

13 Other Legislation Relevant to Hospital Facilities

Nurse to Patient Ratios

AB 394 Nurse Staffing Law (Kuehl, 1999)

California became the first state to establish minimum registered nurse (RN)-to-patient ratios for general acute care hospitals. The ratios are the maximum number of patients assigned to an RN during one shift. Hospitals are also required to establish written policies and procedures for training and orientation of nursing staff. AB 394 restricted hospitals from using unlicensed personnel to provide certain nursing services, under the direct clinical supervision of a registered nurse or not. The law requires the state Department of Health Services (DHS) to establish specific ratios for specific hospital units. Final regulations for implementation were issued in 2003, with the compliance deadline for hospitals to meet the staffing ratios set as January 1, 2004.

Exhibit 13-1

CA Minimum Licensed Nurse-to-Patient Ratios

- Medical, surgical, medical/surgical and mixed units are 1:5
- Step down units are 1:3
- Telemetry units are 1:4
- Specialty Care units are 1:4
- Hospital emergency departments must comply with same requirements as all other units (requires documentation of specific nurse to specific patient assignments)

AB 1760 (Kuehl-D, 2000)

AB 1760 amended AB394 and granted the California Department of Health Services a one-year extension for establishing enforceable nurse-patient ratios. The new deadline was January 1, 2002. Existing law allowed a county hospital in Los Angeles County to phase-in to nurse-to-patient staffing ratio requirement; AB 1760 eliminated the phase-in.

California Code of Regulations Nurse-to-Patient Ratio Changes in 2008

On January 1, 2008, new nurse-to-patient ratios went into effect for step-down, telemetry and Other Specialty Care units as regulated in Title 22 of the California Code of Regulations. Step down units are transitional units between the intensive care unit (ICU) and general medical-surgical floors, the ratio was changes to 1:3 from the previous 1:4. Telemetry units are those where the patients are hooked up to monitors, the ratio was changed to 1:4 from the previous 1:5. Other Specialty Care units are those that specialize in certain types of care, such as cancer, etc., their ratio changed to 1:4 from the previous 1:5.

Hospital Fair Pricing Policies

AB 774 Hospital Fair Pricing Policies (Chan, 2006)

AB 774 established the Hospital Fair Pricing Policies, requiring all licensed general acute care hospitals, psychiatric acute hospitals and special hospitals to raise public awareness of the availability of charity care, discounted payments and government-sponsored health insurance and to standardize its billing and collection procedures. Hospitals are required to adopt specific procedures in regards to eligibility determination, billing practices and debt collection. The review process and their written policies must include clear language for each of these elements for charity care (free) and discount payments). This legislation is later amended by SB 350 and AB 1503.

SB 350 Hospital Fair Pricing Policies (Runner, 2007)

SB 350 amends SB 774. The Office of Administrative Law approved regulations requiring on-line submission of the required information using the OSHPD System for Fair Price Hospital Reporting effective late 2007. This legislation makes clarifications to current law in regards to collection activities associated with a hospital's charity care and discount payment policies.

AB 1503 (Lieu, 2010)

AB 1503 further amends AB 774. It requires emergency room physicians at hospitals that provide emergency care to offer discounts to the uninsured or patients with high medical costs at or below 350 percent of the federal poverty level. Hospitals are required to incorporate language into their current fair pricing policies to notify these patients of the availability of these discounts for ER physician services. A copy of the hospital's charity care and discount payment policy outlining eligibility, review and application procedures must be submitted to OSHPD by January 1, 2008, and every other year thereafter and when a significant change is made.

Transparency Legislation

SB 917 (Speier, 2005)

SB 917, also known as the Hospital Transparency Act of 2005, amends the Payers' Bill of Rights and requires OSHPD to compile and report the 25 most common Medicare DRGs, and the average charge for each, by hospitals and publish it on its website. OSHPD is required to use Medicare All Patient Refined (APR)-DRGs for all hospitals with 10 percent or more of their admissions on Medicare and is also required to create the APR-DRG methodology for hospitals not reported on the Medicare DRG system. Hospitals are mandated to provide copies of its charge master to those who request it and may charge a copy fee. This legislation extends the

deadline for hospitals to provide this list upon request to July 1, 2006.

AB 1045 (Frommer, 2005)

AB 1045 requires hospitals to publicly share the prices for the 25 most common outpatient services and procedures and requires OSHPD to create and update a public database with an online query system to display these average charges for the 25 most common procedures for every hospital in California. Additionally, this legislation requires hospitals to provide a written cost estimate for health care services upon request for an individual who is uninsured.

