiscal years 2005 through 2007.<sup>45</sup> Initially, the Secretary of the U.S. Department of Health and Human Services (“DHHS”) was charged with determining ten “starter set” quality performance measures related to three medical conditions (myocardial infarction, heart failure, and pneumonia) to be reported by hospitals based on patient discharges.<sup>46</sup> The Hospital Quality Alliance (“HQA”)<sup>47</sup> identified the ten “starter set” indicators which are identical to the measures collected by the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”).<sup>48</sup> These ten indicators are grouped by medical conditions and include:

(1) Acute Myocardial Infarction/Heart Attack:

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care professionals, violations or suspected violations of this sub section.

*Id.*

<sup>43</sup> Pub. L. 108-173 (2003).

<sup>44</sup> 42 U.S.C. 1395ww(b)(3)(B)(vii)(I) (2003). Section 501(b) of the Act amended section 1886(b)(3)(B) of the Social Security Act.

<sup>45</sup> *Id.*; 42 C.F.R. § 412.64(d) (2005).

<sup>46</sup> 42 U.S.C. 1395ww(b)(3)(B)(vii)(II) (2003).

<sup>47</sup> The HQA is a collaboration involving: the Centers for Medicare & Medicaid Services (“CMS”), the American Hospital Association, the Federation of American Hospitals, the Association of American Colleges, the Agency for Healthcare Quality, the National Quality Forum, JCAHO, the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Federation of Labor and Congress of Industrial Organizations, and the American Association of Retired Persons. This collaboration, part of the Hospital Quality Initiative launched nationally in 2002, has developed the hospital quality measures to be reported by hospitals pursuant to Section 501(b) of the Medicare Modernization Act. *Id.*

<sup>48</sup> See *infra* Part VII (discussing JCAHO hospital standards for staffing effectiveness).

- Aspirin at arrival
  - Aspirin at discharge
  - ACE inhibitor for left ventricular systolic dysfunction
  - Beta blocker at arrival
  - Beta blocker at discharge
- (2) Heart Failure
- Assessment of left ventricular function
  - ACE inhibitor for left ventricular systolic dysfunction
- (3) Pneumonia
- Oxygenation assessment
  - Initial antibiotic timing
  - Pneumococcal vaccination.<sup>49</sup>

Subsequently, the HQA identified and added ten additional measures (and one additional medical category – surgical infection prevention) to be reported by eligible hospitals.<sup>50</sup> The ten new measures are:

- (1) Acute Myocardial Infarction/Heart Attack
- Thrombolytic agent received within 30 minutes of hospital arrival
  - Percutaneous Coronary Intervention received within 120 minutes of hospital arrival
  - Adult smoking cessation advice/counseling
- (2) Heart Failure
- Discharge instructions
  - Adult smoking cessation advice/counseling
  - Pneumonia blood culture performed prior to first antibiotic received in hospital
  - Adult smoking cessation advice/counseling
  - Appropriate initial antibiotic selection
- (3) Surgical Infection Prevention

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<sup>49</sup> CENTERS FOR MEDICARE & MEDICAID SERVICES, HOSPITAL QUALITY INITIATIVE OVERVIEW 2-3 (2005), available at <http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalOverview200512.pdf> [hereinafter INITIATIVE OVERVIEW].

<sup>50</sup> *Id.* at 2.

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotics discontinued within 24 hours after surgery end time.<sup>51</sup>

The quality indicators are based on scientific evidence, which correlates the measures with best practices for the treatment of the three diseases and prevention of surgical infection.<sup>52</sup> The goal for hospitals is to score 100% on all measures in each category.<sup>53</sup> After hospitals report this data, it is publicly posted in the “Hospital Compare” section of the DHHS website, thereby enabling consumers to make comparisons of hospitals based on the hospital’s scores on concrete quality measures.<sup>54</sup>

Although the quality measures do not directly address nurse-staffing issues, in all likelihood low nurse-staffing levels and high patient caseloads would have an adverse impact on the performance rating of those quality measures that rely heavily on these components in arriving at the hospital’s score.

