



San Fernando Valley Hospital Report

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Presented by:

**Economic Alliance of the San Fernando Valley
In Cooperation with the Valley's Hospital Community**

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The Economic Alliance of the San Fernando Valley is a 501(c)3 nonprofit strategic private-public partnership made up of business, government, education, and community organizations. It operates as an economic development and marketing collaborative, serving the 70,000 businesses and 1.7 million residents of the five-city San Fernando Valley area. The Mission of the Economic Alliance is to “grow and strengthen the economy of the region to improve quality of lives in all of our communities.”

The Economic Alliance is one of twenty-two partners in the California Regional Network, a group of organizations and civic entrepreneurs working collaboratively to improve communities throughout the State of California. This allows our work product to be shared on a statewide and national scale.

In forging these collaborative partnerships, the Economic Alliance acts as a catalyst, convener and honest broker, providing forums, facilitation and resources to address an ever-increasing number of social and economic challenges.

Introduction

The *San Fernando Valley Hospital Report 2004* is a project of the Economic Alliance of the San Fernando Valley. It outlines the current situation in the Valley's hospital community and examines the factors contributing to the coming healthcare crisis.

Over the past year, the Economic Alliance has held several meetings with most of the hospital CEOs in the Valley, allowing them to speak with a unified voice about this potential crisis, while remaining committed to the success of their individual facilities.

While the process cannot provide complete consensus on all issues, this set of shared concerns benefits from a high level of support from participants.

Understanding the key issues and how they affect the hospitals – the core of the healthcare system – is the basis for addressing and hopefully preventing this gradual system-wide collapse.

Executive Summary

The Los Angeles area has the nation's fifth-largest health-care economy in terms of employment. According to Jack Kyser, Chief Economist of the Los Angeles County Economic Development Corporation, hospitals are the sixth-largest employer in the San Fernando Valley, providing jobs for more than 18,000 people. Collectively paying 1.2 billion dollars in wages annually, the hospitals represent one of the principal financial sectors of our economy. And one of the most challenged.

The foundational core upon which the entire healthcare system operates – the hospital – is being threatened. In the past 15 years, approximately 40% of hospitals in the Valley have closed (12 out of 33), while the Valley's population has steadily increased. The collective infrastructure is being stretched beyond capacity. And while the volume of patients is increasing, the hospitals' ability to protect its current structure and plan for necessary expansion is decreasing. If certain concerns are not addressed, hospitals will be financially and physically pushed beyond a breaking point, threatening access to care for all – insured and uninsured alike.

Following is a summary of the major issues that pose the greatest threat to the hospital community in the San Fernando Valley and in California:

- **Uncompensated Care and Increased Costs** – Inadequate reimbursement for the care of uninsured, and in some cases, insured patients. More than 50% of hospitals in California are currently operating in the red.
- **Labor Shortage** – California ranks 49th in the nation in terms of the number of RN's per capita. However, the current shortage goes beyond nurses. The most critical shortages are RN's, pharmacists, and imaging technicians, but there are also recruitment challenges for billers/coders, lab technicians, physical and occupational therapists and housekeepers
- **Nurse Staffing Ratios (AB394)** – California's nurse ratio law requires every hospital in the state to be in "continuous compliance" with government-prescribed staffing standards. Some ratios are reasonable, yet some have the potential to cause financial damage to hospitals and in some cases, jeopardize a patient's medical care. These ratios will eventually cost hospitals more than \$956 million annually and, with the current nurse shortage, may be impossible to comply with.
- **Regulatory Constraints** – Because of the burdensome regulatory environment in the healthcare industry, hospitals have to absorb exorbitant costs for compliance with regulations. However, unlike most businesses, they do not have the ability to recover these costs through raising fees.
- **Technology and Customer Expectations** – Insurance companies often do not provide hospitals with adequate reimbursement for new technology, paying hospitals below their actual costs to provide care. The challenge for hospitals today is to develop methods for using technology in a manner that fairly balances consumer expectations with cost and access issues.
- **Patient Volume Increase and the County's Changing Role** – By projecting current population growth, the Valley will increase by 250,000 to 300,000 people by 2010. It is also estimated that in the next 50 years, the percentage of those aged 65 or older will increase anywhere from 13% to 20%. The closure of County hospitals and clinics will force private hospitals to further underwrite the cost of caring for uninsured and underinsured patients and put additional stress on their already strained resources.