SB 1301 (Alquist, 2006)

SB 1301 requires general acute care hospitals to report specified adverse events to the Department of Health Services (DHS) within a five-day period once the event has been detected, or within a 24-hour period if the event is an urgent or emergent threat to patients, personnel or visitor health and safety. An adverse event would be any event that causes the death or serious disability. Once the report is received, the DHS must complete an on-site investigation within 2 business days. Administrative penalties and civil monetary penalties in an amount up to \$100,000 per violation, can be levied against the hospitals and their licensing may be adversely affected. The legislation also establishes the deadlines of January 1, 2009 to provide the public with written information about corroborated adverse events and January 1, 2015 for those reports to be available to the public via their website.

The list of reportable adverse events as specified by the bill are as follows:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgical procedure performed on a patient
- Object left in patient after surgery
- Death of a patient, who had been generally healthy, during or immediately after surgery for a localized problem

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- Patient death or serious disability associated with the misuse or malfunction of a device
- Patient death or serious disability associated with intravascular air embolism
- Infant discharged to the wrong person
- Patient death or serious disability associated with patient disappearing for more than four hours
- Patient suicide or attempted suicide resulting in serious disability
- Patient death or serious disability associated with a medication error
- Patient death or serious disability associated with transfusion of blood or blood products of the wrong type
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
- Patient death or serious disability associated with the onset of hypoglycemia, a drop in blood sugar
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia, a blood abnormality, in newborns
- Severe pressure ulcers acquired in the hospital
- Patient death or serious disability due to spinal manipulative therapy
- Patient death or serious disability associated with an electric shock
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred in the hospital
- Patient death associated with a fall suffered in the hospital
- Patient death or serious disability associated with the use of restraints or bedrails
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient
- Sexual assault on a patient
- Death or significant injury of a patient or staff member resulting from a physical assault in the hospital

Operational and Facility Legislation

SB 1312 (Alquist, 2006)

SB 1312 granted authority to the Department of Public Health (DPH) to levy administrative penalties against general acute care, psychiatric or special hospitals for code deficiencies or code violations that pose an immediate threat. Penalty maximums were established as up to \$50,000 for the first violation, up to \$75,000 for the second subsequent violation and up to \$100,000 for the third and every subsequent violation thereafter. Later legislation raised the administrative penalty levels before the effective date when DPH adopted these regulations.

AB 2128 (Emerson, 2008)

AB 2128 created a state-mandated local program requiring health facilities to have a dietitian on staff on a full-time, part-time or consulting basis. Those with a dietitian employed on less than full-time are required to employ a full-time dietetic services supervisor who meets the required educational requirements and who will receive regularly scheduled consultations from a qualified dietitian. The deadline for submittal of program flexibility requests, in regards to a dietetic services supervisor possessing more than 5 years of experience and enrolled in a specified education program, was set for December 31, 2009 and if granted would extend that individuals ability to practice as a dietetic services supervisor for an additional 18 months, with an option to extend that end date by an additional 6 months.

AB 2146 (Feuer, 2008)

AB 2146 creates a state-mandated program that prohibits health care providers from including in their care plan or insurer contracts provisions prohibiting nonpayment policies and practices for preventable HACs and it prevents a patient from being charged by the provider for the denied payment. It requires state public health programs to develop and implement policies in regards to the payment of health care providers for HACs, requires the provider's medical director and

director of nursing to make annual reports to their board regarding HACs and requires the Secretary of the CA HHS to report to the Governor and Legislature (by January 1, 2011 and bi-annually after) nonpayment policies for the Healthy Families Program and Medi-Cal and HAC prevention.

AB 2400 (Price, 2008)

Under existing law a hospital that plans to reduce or eliminate emergency medical services must give notice at least advance 90 days. AB 2400 would change that requirement to at least 30 days prior notice for closure, elimination or relocation of supplemental service.

AB 2565 (Eng, 2008)

AB 2565 requires a general acute care hospital to develop and implement a policy in regards to brain death, through discontinuation of cardiopulmonary support for the patient. Hospitals must provide the patient's legally recognized medical decision maker or family or next of kin with a written copy of this policy if it is deemed that there is potential for brain death, and must provide a reasonably brief period once the patient is declared dead. Additionally this legislation requires the hospital to make reasonable efforts to accommodate any special religious or cultural practices expressed by the patient's legally recognized medical decision maker or family or next of kin. It is a state mandated program.

AB 2702 (Nunez, 2008)

Existing law allows for the reimbursement of physicians and hospitals who provide uncompensated emergency medical services from Maddy Emergency Medical Services (EMS) fund and Prop 99 EMS funds, but only in certain locations, including a hospital with a basic or comprehensive emergency department (ED) or a small and rural hospital standby ED. AB 2702 would require counties to distribute these funds to physicians who provide EMS in standby EDs if the following conditions are met 1) the standby

ED is in a hospital in existence as of January 1, 2007, 2) it is located in LA County and 3) there are experienced EMS physicians providing emergency services 24 hours per day.