## VII. JCAHO STAFFING EFFECTIVENESS STANDARDS FOR HOSPITALS

The JCAHO, a national accrediting organization for certain health care entities, has developed “staffing effectiveness” standards for hospitals.<sup>55</sup> Although these standards do not specify patient-to-nurse staffing ratios, the standards require hospitals to analyze screening

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<sup>51</sup> *Id.* at 3.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

The Quality Initiative employs a multi-pronged approach to support, provide incentives and drive systems and facilities – including the clinicians and professionals working in those settings – toward superior care through:

- Ongoing regulation and enforcement conducted by State survey agencies and CMS
- New consumer hospital quality information on our websites, [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov) and [www.medicare.gov](http://www.medicare.gov), and at 1-800-MEDICARE . . .

<sup>55</sup> *Id.*

indicators, which correlate with staffing effectiveness, including staffing ratios.<sup>56</sup>

JCAHO has developed<sup>57</sup> (or revised) five standards for hospitals related to staffing effectiveness. Standard HR.2 requires that a hospital “provides an adequate number of staff members whose qualifications are consistent with job responsibilities.”<sup>58</sup> In conjunction with Standard HR.2, Standard HR.2.1 requires hospitals to use “data on clinical/service indicators in combination with human resources screening indicators to assess staffing effectiveness.”<sup>59</sup>

Standard PI.3.1.1 mandates that health care organizations, including hospitals, collect and monitor data affecting the “performance of processes that involve risks or may result in sentinel events,”<sup>60</sup> and Standard PI.4.3 requires health care organizations to perform an “intense analysis” if the organization believes there exists “undesirable patterns or trends in performance and sentinel events.”<sup>61</sup>

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<sup>56</sup> Joint Commission on Accreditation of Healthcare Organizations, Accreditation Process Improvement (API): Staffing Effectiveness Standards, <http://www.jcrinc.com/subscribers/perspectives.asp?durki=2506&site=10&return=2897>.

<sup>57</sup> JCAHO has developed one new standard (HR.2.1) and revised the intent of four existing standards (HR.2, PI.3.1.1, PI.4.3, and LD.4.3) to reflect staffing effectiveness requirements. *Id.*

<sup>58</sup> Joint Commission on Accreditation of Healthcare Organizations, Hospital Standards for Staffing Effectiveness, <http://www.jcrinc.com/subscribers/perspectives.asp?durki=3116&site=10&return=2897> [hereinafter Hospital Standards].

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* Specifically, under PI.3.1.1, hospitals must at a minimum identify and collect data regarding:

- (1) Medication use;
- (2) Operative and other procedures that place patients at risk;
- (3) Use of blood and blood components;
- (4) Restraint use;
- (5) Seclusion when it is part of the care or services provided;
- (6) Care or services provided to high-risk population;
- (7) Outcomes related to resuscitation; and
- (8) Staffing effectiveness (Standard HR.2.1, *supra*).

*Id.*

<sup>61</sup> *Id.* Per the intent of PI.4.3, an intense analyze is to be performed for:

- (1) Confirmed transfusion reactions;
- (2) Significant adverse drug reactions;
- (3) Significant medication errors; and
- (4) Staffing effectiveness (Standard HR.2.1).

Standard LD.4.3 requires hospital leaders to “ensure that important processes and activities are measured, assessed, and improved systematically throughout the hospital.”<sup>62</sup> Additionally, Standard LD 4.3 provides a summary of how hospital leaders may prioritize or monitor insofar as, “each department collaborates as necessary with other departments in hospital-wide performance improvement activities ... . Leaders ensure that data and other information necessary to improve performance are consistently identified, gathered, and assessed, both by each department internally and in collaboration with other departments as needed.”<sup>63</sup>

Although the JCAHO Staffing Effectiveness Standards do not specifically impose nurse-to-patient staff ratios, the Standards do require hospitals to provide adequate staffing and to also measure and monitor quality indicators, which may be directly and adversely affected by nurse staffing. Thus, hospitals accredited (or seeking to be accredited) by JCAHO must consider these requirements and proceed accordingly.

