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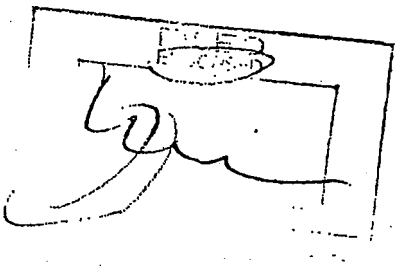

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

CALIFORNIA NURSES ASSOCIATION,

Plaintiff and Petitioner,

v.

ARNOLD SCHWARZENEGGER, Governor of the State of California; KIM BELSHE, Secretary of the California Health and Human Services Agency; SANDRA SHEWRY, Director of the California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES;

Defendant and Respondent,

CALIFORNIA HEALTHCARE ASSOCIATION, A CALIFORNIA NON-PROFIT MUTUAL BENEFIT CORPORATION,

Intervenor.

CASE NO. 04CS01725

DECLARATION OF GINA HENNING IN SUPPORT OF RESPONDENTS' AND DEFENDANTS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PETITIONER'S/PLAINTIFF'S APPLICATION FOR PRELIMINARY INJUNCTION

Date:	March 4, 2005
Time:	3:00 p.m.
Dept:	16
Judge:	The Honorable Judy Holzer Hersher
Trial Date:	TBA
Action Filed:	December 21, 2004

Gina Henning, R.N., declares as follows:

1. I am a manager specialist in the Licensing and Certification Division (L&C) of the Department of Health Services (DHS). I have been a registered nurse for eighteen years, have

worked in acute care hospitals, and was the quality assurance manager for home health and hospice for a major hospital chain. When I began work at DHS in 1995, I surveyed acute care hospitals and other facilities.

2. Since 2000, I have been assigned to developing the nurse/patient ratio regulations at DHS. I drafted the original regulation package, R-37-01, responded to public comments, tracked the impacts of the regulations, and then participated in drafting the emergency changes to the regulations, R-01-04E.

3. After the nurse/patient ratio regulations went into effect in January, 2004, I was assigned to monitor the implementation of the ratios. I was involved in the approval process for program flexibility requests and rural waiver requests. Program flexibility is always available in licensed health care facilities. Under program flexibility, District Offices of L&C decide, based on their knowledge of the needs of the community, whether a health care facility can meet the regulations by a safe alternative. In the case of rural hospitals, a waiver provision was included in Health and Safety Code section 1276.4 under which a rural hospital could be excused from compliance with some aspect of the regulations if complying was damaging to operations and patient care would not suffer. Many requests for program flexibility and rural waivers were directed at the emergency departments of hospitals. For example, in some small rural hospitals, DHS allowed a RN to be both a triage nurse and a base radio responder, under a rural waiver, when there were few calls each day. Under the nurse/patient ratio regulations, a triage nurse is not allowed to also be a base radio responder in the emergency department.

4. In most cases, the program flexibility requests were denied. (Exhibit A.) DHS strictly enforced the letter of the ratio regulations. For example, DHS emphasized to the childrens' hospitals that all units of the hospital had to comply with the one nurse to four patients ratio applicable in pediatric units.. The children's hospitals wanted to apply the medical/surgical ratio of 1:6.

5. Complaints of violations of the nurse/patient ratio regulations also began coming in to L&C. Most complaints were from staff nurses of hospitals, and some were self-reports by hospitals of failure to comply with the ratios since January 1, 2004.

6. L&C investigated the complaints of violations of the nurse/patient ratio regulations. It should be noted that there is no statutory or regulatory time frame for investigating complaints in acute care facilities, as there is in nursing homes, and no sanctions in law for violations. In response to a substantiated complaint in an acute care hospital, L&C writes a deficiency indicating a violation. L&C added headquarters oversight to the complaint investigation process for violations of the nurse/patient ratio regulations. This was to ensure that the District Offices would interpret the regulations consistently. I was involved in determining whether the outcomes of the complaint investigations were appropriate. The complaints involved staff nurses reporting that a certain unit was out of compliance with the ratios on a certain date and shift. There was never an allegation that a patient was harmed as a result. About half the complaints have been investigated to date, and 32 deficiencies issued. (Exhibit B.)