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Uncompensated Care and Financial Constraints

Hospitals are required by federal law to provide medical screening and treatment to all patients entering an emergency room regardless of their ability to pay for care. In the business of saving lives, this is a necessary law. Nobody should be in a life-threatening situation and be refused treatment because they are without insurance. However, the system for reimbursing the hospitals for this medical care has broken down and hospitals remain uncompensated, being forced to absorb the cost of this care. With 2.7 million uninsured people in Los Angeles County (approximately 1.7 of which are non-elderly residents),¹ the closure of County hospitals and clinics means that private hospitals have to treat and pay for even larger volumes of un-funded patients. Not only does this result in high volumes of traffic and wait times in the emergency rooms, but results in hospitals accruing enormous debt.

Many private hospitals have buckled under this financial stress. In the past 15 years, approximately 40% of hospitals in the San Fernando Valley have closed, leaving 21 hospitals to care for a population that was previously cared for by 33 hospitals.² With each closure, the remaining hospitals are being stretched beyond capacity. Statewide, more than 50% of hospitals are operating in the red.³

As a society, we spend much more money on ER visits for the uninsured than we would if everyone had access to preventative care. The uninsured or even those on federal insurance programs do not have access to primary/preventative care, if at all. When they get sick, they do not go to the doctor. Their common cold turns into pneumonia, which turns into sepsis, which becomes an ER visit, again increasing wait times for all patients and creating more debt for the hospitals.

Uncompensated care goes beyond the uninsured. Even if people are insured, hospitals are still absorbing some of their cost for medical care. Insurance companies cover all services for their patients, but often do not provide hospitals with adequate reimbursement, paying hospitals below the cost to provide care.

Additionally, traditional hospitals now have to share their patient populations and revenue streams with a proliferation of outpatient surgical centers that have lower overhead costs and fewer regulatory restrictions.

Due to regulatory as well as practical constraints, non-hospital surgical centers see patients who are healthier than many of those who end up in hospital operating rooms. Without Intensive Care Units to handle patients who develop complications during surgery, non-hospital surgical centers have to screen out foreseeable high-risk patients. Consequently, the traditional hospitals receive an increased number of these high-risk patients, who are treated at a commensurately higher cost.

Hospitals are constantly playing catch up, not having funds to invest in capital, human and otherwise, to increase their capacity for care. Instead, due to these enormous financial constraints, while patient volume is increasing, hospital capacity is decreasing. This is obviously not a winning combination.

¹ UCLA Center of Health Policy Research. California Health Interview Survey (CHIS), 2001

² 2003 American Hospital Association Guide and 2004 Healthcare Association of Southern California

³ California Health Association – Implementation of California’s Nurse Ratio Law – Q&A

Labor Issues And Shortages

California ranks 49th in the nation in terms of the number of RN's per capita.⁴ Statewide, California hospitals currently operate with a more than 15 percent RN Vacancy rate – one out of every 6 nursing jobs goes unfilled because hospitals cannot find nurses to hire.⁵

The current health care labor shortage goes beyond nurses and is not a short-term problem as the industry has experienced in the past, but a broader and more severe long-term shortage. The most critical shortages are RN's, pharmacists, and imaging technicians, but there are also recruitment challenges for billers/coders, lab technicians, physical and occupational therapists and housekeepers.

Demographic information shows that the workforce is shrinking and aging. California currently graduates about 5,000 nursing students each year. However, more than that are retiring each year. Within the next four years (by 2006) more than 28,000 RN's in California are likely to retire.⁶

There are fewer potential workers coming behind the aging baby boomer generation, and careers in healthcare are viewed as less attractive to those entering the workforce. Healthcare is the only sector to continue to drop in unemployment rates and yet it is currently experiencing a demand for hospital workers in all positions.

Hospitals have answered the shortage with major increases to salaries, but with little to no affect. Hospitals are currently spending 60-70% of their operating budget on payroll, with the average full-time nurse's salary starting at \$60,000 plus benefits, going to \$80,000 plus benefits for a 15-year veteran.⁷

These severe shortages threaten the ability of hospitals to meet the patients' needs. With the addition of regulations such as AB394 (discussed below), the shortage is reaching critical levels. Hospitals are being forced to choose between treating patients, thus breaking the law, or transferring patients to other hospitals, jeopardizing their medical outcomes.

Nurse Staffing Ratios (AB394)

In 1999, California became the first state in the nation to sign into law mandated minimum nurse-to-patient ratios (AB394) in acute care and psychiatric hospitals.

The Department of Health Services (DHS) put a great deal of time and thought into the development of these ratios. Given that this is the first such law in the nation, DHS is truly charting new territory. Some of the ratios – such as the medical-surgical units – make good sense. Others, however, may cause harm to an already fragile system.