## VIII. POLICY ISSUES

### A. Nurse Staffing Issue Coincides With New Medicare Requirements

As health care costs continue to rise along with the number of Medicare-eligible Americans, there has been a strong impetus on the federal level to tie funding for health care with quality measurements.<sup>64</sup> Even before the Medicare Modernization Act was passed, DHHS and the Center for Medicare and Medicaid Services (“CMS”), in late 2001, launched a “Hospital Quality Initiative” aimed at measuring and reporting hospital quality data.<sup>65</sup> The goals of this Initiative, which

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*Id.*

<sup>62</sup> Hospital Standards, *supra* note 58. Per the Intent of LD. 4.3, “Leaders prioritize the activities to be measured, assessed, and improved. Priorities relate to hospital-wide activities, staffing effectiveness (HR.2.1), and patient health outcomes. Important internal processes and activities are those that affect patient outcomes most significantly. Leaders take steps to improve performance of these processes and activities throughout the hospital.” *Id.* (emphasis in original).

<sup>63</sup> *Id.*

<sup>64</sup> INITIATIVE OVERVIEW, *supra* note 49, at 2.

<sup>65</sup> *Id.* at 2 (discussing the means for measuring and reporting hospital quality data):  
The Hospital Quality Initiative is complex and differs in several ways from the Nursing Home Quality Initiative and Home Health



now includes collaboration among public and private sources to develop quality indicators, are to assist consumers in making informed decisions regarding their health care and to encourage improvements in the quality of health care provided by hospitals and other health care providers.<sup>66</sup>

These efforts, along with the requirements of the Medicare Modernization Act, have culminated in the publicly accessible “Hospital Compare” website<sup>67</sup>, allowing health care consumers to now compare hospitals based on various quality indicators. A quality measure is medical information from patient records converted into a rate or percentage that can be used to determine the quality of care at a given hospital or to compare hospitals. The hospital quality measures include:

- Eight measures related to heart attack care;
- Four measures related to heart failure care;
- Six measures related to pneumonia care;
- Two measures related to surgical infection prevention.<sup>68</sup>

Accordingly, health care consumers who are able to access and use this information when making health care decisions will likely seek medical care at hospitals with higher quality measurements, thereby placing an incentive on hospitals to improve the quality of care they provide related to the measured indicators. Further, hospitals have a financial

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Quality Initiative. In the previous initiatives CMS had well-studied and validated clinical data sets and standardized data transmission infrastructure from which to draw a number of pertinent quality measures for public reporting. *In contrast with the earlier initiatives, there was no comprehensive data set on hospitals from which to develop the pertinent quality measures, nor are hospitals mandated to submit clinical performance data to CMS. However, section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a strong incentive for eligible hospitals to submit quality data for ten quality measures known as the “starter set”. The law stipulates that a hospital that does not submit performance data for the ten quality measures will receive a 0.4 percentage points reduction in its annual payment update from CMS for FY 2005, 2006 and 2007.*

*Id.* (emphasis added).

<sup>66</sup> *Id.*

<sup>67</sup> Hospital Compare, <http://www.hospitalcompare.hhs.gov>.

<sup>68</sup> Quality Measures, <http://www.hospitalcompare.hhs.gov/Hospital/Static/About-HospQuality.asp?dest=NAV|Home|About|QualityMeasures#TabTop>.

incentive to monitor and report quality data, as hospitals that do not do so will receive a .4 percent cut in their payment rate for services provided to Medicare patients.<sup>69</sup>

Seemingly, the convergence of these incentives, that is the incentive for hospitals to report quality data to receive full payment from Medicare, and the incentive to score high on quality measurements to attract or retain patients, should result in hospitals more closely monitoring and evaluating their performance as to quality of care-related indicators. A crucial piece in the quality picture is nursing care. Therefore, any efforts by hospitals to improve quality must take into account the role of nurses in patient care and the impact of nurse understaffing, particularly on critical care units.

### B. Hospitals May Establish Internal Nurse Staffing Ratios

A hospital's internal policy that establishes its own nurse staffing ratios may raise the question of why nurse staffing has been gaining wider attention than other hospital staffing issues. After all, the shortages in clinical laboratory technologists, clinical laboratory technicians, physical therapists and physical therapy assistants and aids may also create risks related to the quality of patient care.<sup>70</sup> The counterpart to

<sup>69</sup> 42 C.F.R. § 412.64(d)(2005), 42 U.S.C. 1395ww(b)(3)(B)(vii)(I)(2003).