7. With the implementation of the nurse/patient ratio regulations in January, 2004, L&C began receiving reports of disruptions in the health care system as a result of the ratios, and of loss of patient access to care. It became important to quantify these impacts of the new ratio regulations. I compiled a chart of hospital closures of whole facilities and units, as well as downgrades in emergency department services, when there was a nexus between the closure of a unit or hospital or a downgrade in services and the ratio regulations. I gathered this information from newspaper reports, visits to hospitals and health care systems, and communications from hospitals and the California Healthcare Association. (Exhibit C.)

8. Hospitals were saying that, given the other financial pressures on them, the nurse/patient ratios were the last straw. Faced with an enormous expenditure to increase staffing, they would be unable to meet their financial commitments. The response of DHS was that hospitals could delay admissions, discharge patients (if this could be done safely), call nurses in, redirect charge nurses to provide direct care, delay elective surgeries, and close units if they could not meet the ratios.

9. The Alameda County Medical Board complained to DHS during a site visit that patients were stacking up in the waiting room of emergency departments because emergency nurses with more than four patients assigned (the ratio in the emergency department) were

refusing to handle more patients. Care was being delayed and wait times were increased. Patients were also stacking up in the emergency departments when nurses on floor units had the maximum number of patients assigned under the ratio regulations. Patients who needed an inpatient bed were not being moved to the floor.

10. The turmoil in emergency departments observed after the implementation of the nurse/patient ratio regulations resulted from the fact that hospitals cannot refuse emergency patients. Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), any patient who presents to an emergency department of a hospital must be evaluated by the hospital and provided with necessary emergency services. When the patient is stable, the patient may be transferred to another hospital.

11. Communications from the Emergency Nurses' Association indicated that the organization did not believe that the ratios were reasonable. The Emergency Nurses Association also believed that the documentation requirement was a nightmare. The emergency nurses were being slammed by the ratios because the hospital floor would not take patients and the patients were staying in the emergency department. They were also spending considerable time documenting patient assignments which were constantly changing.

12. DHS responded to these complaints about problems in emergency departments as a result of the ratio regulations. However, in the emergency regulations, R-01-04E, DHS did not loosen the ratio for emergency departments. DHS merely relieved the emergency nurses of the burden of documenting patient/nurse assignments which were constantly shifting. DHS also changed the regulation to state that when the emergency department reaches saturation, due to a sudden unpredictable and unforeseeable influx of patients, the emergency department may legally continue to provide care, so long as the hospital demonstrates prompt efforts to return to the one to four ratio. A safety valve was always contained in the original nurse/patient regulations, in terms of a health care emergency. Because the term "emergency" had legal implications in the health care industry which triggered other requirements, DHS changed the regulatory term to "saturation" for emergency departments only.

13. Exhibit D contains the language of the emergency regulation pertaining to

emergency departments. The only substantive change from the original regulation was in documentation requirements in 22 Cal.Code Reg. 70217(e). The change permits emergency departments to document times of patient arrivals and departures and the licensed nurses on duty on a day-to-day, shift-by-shift basis, rather than specific licensed nurse assignments. Although a new section "s" was added to 70217 in R-01-04E, this is not a substantive change, but a change of terminology. Section 70217 (s) requires that emergency departments reaching saturation because of an unforeseeable influx of patients which exceeds the historically established trends for the emergency department, demonstrate that prompt efforts were made to maintain required staffing levels. The original regulation, R-37-01, contains a section "q" which indicates that if a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined as an unpredictable occurrence relating to healthcare delivery requiring immediate medical interventions and care.

14. With regard to the decision to delay the implementation of the enriched 1 to 5 ratio in medical/surgical units, DHS considered the scope and magnitude of hospital and unit closures, and emergency department downgrades. While hospitals had complained before the regulations went into effect that they would experience problems in complying with the ratios, DHS had no way of predicting the real impact of the ratios, which are the first nurse/patient ratios implemented in the United States. After the implementation date, January 1, 2004, hospitals were reporting that no matter how aggressively they recruited nurses, they still had vacancies and could not comply with the ratios at all times. They also complained of the substantial financial burden of compliance with ratios at a time when reimbursement for services was diminishing. Allowing the medical/surgical ratio to be enriched to 1 to 5 on January 1, 2005 would have exacerbated the disruptions to the health care system allegedly stemming from the ratios.

