



STATE HEALTH NOTES

VITAL SIGNS FOR STATE POLICYMAKERS

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GRAPHICALLY SPEAKING

Over 60 percent of employers are looking for ways to reduce spending on employee health benefits, and 4 percent are planning on cutting coverage altogether.

STATE NEWS

IMPROVING THE QUALITY OF CARE: THE CONTINUING DEBATE OVER NURSE-PATIENT RATIOS

Matthew Gever

How many nurses are enough? That is the question in states that are debating whether or not to mandate nurse staffing standards at hospitals.

Such standards are not the newest aspect of quality of care deliberations, but the issue may grow in importance as baby boomers age. By 2025, the United States may need 500,000 more registered nurses than it has, according to a March 2008 [report](#) from experts at Vanderbilt University and others.

Nurse staffing standards are needed to protect patient safety, say some lawmakers. "Ratios greatly reduce costly medical errors, hospital infections and the significant expense of replacing the increasing numbers of RNs who leave the bedside due to unsafe staffing conditions," said Senator Daylin Leach of **Pennsylvania**, where [HB 147](#) is currently being debated.

However, some recent studies of California's policy have come to less sanguine conclusions. "Most of the quality measures do not appear to have been directly affected by the increase in RN staffing," said a [study](#) published in February by the California HealthCare Foundation (CHCF).

This year, at least nine states and Congress are considering legislation that would require hospitals to meet specific nurse-to-patient ratios. Advocates want to follow the lead of **California**, which in 1999 became the first—and so far the only—state to mandate specific nurse-to-patient ratios in hospitals when it passed [AB 394](#).

Most of the bills now under consideration would base nurse staffing on the numbers of patients in a ward. For example, the regulations that detail how California's law should be carried out require one nurse for every four patients in an emergency department; every five patients in medical-surgical units; every two patients in maternity wards; and for every six in behavioral health units. The state's Department of Health Services developed these ratios through its own analysis of the existing literature on the topic, visits to state hospitals and meetings with professional groups.

Pro and Con

A number of studies have found a relationship between lower staff ratios and certain improved health outcomes. For example, a series of [studies](#) from the Agency for Healthcare Research and Quality found "significant associations between lower levels of nurse staffing and higher rates of pneumonia, upper gastrointestinal bleeding, shock/cardiac arrest, urinary tract infections, and failure to rescue."

Many of the health-care leaders interviewed for the CHCF study said they expected that the ratios would eventually improve the quality of care by increasing the interaction between nurses and patients. However, the CHCF found that since the California law went into effect, the average length of patient stay has remained the same, and other nursing-sensitive measures such as pressure ulcers, post-surgery sepsis and pneumonia mortality showed minimal or no improvement.

The authors of another [study](#), in the journal *Health Affairs*, suggested that mandating nurse-staffing ratios could raise hospital costs more than previously anticipated. The study found that the real wages for nurses in California cities increased by an average of 7.8 percent more than the wages for nurses in other metropolitan areas across the nation.

Nurses themselves are divided on the issue. While most favor lower staffing ratios, some don't want lawmakers to get involved. For example, the **Arizona** Nurses Association "feels strongly that these ratios must be set, not by legislators or government officials, but in the workplace in direct coordination with nurses themselves," according to a spokesperson for the group. The Grand Canyon State is currently considering [HB 2186](#), which sets a series of nurse-patient ratios similar to California's.

Some nurses, however, see legislation as essential protection from staffing cuts by hospital management. "These are the same administrators who have spent the last two decades cutting corners and dangerously increasing nurses' patient loads," said a statement from the **Massachusetts** Nurses Association. Last session, lawmakers in the Bay State considered but did not pass [SB 2816](#), which originally included a ratio provision.

Others think that the real issue is not ratios but rather developing policies to address the shortage of nurses. "Demand for full-time registered nurses in **Texas** in 2008 exceeds supply by 22,000," said Dan Stultz of the Texas Hospital Association, who added that this gap in demand for nurses will grow to 70,000 by 2020. The Lone Star State is now considering a ratio bill in [SB 1000](#).