<sup>70</sup> U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook (OOH), 2006-07 Edition, <http://www.bls.gov/OCO>.

Employment of clinical laboratory workers is expected to grow faster than average\* for all occupations through the year 2014, as the volume of laboratory tests continues to increase with both population growth and the development of new types of tests.

U.S. Department of Labor, Bureau of Labor Statistics, Clinical Laboratory Technologists and Technicians, <http://www.bls.gov/oco/ocos096.htm>.

Employment of physical therapists is expected to grow much faster than average\* for all occupations through 2014.

U.S. Department of Labor, Bureau of Labor Statistics, Physical Therapists, <http://www.bls.gov/oco/ocos080.htm>.

Key phrases in the *Handbook*

Changing employment between 2004 and 2014	
If the statement reads:	Employment is projected to:
Grow much faster than average	Increase 27 percent or more
Grow faster than average	Increase 18 to 26 percent

this question is whether hospital administrators should exercise independent judgment on nurse staffing issues for a particular hospital, without having to adhere to externally mandated nurse staffing requirements. While hospital administrators have traditionally been able to act almost autonomously on issues of nurse staffing, administrators appear to be slowly losing this autonomy to accreditation requirements, legislative initiatives, and regulatory oversights.

This change in operation seems to be based on the rationale that nursing care is unique to the overall quality of health care received by a patient.<sup>71</sup> It was in this context that the Health Resources and Services Administration Division of Nursing, Health Care Financing Administration, Agency for Healthcare Research and Quality, and National Institutes of Nursing Research of the National Institutes of Health co-sponsored a study based on 1997 data to analyze whether there is evidentiary support as to the existence of a relationship between potentially nursing-sensitive patient outcomes and nurse staffing in inpatient units in acute care hospitals.<sup>72</sup> Critical to the study was “[v]iewing nursing care as an integral part of the clinical care process rather than as an isolated or separate component.”<sup>73</sup> Although the study was not conclusive for all patient outcomes related to nurse staffing,<sup>74</sup> the study did indicate strong and consistent relationships between nurse staffing and urinary tract infections, pneumonia, length of stay, upper gastrointestinal bleeding and shock in medical patients.<sup>75</sup> The sponsors of the study selected these relationships for investigation as the extensive review of literature, discussions with experts, and other pre-study activities indicated that these relationships in which patient Outcomes Potentially Sensitive to Nursing (“OPSNs”).<sup>76</sup> In major

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U.S. Department of Labor, Bureau of Labor Statistics, Key phrases in the Handbook, <http://www.bls.gov/oco/oco20016.htm>.

<sup>71</sup> JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, HEALTH CARE AT THE CROSSROADS, STRATEGIES FOR ADDRESSING THE EVOLVING NURSING CRISIS 4 (2003).

<sup>72</sup> JACK NEEDLEMAN ET AL., *Nurse Staffing and Patient Outcomes in Hospitals: Executive Summary*, in UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICE ADMIN xxiii (2001).

<sup>73</sup> *Id.*

<sup>74</sup> For example, for major surgery patients the only patient outcome which showed a strong relationship with nurse staffing was failure to rescue. There was a weaker connection between nurse staffing and urinary track infections and pneumonia. *Id.*

<sup>75</sup> *Id.* at ii.

<sup>76</sup> *Id.* at i.

surgery patients, there was strong and consistent evidence of a relationship between failure to rescue and nurse staffing.<sup>77</sup>

Even if not definitively supported by the data thus far, Medicare reimbursement, JCAHO standards, and other regulatory and statutory directives are forcing hospitals to focus on nurse staffing for its perceived importance to patient care. Consequently, hospital administrators may no longer ignore the difficult task of adopting their own internal standards for nurse staffing. Rather, hospital budgetary planning will have to include affordable resolutions related to nurse staffing and procedures or mechanisms to ensure that internally established guidelines are consistent with external regulatory requirements. In other words, while legislatures may decide not to impose mandated nurse-patient ratios similar to the California statute, administrators and health care policy-makers will no longer be able to disregard ratio guidelines and survey information in establishing their own internal nurse staffing requirements.