For instance, the unpredictable nature of patient needs and volumes in hospital emergency departments (ED) makes compliance with pre-established staffing ratios very difficult. Even DHS, which developed the ratios, acknowledges that the ED ratios are “problematic.” In the event of an accident involving several people, very few hospitals will have the staff immediately available to meet state-mandated ratios. This dilemma

⁴ California Healthcare Association – Implementation of California Nurse Ratio Law – Q&A

⁵ California Healthcare Association – Implementation of California Nurse Ratio Law – Q&A

⁶ California Healthcare Association – Implementation of California Nurse Ratio Law – Fact Sheet

⁷ Hospital CEO Roundtable, Economic Alliance of the San Fernando Valley, 2004

may place a hospital in the position of having to decide whether to treat these critically ill patients and thus violate the law, or send these patients to another hospital, thus complying with the law, but potentially jeopardizing the patients' medical outcomes.

Inpatient psychiatric ratios are another example of problematic staffing regulations. Psychiatric services are very unique in that the treatment plans for psychiatric hospital patients are heavily focused on encouraging normalized behavior, and are most successful during times when patients are the alert and interested. Thus, psychiatric hospital staffing is weighted heavily during daytime hours. Requiring a 1:6 nurse ratio on the night shift may cause some hospitals to move valuable nurses from the day shift to the night shift. Psychiatric services may be compromised and valuable nursing resources may be used inappropriately.

Under existing state law, the DHS has the ability to impose fines and issue citations for violations of the nurse ratio law. If DHS finds violations, the department can suspend or revoke a hospital's operating license. Hospitals may be subject to criminal penalties including jail time; possible expulsion from the Medicare and Medi-Cal programs; and civil lawsuits for negligence/abuse and unfair business practices.

Yet, there is conflict between the Federal Emergency Medical Treatment and Active Labor Law (EMTALA) and the nurse ratio regulations. EMTALA requires hospitals to screen and stabilize any patient who comes into an emergency department. Yet, California's nurse ratio law prohibits hospitals from treating patients if the hospital unit doesn't meet the prescribed nurse-to-patient ratio. If a hospital fails to meet the EMTALA requirements because it is not in compliance with the ratio law, the hospital could be subject to federal fines and penalties, as well as potential malpractice lawsuits. If the hospital provides care to a patient when it is out of compliance with the state ratio law, the facility could be subject to state fines and penalties, as well as potential civil litigation.

DHS has estimated that the ratio law will cost hospitals \$422 million in 2004 and \$652 million in 2005. By 2008, after all the ratios have been phased in, DHS estimates the cost will be \$956 million annually.⁸ This is over and above the money hospitals currently spend on nursing salaries and benefits. This is an unfunded state mandate that comes at a time when 51 percent of California's hospitals are operating in the red.

The DHS estimates that 5000 new nurses will be required to implement the ratio law. This comes on top of California's existing nursing shortage. California currently graduates about 5,000 nursing students a year – but with the growth of our population and the aging of the nursing workforce – it is estimated that 10,000 new nurses will need to graduate each year to meet the need.⁹ According to the state Economic Development Department (EDD), California will be short more than 30,000 nurses by 2006. By 2010, the shortage will more than triple – to 109,000.

Even if all the ratios were appropriate and beneficial to the healthcare industry, California hospitals simply do not have enough nurses to meet the requirements of this law. If a hospital has done everything possible to meet the prescribed ratios, but is unable to schedule enough nurses for a given shift or unit, the result may be that hospitals are forced to shut down services or reduce capacity – which may result in longer waiting times for patients seeking care.

⁸ California Healthcare Association – Implementation of California Nurse Ratio Law – Q&A

⁹ California Healthcare Association – Implementation of California Nurse Ratio Law – Q&A

Regulatory Constraints

In non-healthcare enterprises, government scrutiny is a rarity, whereas, in the healthcare industry, these restraints are normal and commonplace. Compliance activities are focused on quality, regulatory review and reimbursement. In the quality arena, hospitals must answer to an exhaustive list, including the Joint Commission for the Accreditation of Hospitals, the Medical Board of the State of California, Occupational Safety and Health Administration (OSHA), Office of Statewide Health Planning and Development (OSHPD), Federal Drug Administration (FDA), and various entities of the Department of Health Services (DHS) including, Pharmacy, Nursing, Infection Control Licensing, etc.