Other states currently considering nurse-patient ratio bills are **Florida** ([HB 241](#)), **Illinois** ([HB 485](#)), **Nevada** ([AB 121](#)), **New York** ([AB 2264](#)), **New Jersey** ([AB 1531](#)), **Oregon** ([SB 564](#)) and **West Virginia** ([HB 2949](#)). Congress is considering [S 54](#), which would mandate ratios for hospitals that serve Medicare patients. These bills would implement ratios similar to those of California.

STATE NEWS

STIMULUS A "DOWN PAYMENT" FOR PUBLIC HEALTH: WHAT STATES CAN DO

By Katherine Rogers

State and local health officials applauded the inclusion of significant public health spending in the stimulus bill signed by President Obama last month, which included \$650 million for community prevention programs and another \$500 million for bolstering the health and public health workforce. However, a new report suggests that prevention and public health programs remain in danger and suggests ways for states to create long-term funding streams.

The [report](#), released March 9 by the Trust for America's Health (TFAH), reports that in recent years, significant cuts in federal public health spending may have weakened states' ability to prevent outbreaks, curb chronic illness and limit the growth of health spending.

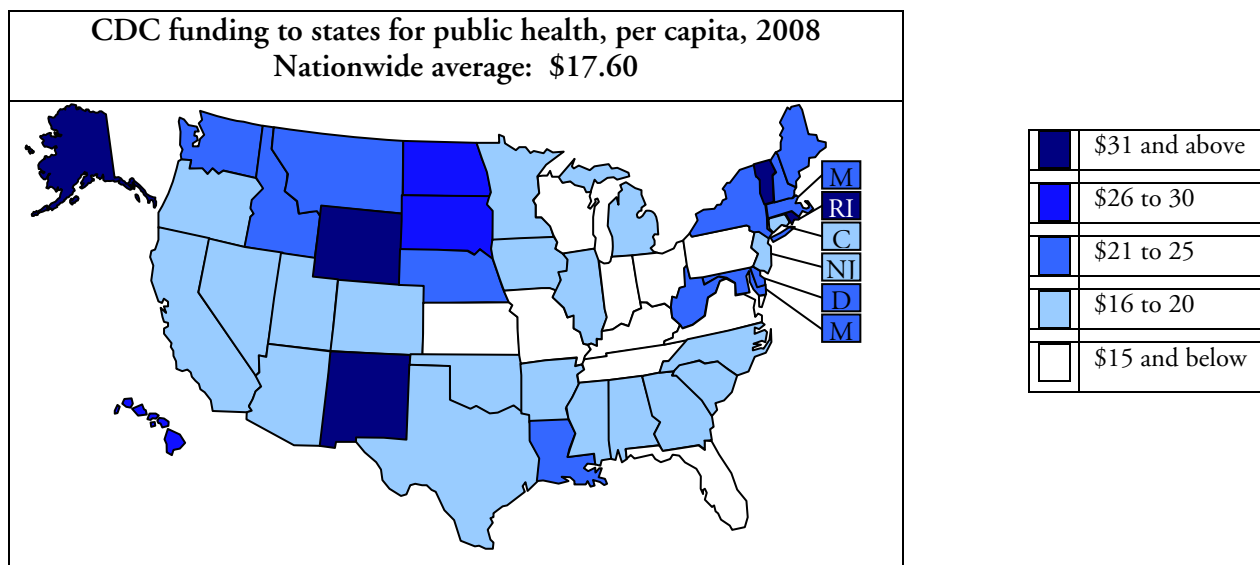
The report notes that an estimated 11,000 public health jobs have already been lost, a number that may continue to grow. Another TFAH report released in December found federal funding to states for state and local preparedness has fallen 25 percent since 2005.

Significant Returns

Most health-care experts agree that public health spending may deliver a significant return by preventing costly illnesses and outbreaks. "Even in these troubled times, prevention is an investment we can count on to deliver a big payoff—sparing millions of people from developing preventable diseases while saving billions in health care costs," said Risa Lavizzo-Mourey, president and CEO of The Robert Wood Johnson Foundation, which funded the TFAH study.

Public health spending, however, has traditionally been dwarfed by health-care expenditures, which averaged about \$3,500 per capita in 2006, according to the [Centers for Disease Control and Prevention](#) (CDC). "Even in better economic times, the country's investment in keeping the public healthy and safe is a tiny fraction of what we spend on treating people after they've become sick," said Jeff Levi, executive director of TFAH.