Research data suggests that there is some relationship between nurse staffing and patient outcomes.<sup>78</sup> Since nurse staffing and its impact on patient quality has garnered media attention outside beyond just the health care system, legislatures and other health care policymakers seem to be no longer content to allow hospital administrators to independently decide on nurse staffing issues. Under these circumstances, hospital administrators should consider setting internal nurse staffing levels to avoid having nurse staffing decisions imposed on them by external regulatory bodies.

### C. Efforts To Eliminate The Nurse Shortage

Ironically, as there appears to be a strong push to increase the number of nurses in acute care hospitals, there are not enough nurses available to fill the vacancies.<sup>79</sup> Equally exacerbating the situation is the ever-growing aging population requiring more nurse assistance.<sup>80</sup> Thus, the

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<sup>77</sup> Among the surgical patients studied, there was a significant relationship between nurse staffing on both mortality and mortality following complications. These results seem to suggest that substantial decreases in mortality could result from increasing registered nurse staffing, especially for patients who develop complications. *See also* Linda H. Aiken et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288 JAMA 1987, 1990-1991 (2004).

<sup>78</sup> *See supra* text accompanying note 2.

<sup>79</sup> *See generally* NURSING SHORTAGES, *supra* note 4.

<sup>80</sup> *Id.* at 11.

issue of nurse staffing is not only a factor affecting hospital budgets, but it also brings up the problematic issue of how to curtail a shrinking nurse work force. Hospital administrators and policymakers are thus strapped with the added dilemma of how to draw more individuals into the nursing field.

Unfortunately, there is a tension between these two issues. While hospital administrators are already strained to manage a finite budget, they are also faced with the need to offer economic incentives to encourage entry into the nursing field and to fill existing nursing vacancies.<sup>81</sup> Hospital administrators will likely be forced to closely consider how to achieve optimal nurse staffing through alternative means with limited economic resources. In this context, hospital administrators or health care policymakers will have to assess whether the goals related to nurse staffing and a nurse shortage are producing an overall increase in the quality of patient care. After all, none of these goals would draw attention if it were not for their perceived connection to patient care.

With this recognition of how a nurse shortage may have a bearing on nurse staffing and the ultimate quality of patient care, there have been several proposals suggested to draw more individuals into the nursing field.<sup>82</sup> Again, if we look at the California experience, the

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[D]emand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond. The population age 65 years and older will double between 2000 to 2030. During that same period the number of women between 25 and 54 years of age, who have traditionally formed the core of the nurse workforce, is expected to remain relatively unchanged. This potential mismatch between future supply of and demand for caregivers is illustrated by the change in the expected ratio of potential care providers to potential care recipients.

*Id.*; see *id.* at 12 fig.3 (“Decline in Elderly Support Ratio Expected, 2000 to 2040”).

<sup>81</sup> U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 1, at 4-42.

<sup>82</sup> John Leighty, *Momentum Builds to Solve Nursing Shortage*, NURSEWEEK, April 25, 2005, available at [http://www.nurseweek.com/news/Features/05-04/NursingShortage\\_print.html](http://www.nurseweek.com/news/Features/05-04/NursingShortage_print.html). One course of action adopted by Gov. Arnold Schwarzenegger is to use federal workforce investment money over which he has discretion to increase the educational capacity for educating RNs to fill vacancies. *Id.* The plan focuses using the funds to increase nursing faculty and forge joint ventures with hospitals. *Id.* The development of increased educational capacity and programs for nursing to solve the California nursing shortage appears to be supported by educators that, “state nursing schools are turning away about 40% of qualified applicants because of faculty shortages and a lack of classroom space and training facilities.” *Id.*

governor has initiated a five-point program to help solve the shortage of nurses in California, which provides:

1. The funding of \$18 million a year for the next five years to support nurse education to expand and increase nurse education opportunities.
2. The support of partnerships between nursing schools and health facilities to build more educational programs.
3. The recruitment of more qualified instructors.
4. The development of new avenues to nursing careers with high school and college nursing academies and apprenticeships.
5. The aggressive initiation of efforts to seek additional funds for nurse education from federal and other funding sources.<sup>83</sup>

The California focus appears to be on financial and educational support to draw individuals into choosing nursing as a career. It is noteworthy that the California initiative does not target the current working conditions of nurses.<sup>84</sup> Instead, the primary goal is to recruit new people into the profession. However, whether the mere encouragement of nursing careers will significantly alleviate the nursing shortage remains to be seen. While these efforts should not be underestimated, it is important to recognize that once individuals are recruited as nurses, they need to remain part of a stable work force.