Medicare, Medi-Cal/Medicaid, Lumetra, and other managed care payers perform audits and reviews of care and charges. These reviews are capacious and time consuming, taking numerous correspondences and reviews for resolution. Hospitals must hire employees whose sole purpose is to handle these audits.

New regulations governing future earthquake preparedness call for major upgrades to many hospitals or, in some cases, complete replacement of hospital structures.

To construct or renovate non-hospital areas takes approximately 2 weeks for city building department review, whereas the same review may take 9 months or more for a hospital related project. The Office of the State Architect, OSHPD, DHS, and the County Fire Marshall must be involved in the process.

Clinical staff spend many hours documenting the treatment of patients and the procedures that are followed. The regulation of this industry causes fewer potential employees to gravitate into the healthcare industry as the satisfaction in caring for people becomes overshadowed by regulatory review and more time away from patients.

With a mission as vital as saving lives, hospitals understand the concept of standards and regulations, however because of the burdensome regulatory environment in the healthcare industry, hospitals must absorb exorbitant costs for compliance with regulations. There is no reimbursement or relief and no ability to recover these funds.

Technology and Customer Expectations

As technology continues to improve and prolong life with a growing array of diagnostic equipment and therapeutic interventions, new discoveries are being announced daily. Less than 50 years ago, the structure of DNA first became known. Just recently it was announced that the "genetic mapping" of the human body had been completed.

But the engines of our medical economy are struggling to keep pace with our ingenuity and our desire to apply this new expanse of knowledge.

Challenges include analysis of the applicability, efficacy and shelf life of new technologies, the impact of competition from new types of health care delivery systems, as well as the need to reserve capital for construction of new medical facilities and renovation of existing facilities.

Health care leaders are developing technology assessment groups within their own organizations to guide them through the process of deciding on the purchase of new equipment and the adoption of new procedures. These assessments will want to validate that the new technology can provide the benefits promised. They will also calculate

whether the costs of acquiring a new technology are appropriate and reasonable in the face of other competing demands for capital (such as hospital replacement).

The public's expectations have been increased by equipment manufacturers directly marketing to the public, showcasing their equipment on television shows such as "ER," etc. Health plans are introducing "tiering" systems to allow their members to select their hospital based on both on price and quality. People want the best when it comes to healthcare, and understandably so, but it must be identified who is going to pay for it. Unfortunately, uncompensated care becomes an issue here as well. Insurance companies often do not provide hospitals with adequate reimbursement for new technology, paying hospitals below the cost to provide care.

The challenge for hospitals today is to develop methods for using technology in a manner that fairly balances consumer expectations with cost and access issues.

Patient Volume Increase

Current population growth projected forward, the Valley will grow by an additional 250,000 to 300,000 by 2010.¹⁰ It is also estimated that from 1995-2050, the percentage of people age 65 or older will increase by 13% to 20%.¹¹

As the hospital industry continues to handle an increase in patient volume, access to healthcare will become an issue for all persons – insured and uninsured alike. The affects of the volume increase are already being seen in lengthy waiting lines at local emergency rooms and limited access to inpatient beds.

The most complex component of patient volume increase is the uninsured population, whom tend to access medical care via emergency rooms.

An insured patient has access to primary/urgent care, using the emergency room for true emergency and trauma cases. However, when an uninsured person gets sick, they do not have access to a primary care physician. Their common ailment is either treated in an emergency room (costly to hospitals) or goes untreated, becoming a more dangerous illness still resulting in a visit to the emergency room at an even higher potential cost to the hospital.

Those relying on federal and state coverage (i.e. Medi-Cal and Medicare) are also using emergency departments for urgent or after-hours care because private physicians either are unaffordable without insurance, do not take Medi-Cal/Medicare payments, or are not open on evenings and weekends.

In the case of specialty care, the private sector is largely unavailable to Medi-Cal patients. Outpatient/inpatient consultations and interventions are almost always unavailable. And just as access to primary care is limited, the number of private specialists who provide care to Medi-Cal patients is severely limited. Many patients are referred to the County system precisely because of this gap in the private sector. Patients who need general surgery, orthopedic surgery, neurology/neurosurgery, specialty care and many others, find that only physicians salaried by the County system are available to them.

¹⁰ U.S. 2000 Census Data by the Economic Alliance of the San Fernando Valley

¹¹ Coffman J. et al. "Nursing in California: A Workforce Crisis." San Francisco: California Workforce Initiative and the UCSF Center for Health Professions, January 2001.

