NO on 1

BAD for Patients. WRONG for Massachusetts.

THE CALIFORNIA EXPERIENCE: NOT A TEMPLATE FOR MASSACHUSETTS

In 2004, California became the first and only state to implement minimum nurse staffing ratios in acute care hospitals. Similar laws have been proposed in numerous other states since, but have been rejected in every one. Since then, studies have examined the effect of government-mandated nurse staffing ratios on patient safety, quality of care, and hospital financial performance.

QUALITY & PATIENT SAFETY

To date, findings have shown that in California ratios have increased hospital costs with little to no benefits to patient care quality and safety.

A 2013 systematic review[1] of research literature focusing on how mandated staffing ratios affected patient outcomes and satisfaction in California found the following:

- Although nurse-to-patient ratios and RN hours per patient day increased, this did not have a statistically significant impact on any of the patient outcomes.
- In interviews with 12 hospital leaders from 23 California hospitals, researchers report that participants did not feel that patient satisfaction had improved since the implementation of the ratios.
- The findings from the majority of these studies do not support the assumption that increases in nurse staffing would lead to better quality of care, improvements in patient safety, or increased patient satisfaction.

The bottom-line conclusion is that even though the California ratio law is less restrictive than what the MNA is proposing, it has wreaked havoc with California hospital finances and has not improved quality of care for patients.

HOSPITAL FINANCES

The majority of studies that measured the financial impact of imposing mandated nurse staffing ratios in all units of a hospital showed increased costs for California hospitals, which one would expect with an increased demand for RNs across the state.

- A 2013[1] article explored the findings of 10 studies associated with the financial implications of California's nurse-to-patient ratios. After the ratios had been implemented for 8 years, this study concluded that ratios increased the cost of providing care, and forced hospitals to cut non-nurse staff, programs and services. Additionally, wages increased by more than 7-9%, contributing to significant increases in labor costs for California hospitals.
- Research[2] has shown that staffing ratios disproportionally affect safety-net hospitals that are generally already more financially constrained.

MASSACHUSETTS VS. CALIFORNIA HOSPITALS

Massachusetts hospitals already have among the best quality outcomes in the nation. The latest evidence-based, nursing–sensitive measures reported through the Centers for Medicare and Medicaid Services' Hospital Compare website shows that Massachusetts scores the same as or higher than California hospitals in hospital quality as well as patient satisfaction.

- Massachusetts scores equal to or better than California in ALL 11 HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) measure categories and receives scores equal to or better than the national average in 9 of 11 (82%) measure categories.
- Massachusetts scores equal to or better than California on all 6 mortality prevention measures and equal to or better than the national average on 5 of 6 mortality measures.
- Hospital readmissions: Massachusetts scores comparable to both California and the national average on 4 of the 8 readmissions measures (50%).
- Patient Safety Indicators (PSIs): Massachusetts scores equal to or better than both California and the National Average on 10 of the 11 patient safety indicators (91%).

Paid for and authorized by the Coalition to Protect Patient Safety

[1] Serratt, T. (2013). California's nurse-to-patient ratios, Part 1: 8 years later, what do we know about nurse-level outcome? Journal of Nursing Administra-tion, 43(9), 475-480.

[2] Conway, P. H., Tamara Konetzka, R., Zhu, J., Volpp, K. G., & Sochalski, J. (2008). Nurse staffing ratios: trends and policy implications for hospitalists and the safety net. Journal of Hospital Medicine, 3(3), 193-199.