15. DHS was also aware that the Patient Classification System (PCS) continues to co-exist with the 1 to 6 ratio to ensure that the sickest patients in medical/surgical units receive additional nursing attention. In enacting AB 394, the statute which mandated nurse/patient ratios, the Senate Health and Human Services Committee made an interpretation error in

proclaiming that the PCS was not being observed in 87% of hospitals. By counting the number of deficiencies written about the PCS in a year, and applying that number to the number of hospitals surveyed by DHS in one year, the Committee came to the conclusion that the overwhelming majority of hospitals were out of compliance with the PCS. However, there are many PCS requirements which have nothing to do with staffing and multiple deficiencies can be written on a single hospital's PCS. (See Exhibit E.) Although DHS communicated to the Committee that their statement was a misrepresentation, it was not corrected. (Exhibit F.)

16. Further, in drafting the nurse/patient ratios, I did an exhaustive literature search on the impact of nurse staffing on patient care. Research has shown that just increasing the number of nurses does not necessarily improve the quality of care for patients. Other factors are significant, such as whether the nurses are experienced or registry nurses. Enriching the ratios on January 1, 2005, would have forced hospitals to rely more heavily on inexperienced nurses, foreign nurses, and registry nurses in order to comply with the 1:5 ratio. It might also have led to even more layoffs of non-nursing staff, such as certified nurse assistants, technicians, ward clerks, transporters, etc., because of the expense to hospitals. Licensed nurses have to fill the functions of these non-skilled staff, diverting them from skilled patient care and defeating the purpose of the ratios. After the implementation of the ratios, hospitals laid off certified nursing assistants to pay for added licensed nurse staff required by the regulations.

17. During the time that the ratio regulation was being drafted, the study by Linda Aiken was published. The Aiken study showed a correlation between increases in nurse staffing and improved patient outcomes. However, other studies have shown strongly that other factors, such as spending money to automate medication systems and put bar codes on patient wrist bands, also may improve patient outcomes. There is no research which shows at what level the nurse to patient ratios become unsafe or at what level there is no additional benefit from enhancing nurse staffing.

18. In arriving at the ratios for various hospital units, L&C relied heavily on studies and articles indicating that certain ratios were better in certain specialty units, such as pediatrics or OB/GYN. We also relied on physician and nurse specialty organizations for

recommendations. With regard to medical/surgical units, there was nothing in the literature and no clear consensus of professionals about what the ratios should be. To arrive at a decision on the medical/surgical ratio, we looked at data from the Office of Statewide Health Planning and Development (OSHPD). This data was confirmed by an on-site survey of California hospitals. The data revealed that 75% of medical/surgical units were being staffed at the 1 to 6 level. From that observation, we concluded that this ratio must be what most hospitals think is safe.

19. By setting the required medical/surgical ratio at 1 to 6, DHS hoped to increase staffing in the lowest quarter of hospitals in the state. The decision to enrich the ratio to 1 to 5 in the second year of the ratio regulations was made, in part, because of arguments made by the nurses' unions, which wanted the ratios set at 1 to 4 or 1 to 3 in medical/surgical units. DHS was also trying to increase staffing in the units where most patients are found. However, there was no independent, empirical evidence about appropriate staffing levels in medical/surgical units. In writing the Final Statement of Reasons for R-37-01, we made this clear. (Exhibit G, p. 36.)

20. Before mandating that the medical/surgical ratios be enhanced, DHS gave the provider community one year, in light of the nursing shortage, to build up their pool of nurses, develop a strategy for compliance, and plan budgets. (See Final Statement of Reasons, R-37-01, pp. 35-36.) (Exhibit G.) Subsequent events have shown that this one year delay was insufficient.