Data has suggested that job dissatisfaction is also a major factor contributing to the nurse shortage.<sup>85</sup> A research study by the

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<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

While surveys indicate that increased wages might encourage nurses to stay at their jobs, money is not always cited as the primary reason for job dissatisfaction. According to the FNHP [Federation of Nurses and Health Professionals] survey, of those RNs responding who had considered leaving the patient-care field for reasons other than retirement over the past 2 years, 18 percent wanted more money, versus 56 percent who were concerned about the stress and physical demands of the job. However, the same study reported that 27 percent of current RNs responding cited higher wages or better health care benefits as a way of improving their jobs. Another study indicated that 39 percent of RNs who had been in their current jobs for more than 1 year were dissatisfied

Federation of Nurses and Health Professionals found that half of the currently employed RNs who were surveyed had considered leaving the patient-care field for reasons other than retirement over the past two years.<sup>86</sup> The various research studies attribute job dissatisfaction to factors such as inadequate staffing, heavy workloads, increased use of overtime, wages and health care benefits, stress, physical demands, and inattention by administrators to nurse concerns.<sup>87</sup>

Significantly, it is desirable to coordinate these concerns about working conditions with recruiting efforts. As such, administrative decisions from mandatory overtime to nurse staffing ratios should also be viewed comprehensively in terms of their effect on the improvement of working conditions for nurses, elimination of nursing shortages, and recruiting efforts. Policymakers and hospital administrators are thus entrusted with the complicated management directive of how to take advantage of aggressive recruiting efforts, successfully maintain a nursing workforce after recruitment, and ultimately increase the quality of patient care.

## IX. CONCLUSION

This article has provided a brief overview of the relevant federal and state statutes, and other corresponding industry standards and studies

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with their total compensation, but 48 percent were dissatisfied with the level of recognition they received from their employers. AHA [American Hospital Association] recently reported on a survey that found that 57 percent of responding RNs said that their salaries were adequate, compared to 33.4 percent who thought their facility was adequately staffed, and 29.1 percent who said that their hospital administrations listened and responded to their concerns.

NURSING SHORTAGES, *supra* note 4, at 10.

<sup>86</sup> FEDERATION OF NURSES AND HEALTH PROFESSIONALS, *THE NURSE SHORTAGE: PERSPECTIVES FROM CURRENT DIRECT CARE NURSES AND FORMER DIRECT CARE NURSES* (2001). Notably, of the registered nurses who responded to this study, only 18% cited dissatisfaction with their monetary compensation, whereas, 56% of the RNs were dissatisfied with their working environment (specifically, the stress and physical demands of the job). *Id.* Another study conducted by the American Hospital Association found that 57% of the RNs responding to the survey stated that their salaries were adequate, whereas, 33.4% believed there is adequate staff for the amount of work to be done, and 29.1% stated hospital administrators listened and responded to nurses' concerns. AMERICAN HOSPITAL ASSOCIATION, *The Hospital Workforce Shortage: Immediate and Future*, 3 TRENDWATCH 1, 2 (2001), available at

<http://www.ahapolicyforum.org/ahapolicyforum/trendwatch/content/twjune2001.pdf>.

<sup>87</sup> NURSING SHORTAGES, *supra* note 4, at 8-10.

on the issue of nurse staffing. One of the most significant ideas that may be drawn from this overview is that nurse staffing cannot be ignored in any realistic policy initiatives undertaken by the federal or state governments, hospital administrators, or other health care decision-makers or stakeholders. While the ultimate goal is patient care, in all likelihood there are several ways to achieve the result depending on whose perspective forms the basis of the approach.

For the state and federal government, the approach may include cost-reducing incentives; for nurses and labor organizations, it may be working conditions; and for hospital administrators, it may be budget management and accreditation. No approach exists in a vacuum. The most successful administrators will adopt several approaches. For these administrators, success will rest on their abilities to foster a consensus among the varied groups that advocate a particular approach to the nurse staffing issue, which should ultimately result in better care for patients.