The report examines federal and state funding of traditional public health programs, as well as some key health indicators, and finds wide variations in all. CDC grants—awarded both through a competitive application process and based on states' needs—ranged in 2008 from \$12.74 per capita in **Indiana**, to \$52.78 per capita in **Alaska**, a \$40 difference (see map below). Midwestern and southern states collected the fewest federal public health dollars, with Midwestern states receiving \$15.40 on average, about \$2 less per capita than the national average.



Data from *Shortchanging America's Health: A State-by-State Look at How Federal Public Health Dollars Are Spent*, Trust for America's Health, 2009.

In 2008, states spent a median \$33.71 per person for public health; state expenditures ranged widely, from \$3.37 in **Nevada** to \$172.21 in **Hawaii** (in state-only spending). The report notes that each state allocates and reports its budget in a different way, so comparisons are difficult.

As for health indicators, an examination of state data found that adult obesity rates ranged from a low of 18.4 percent in **Colorado** to a high of 31.7 percent in **Mississippi**, and rates of uninsured adults varied from a low of 5.4 percent in **Massachusetts** to a high of 25.2 percent in **Texas**.

A role for states

States play a significant role in public health. Among many other tasks, they are responsible for monitoring and investigating emerging health issues, informing the public about health, enforcing state health laws, and preparing for and responding to disasters and health crises.

To take on such a large role in protecting the public health, states need the support of the federal government and the necessary resources. The TFAH report notes that these resources must be coupled with increased accountability for states and localities to ensure funding is being used in the most effective ways and achieving desired health outcomes. Novel options include granting states and localities greater flexibility in spending for increased reporting and accountability to federal funders, tying Medicaid or federal health spending to state investment in prevention programs, or establishing standard guidelines or benchmarks for core public health functions.

Increased funding paired with improved accountability may provide states and the federal government with an opportunity to promote public health programs and protect their investment—a long term solution from which everyone can benefit.

STATE NEWS

STATES MUST COMPLY WITH NEW CHIP RULES FOR DENTAL CARE

Christina Kent

States face a vast number of obstacles when it comes to giving Medicaid-enrolled children access to oral health care. Now they'll confront some new issues as they implement the Children's Health Insurance Program Reauthorization [Act](#) of 2009, signed into law last February.

The law that created the State Children's Health Insurance Program (now called simply CHIP) gave states the option of providing dental services to children—all states choose to do so. The reauthorization *requires* that states provide dental services to enrolled children, starting Oct. 1, 2009.

The National Dental Association, the American Dental Association and 12 other organized dental groups have applauded the new requirement, on grounds that when state finances are low, the CHIP dental benefit is often one of the first programs to be cut.

The original CHIP law also gave states the option of providing children with dental coverage that is equivalent to:

- a frequently selected Federal Employees Health Benefits Plan;
- a popular state employees benefit plan; or
- a commercial dental benefit plan that has the largest non-Medicaid enrollment of dependents.

The reauthorization does the same.

The new law imposes a number of reporting requirements on states, which now must tally up the number of enrolled targeted low-income children who receive any, preventive, or restorative dental care under the state plan. The reauthorization also mandates that states report the number of eight-year-old children who have received a dental sealant on at least one permanent molar tooth.

By August, beneficiaries must be provided with a complete list of dentists and dental service providers who will treat children enrolled in Medicaid or CHIP. A description of dental services provided must also be provided by August and updated at least annually.

Federally Qualified Health Centers may contract with private dentists in order to expand their capacity to deliver dental services to their clients. The General Accounting Office is to provide Congress with a report on the feasibility of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

While the requirements may sound daunting to some, states have come up with enormously innovative ways to give Medicaid-enrolled children access to oral health services, and it's possible that such programs may inform states' efforts to comply with the new CHIP rules.

Expanding the Numbers

Virginia, for example, has greatly increased the number of children in Medicaid and CHIP who receive dental care.

In 2003, fewer than 24 percent of the 450,000 children in Virginia's Medicaid and CHIP received any dental care, Patrick Finnerty, director of Virginia's Medicaid program, told Congress in September 2008. Only about 6 percent of the dentists in the state were actively treating Medicaid and CHIP children.

"While we had a pretty good idea of what the problems were, we sat down with the leadership of the Virginia Dental Association and heard loud and clear that we needed to make some changes," Finnerty said.