21. When DHS did the on-site survey of hospital staffing, the researchers looked at nurse staffing at the beginning of a shift. They did not look at variation over the course of a shift. DHS wrote the nurse/patient regulations to be in effect "at all times," including breaks and lunches. The California Healthcare Association unsuccessfully sued DHS over this interpretation, which DHS vigorously defended in court. (California Healthcare Association v. California Department of Health Services, Case No. 03CS01814, Sacramento County Superior Court.) When the necessity of meeting the 1 to 6 ratio at all times is considered, it is highly likely that 75% of the hospitals in the original survey were not meeting the 1:6 ratio at all times. This meant that DHS had underestimated the number of nurses needed for hospitals to maintain compliance with the nurse/patient ratio regulations.

22. The nursing shortage in California is severe. California consistently ranks 49th or

50th among the states in the number of nurses per capita. In addition, the nurses in California are aging, with the average age being 49. California only trains about half the nurses needed and relies on nurses coming from other states and countries. California's population is also growing every year and aging, increasing the demand for health care. (Exhibit H.)

23. In the original regulation package, R-37-01, DHS was faced with a legislative mandate and had no choice but to establish nurse/patient ratios in spite of the nursing shortage. In postponing the enhancement of the 1 to 6 ratio in medical/surgical units for three years, DHS decided to leave the ratios at the status quo in order to study what the effects of the ratio regulation were on the health care delivery system, the nursing workforce, and patient outcomes. Faced with serious allegations that the nurse/patient ratios are impeding patient access to care, DHS must study what is happening. Hospitals are reporting that they have many nurse vacancies, in spite of offering bonuses and other incentives to nurses. They are also closing and downsizing and blaming the ratios. To date, there is no concrete evidence that the implementation of the ratios has improved patient outcomes, and some evidence that the ratios have been disruptive to the health care system.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 15th day of February, 2005, at Sacramento, Caslifornia.

Gina Henning, R.N.

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DECLARATION OF SERVICE
(C.C.P. §§ 1011, 1012, 1012.5, 1013)

Case Name: **CALIFORNIA NURSES ASSOCIATION v. ARNOLD SCHWARZENEGGER, Governor of the State of California; KIM BELSHE, Secretary of the California Health and Human Services Agency; SANDRA SHEWRY, Director of the California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES; CALIFORNIA HEALTHCARE ASSOCIATION, A CALIFORNIA NON-PROFIT MUTUAL BENEFIT CORPORATION**

No.: **04CS01725**

I declare: I am employed in the County of Sacramento, California. I am 18 years of age or older and not a party to the within entitled cause; my business address is 1300 I. Street, Sacramento, California.

On February 17, 2005, I served the attached

DECLARATION OF GINA HENNING IN SUPPORT OF RESPONDENTS' AND DEFENDANTS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PETITIONER'S/PLAINTIFF'S APPLICATION FOR PRELIMINARY INJUNCTION

in said cause, by placing a true copy thereof enclosed in a sealed envelope and served as follows:

____ United States mail by placing such envelope(s) with postage thereon fully prepaid in the designated area for outgoing mail in accordance with this office's practice, whereby the mail is deposited in a United States mailbox in the City of Sacramento, California, after the close of the day's business

__X__ California Overnite (Overnight Courier)

____ Facsimile at the following Number:

__X__ Personal Service, via Capitol Couriers, at the below address(es):

to the parties addressed as follows:

VIA CALIFORNIA OVERNIGHT MAIL
LAW OFFICES OF JAMES EGGLESTON
1330 BROADWAY, STE. 933
OAKLAND, CA 94612

VIA HAND DELIVERY
JAMES EGGLESTON
C/O CALIFORNIA NURSES ASSOCIATION
ATT: VICKI BERMUDEZ
1107 9TH STREET, STE. 900
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VIA HAND DELIVERY
ROBERT LEVENTHAL
WILLIAM ABALONA
FOLEY & LARDNER
1215 K STREET, STE. 1920
SACRAMENTO, CA 95814-3947

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct, and that this declaration was executed at Sacramento, California on February 17, 2005.

MAGGIE JACKSON