The closure of County facilities in the San Fernando Valley will create an even larger gap in the system of care for federally insured and uninsured patients. While they will continue to stream into emergency departments for ambulatory care, if they need follow-up outpatient specialty consultation, or inpatient specialty care after being admitted, the largest gap in the private sector will be revealed at the most critical moments. Private hospitals with obligations to meet the needs of inpatients will be forced to further underwrite the cost of on-call specialists and put even greater financial stresses on hospitals struggling to meet the needs of these populations.

Hospital Beds

Overall, there are approximately 3,000 acute care medical/surgical beds in the greater San Fernando Valley area; there are also approximately 400 psychiatric beds; another 1,000 beds are classified as “swing” and/or “skilled nursing.”¹² So for the Valley’s population of 1.7 million people, are there enough beds? Well yes, but barely.

According to a basic bed calculation*, the amount of beds are enough if the Valley’s hospitals function at an average census of 93%. The fact is that for all of the hospitals to be at 93%, capacity in the aggregate (all the time) would be near impossible. The nationwide Advisory Board generally defines aggregate hospital capacity at 80%.

Even if the hospitals can maintain that level, losing any beds would place the region in a precarious situation. Unfortunately, there are several threats to hospital capacity, such that in five years, the Valley could be seriously under-bedded. And with potential closures due to nurse staffing ratios, that five-year grace period might become five months.

Most hospitals are without resources to adequately expand capacity, higher more staff, and invest in infrastructure. And with the changing role of the County, hospitals throughout the Valley are preparing for the worst.

The County’s Changing Role¹³

The County’s function in the health care system cannot be overestimated. As the second largest public health delivery system in the nation, Los Angeles County Department of Health Services (DHS) cares for an estimated 800,000 Medicaid and indigent patients at a cost of \$2.4 billion per year. As of October 2002, the system consisted of a loose network of five hospitals, four comprehensive urgent care centers and 13 primary care clinics.

The County hospitals are the linchpin in the regional emergency and trauma system providing approximately 12% of the emergency room visits within the County and 14% of the regional (general acute) hospital patient days (656,000). More than 8,300 patients are transferred to County facilities each year from surrounding private hospitals.

The challenges of providing health care in the County will escalate as major structural changes take place within DHS. The proposed changes are aimed at addressing the current high demand, limited resources and budget deficits.

¹² San Fernando Valley Hospital Survey, Economic Alliance of the San Fernando Valley, 2003

¹³ Statistics for this section provided by Community Health Councils/Los Angeles County Safety Net Task Force and Los Angeles Department of Health Services in October 2002

In 1995, the DHS faced more than a \$685 million budget short fall as a result of escalating medical costs, low reimbursement rates and the loss of County revenue through taxpayer initiatives such as Proposition 13, inter-state transfers and declining county matching funds. The County was able to secure funding in 1995 and 2000 under a federal 1115 Medicaid waiver that supported the restructuring and realignment of its public health system. While the waiver provided reimbursement for an expanded outpatient service network and resulted in a series of increased efficiencies and cost savings, there was little change in the underlining structural budgetary problems that perpetuated the financial short fall. The County will once again have a shortfall expected to grow in excess of \$788 million by 2005.

In an effort to balance this monumental structural deficit, the County is looking to re-define its role in supporting health services for uninsured and underinsured populations. This has included taking steps to begin downsizing the system. The collapse of this system has far reaching implications for not only the more than 1.7 million uninsured in the County but the entire regional, if not national, health care delivery system.

What is occurring in Los Angeles and the San Fernando Valley is occurring throughout the nation. However, the significantly larger indigent population in Los Angeles County magnifies the impact locally. At a time when the nation faces increasing public health and homeland security threats, the public health and health care safety net delivery system throughout the nation is eroding. Capacity and funding are both non-existent within the private sector to replace the role and function of LA's public health care system. Private health care systems in communities throughout the nation are similarly dependent on the safety net, as is Los Angeles. If an effective solution is found for Los Angeles County, it may provide a template for the nation's growing health care crisis.

*** Bed Calculation**

The Advisory Board has determined that for every thousand people, 600 bed days are needed. So the bed calculation is as follows:

# of acute care year medical surgical beds	X	365 days	=	# of available bed days per
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$$3000 \times 365 = 1,095,000$$

600 bed days	X	per thousand people	=	# of needed bed days
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$$600 \times 1700 \text{ (1.7 million people)} = 1,020,000$$

# of needed bed days	÷	# of available bed days/year	=	average census hospitals need to function at
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$$1,020,000 / 1,095,000 = .93 = 93\%$$

Sources

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