State officials then sought and received approval from lawmakers to:

- increase Medicaid payments for some dental services by 30 percent;
- carve out dental services from five managed-care companies; eligible children now receive oral health services from one vendor, which eliminates the disruption in care that can occur when children move among different plans; and
- decrease paperwork hassles; administrative processes now meet organized dentistry's standards.

The state also rebranded the program as "Smiles for Children," which helped show dentists that the state was sincere in reaching out to them, Finnerty said. Since the program was launched in July 2005, the number of dentists participating in Medicaid and CHIP has increased by 80 percent. "A key indicator of success for us is that a higher percentage of dentists are actively billing for services," Finnerty added. "And our provider and patient surveys show a high level of satisfaction with the program."

Reaching Them Where They Learn

In **South Carolina**, school children may start to receive free, periodic dental checks at school, if a law currently being debated goes through.

Under SB 0268, the state Department of Health and Environmental Control would initiate a pilot program in three to five of the state's poorest counties. Children entering kindergarten, third, seventh and 10th grades, or whenever they first enroll in school, would be screened for dental issues by an authorized practitioner, which may include dentists, hygienists, certified dental assistants, physicians, nurses and anyone who has qualified under the department's program guidelines.

Children who need further oral care would be referred to a dental coordinator, who would help find a dentist for children who lack one, make appointments and provide transportation, if needed. If the child qualifies for, but isn't enrolled in, Medicaid or CHIP, the coordinator would help parents navigate the enrollment process.

A screening must be performed for students in the targeted counties unless a parent or guardian completes an exemption form provided to them by the school.

"We've got children who are just not mentally alert or missing many days because of [dental issues]," Senator Ray Cleary, a dentist, told the *Augusta Chronicle*. "Our education in South Carolina needs to go forward." If the General Assembly limit the pilot project to three adjoining counties, so that the agency could hire a single coordinator, agency officials estimate that the program will cost \$63,000 in the first year.

For more information on dental provisions in the reauthorization act, please go to:
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2enr.txt.pdf
A summary is available at:
<http://ccf.georgetown.edu/index/schipreauthorization>

For more information on state programs to improve oral health, please go to:
www.cdc.gov/NCCDPHP/publications/AAG/doh.htm.
http://www.nasmd.org/oral_health/main.asp

HIGHLIGHTS

CHILDREN'S HEALTH

Coverage for All

Maryland is one step closer to requiring universal health care for all children in the state. A bill ([SB 577](#)), introduced by Senator Rob Garagiola, would require parents to provide health coverage for their children and allow families who make more than 300 percent of the federal poverty level—about \$66,000 a year for a family of four—to buy into the Maryland Children's Health Program. The mandate would take effect in 2010, but the enforcement of the statute—a \$25 tax penalty for single filers and \$50 for joint filers—would not occur until the 2012 tax season and would sunset in 2013. Under current law, families earning up to 300 percent of federal poverty are eligible for the state's children's health insurance program. If passed, families would be eligible to buy in at about \$170 per child per month. Senator Garagiola called the requirement a "soft mandate" and is pushing for the bill primarily as an education and outreach program. Currently, 100,000 of the 140,000 uninsured children in the state are already eligible for existing state health-care programs. "The goal is to make sure families know about and take advantage of these programs, Garagiola told the *Capitol News Service*. The legislation also would require the Maryland Health Care Commission, the Department of Health and Mental Hygiene and the Maryland Insurance Administration to file reports with the General Assembly in 2011 and 2013 outlining recommendations for further education and outreach, as well as possible ways to assist more families to provide health care for their children.

MALPRACTICE

Sometimes Sorry Works

Some New Jersey hospitals have seen a decline in malpractice lawsuits since participating in a program that aims to prevent litigation by offering patients formal apologies and in some cases money, reports the *McClatchy-Tribune/Oklahoman*. Officials from the [Medical Society of New Jersey](#) are currently evaluating a program called "[Sorry Works!](#)" and report that apologies to patients have