AB 2747 (Berg, 2008)

AB 2747 states that once a patient is diagnosed with a terminal illness with the prognosis that they have less than one year to live, health care providers will provide information and counseling regarding legal end-of-life options (such as palliative care and hospice care) upon request and supply a referral or transfer if they do not want to comply with the patient's end-of-life option choice.

SB 158 (Florez, 2008)

SB 158 created a Department of Public Health infection surveillance, prevention, and control program. The program will oversee prevention and reporting of HACs in general acute care hospitals. It requires hospitals to develop patient safety plans with various health care staff in order to implement a facility-wide hand hygiene program. Additional provisions include:

- Prohibiting use of an intravenous connection, epidural connection or enteral feeding connection that will also fit into another type of connection port as of January 1, 2011
- Expands existing Healthcare Associated Infection Advisory Committee responsibilities
- Requires training or continuing education requirements for hospital epidemiologists or similar persons providing services at the facility.

SB 541 (Alquist, 2008)

SB 541 increased the levels for the administrative penalties levied against general acute care, psychiatric or special hospitals for code deficiencies or code violations that poses an immediate threat. New maximum penalties increased up to \$75,000 for the first violation, up to \$100,000 for the second subsequent violation and up to \$125,000 for the third and every

subsequent violation thereafter. This legislation also authorized the DPH to levy administrative penalties for unauthorized access to, use, or disclosure of patients' medical information and for failure of the hospital to report such incidents. Additionally, this bill will create an Internal Departmental Quality Improvement Account where the penalties will be deposited.

SB 891 (Correa, 2008)

SB 891 would temporarily, until January 1, 2014, establish the Elective Percutaneous Coronary Intervention Pilot Program authorizing up to 6 general acute care hospitals licensed to perform cardiac catheterization laboratory service and meet the additional criteria to perform scheduled, elective primary percutaneous coronary intervention (PCI) on eligible patients.

SB 1058 (Alquist, 2008)

SB 1058 enacts the Medical Facility Infection Control and Prevention Act to establish standards to protect patients from exposure to pathogens in health facilities, including Methicillin-resistant *Staphylococcus aureus* (MRSA), to ensure they are adequate in reducing the incidence of these antibiotic-resistant infection acquired in health facilities.

SB 1260 (Runner, 2008)

SB 1260 requires the Department of Public Health (DPH) to separately identify on the license of a hospital (general acute care, acute psychiatric, or special) each supplemental service, including outpatient services, and identify the kind of services offered at each site.

AB 1083 (Perez, 2009)

AB 1083 requires all licensed general acute care, acute psychiatric and specialty hospitals to conduct a security and safety assessment at least once a year, effective July 1, 2010. A security plan must be developed based upon the assessment and annually updated. The plan must include measures to protect personnel, patients and

visitors from aggressive or violent behavior. Incidents must be tracked as part of the quality assessment and improvement program.

AB 1544 (Jones, 2009)

AB 1544 establishes a state mandate that the State Department of Public Health must within 100 days approve a completed application and issue a new license to general acute care hospitals that meet certain criteria to add or modify an outpatient clinic service as a supplemental service and to have it included on the hospital's license. This legislation limits the outpatient clinic service to nonemergency primary health care in a clinical environment to patients who remain there less than 24 hours.

AB 415 (Logue, 2010)

AB 415, also referred to as the Telehealth Advancement Act of 2011, updates and defines current terminology related to telehealth and will allow patients to utilize telehealth services by giving verbal permission. Additionally it authorizes teleophthalmology and teledermatology by store and forward for Medi-Cal. This legislation revises the Telemedicine Development Act of 1996 (TDA).

SB 502 (Pavley and De Leon, 2010)

AB 502 requires all general acute care hospitals with a perinatal unit to have an infant-feeding policy that promotes breastfeeding, post that policy for the public and communicate and train perinatal staff in that policy.

AB 1863 (Gaines, 2010)

AB 1863 extends the standards and reporting deadlines for health facilities in regards to backup generator testing.

AB 1136 Safe Lifting – Hospitals (Swanson, 2011)

AB 1136, also referred to as the Hospital Patient and Health Care Worker Injury Protection Act, amends the California Occupational Safety and Health Act of 1973. It requires patient care units of general acute care hospitals to include the provision of trained lift teams in their safe patient handling policy as a part of the Injury Illness and Prevention Program (IIPP). Staff specifically trained in safe lifting techniques must be available at all times. A healthcare worker who elects not to lift, reposition or transfer a patient is exempt from disciplinary action. The legislative intent was to reduce the number of hospital workers who were sustaining injuries while lifting, moving and transferring patients. The hospital is required to provide training to health care workers on the proper use of lifting devices and equipment, the five areas most at risk during lifting and how to use lifting equipment safely. General acute care hospitals within the Department of Corrections and Rehabilitation or the State Department of Developmental Services are exempt. ❖