reduced litigation expenses by two-thirds at some U.S. hospitals. Expressing regret is a fundamental shift from the 'deny and defend' culture of medicine, but some hospital officials believe that openly admitting medical errors eases patients' anger and discontent, thereby reducing lawsuits. Officials from Valley Hospital in Ridgewood, New Jersey, report that lawsuits have declined by more than 50 percent since it began making formal apologies. "We want to try to do the right thing in these instances and resolve things ... in a better way than blood and guts litigation," Larry Downs, general counsel for MSNJ, told the *McClatchy-Tribune/Oklahoman*. Officials from the New Jersey Hospital Association said they support the idea but are concerned that an apology is an admission of liability and can actually encourage patients to file lawsuits. Richard Winters, chair of the medical board at Hackensack University Medical Center, said, "Until we have meaningful tort reform in this country and people can't sue for spilling coffee on themselves, we will have a hard time bringing [doctors] to the table." Thirty-six states have apology laws on the books, which encourage physicians to apologize for medical errors but protects them against malpractice suits that may result after they express sympathy to patients affected by such errors, according to research published in *Modern Medicine*.

SUBSTANCE ABUSE

Treatment Instead of Time

A bill working its way through the **Kentucky** legislature would offer some drug offenders treatment instead of a felony conviction. [SB 4](#), which won unanimous approval from the House Judiciary Committee, would allow people charged with certain drug-related crimes to receive substance abuse treatment and have charges set aside if they successfully complete the program through a legal process known as diversion. Treatment would occur at either a county jail or in the community. With the majority of individuals behind bars for drug-related offenses, the goal of the legislation is to curtail the soaring prison population and save money, Senator Dan Kelly, the bill sponsor, told *The Courier-Journal (Louisville)*. "It's cheaper to provide drug treatment in a county jail or in the community than to house people in prison," Senator Kelly said. Those eligible for treatment, which would last up to 18 months, would include people charged with lesser felony drug offenses. Individuals charged with violent or sex offenses are not eligible. SB 4 does not include any new funds but will rely on savings that result from reduced incarceration. Roughly \$9 million is already allocated to the Justice Cabinet for substance abuse services through FY 2010. The state Corrections Department would expand existing substance abuse programs from 15 county jails to 25 and work with community and faith-based drug treatment and recovery programs, Karyn Hascal, a corrections official who helped draft the bill, told the *Courier-Journal*. If the program is successful, it could reduce the state's prison population by 20 percent—4,400 inmates—within five years.

GRAPHICALLY SPEAKING

EMPLOYERS DROPPING, REDUCING HEALTH COVERAGE

Anna C Spencer

Two out of every three U.S. employers are examining ways to reduce the amount they would otherwise contribute to employees' health-care expenses in 2010, according to a [study](#) by Hewitt

Associates. The report also found that 4 percent of U.S. employers are planning "to discontinue providing health-care benefits altogether."

Hewitt surveyed more than 340 large firms comprising more than 5 million employees. The report found that in 2009, the combined average premium and out-of-pocket costs for health-care coverage will rise by about 9 percent to \$3,826 a year per employee and annual insurance costs for companies will increase by 6.4 percent to \$8,863 per worker. In 2009, workers likely will see their annual contributions to premiums increase by nearly 8 percent to \$1,946, which is about 22 percent of the overall premium. Employees' out-of-pocket costs for co-payments and deductibles often increase along with the premium. Workers in 2009 will spend \$156 out-of-pocket monthly, a 10.1 percent increase over 2008, said the study.

The upside? The need to cut costs has led employers to offer more incentives to entice workers to use more wellness services, such as preventive health screenings and health club memberships. "[Employers] are continually looking for ways to reduce benefit costs without reducing benefits," Larry Boress, president of the Midwest Business Group on Health, told the *Chicago Times*. Employers are seeking to cut costs for workers by reducing administrative fees, promoting the use of generic drugs, requiring mail order prescription refills for maintenance drugs and conducting eligibility audits to ensure that coverage is not being offered to ineligible employees or their families.

Economic Downturn Impact on 2010 Health Care Programs

	Increase	No Impact	Reduce	Eliminate
Benefit plan design offerings	13%	37%	49%	<1%
Prevalence of consumer-driven health care plans	40%	55%	3%	2%
Employer health care subsidy	6%	28%	65%	0%
Full-time health care benefits	2%	82%	16%	0%
Incentive programs	20%	44%	30%	6%
Part-time health care benefits	1%	80%	13%	6%
Retiree health care benefits	0%	61%	26%	13%
Wellness programs	33%	41%	24%	2%

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