A QUESTION OF PRIORITIES:
Profits, Short Staffing, and the Shortchanging of Patient Care at UC Medical Centers

EXECUTIVE SUMMARY

The public sees University of California Medical Centers as premier, world-class facilities. We rely upon them when our loved ones face the most serious illnesses because we expect them to provide the highest level of care. With the UC Medical System earning $6.9 billion in operating revenues and hundreds of millions in profits, it has the resources to do just that.

But recently, patient care advocates have witnessed something else: administrative decisions that prioritize UC’s profit margins over patients’ health. These decisions reflect a shift in values that reached a tipping point with a system-wide policy in 2011 that decentralized UC budget practices, and turned each medical center into an independent profit center.

This culture change is evidenced by a sharp rise in management salaries and compensation, excessive management costs, and unprecedented borrowing to construct new buildings. Since 2009, management at UC Medical Centers has grown by 38 percent, adding $100 million to the annual payroll cost of management. Debt service payments have almost quadrupled since 2006. This diversion of patient care dollars results in management’s need to capture “efficiencies” to bolster profit margins.

While “efficiencies” can be positive, they can also have serious negative consequences. Often taking the form of aggressive cost-cutting measures, some translate into chronic short staffing, over scheduling of operating rooms, prioritizing “VIP” patients over everyone else, shortchanging charity care, and outsourcing essential services. These degrade the medical centers’ core mission.

Care providers are painfully aware of administrative priorities that too often leave them unable to provide the care that patients deserve. Patient care workers suffer unnecessary stress and fatigue, and at times work without adequate training on the use of hazardous materials used to sterilize patient care areas. Some report being so rushed in their work that dirty patient care areas may not be properly sanitized before new patients arrive.

While workers are already feeling squeezed, the University is threatening to cut staff. At UCSF Medical Center, management recently announced its plan to reduce 300 hospital workers, or 4 percent of its full-time workforce. These reductions are being proposed at a time when the medical center is only just recovering from having to ration respiratory care services in January 2013 because of inadequate staffing levels. To make matters worse, the hospital’s CEO admits that, in his view, these cuts are needed, at least in part, to free up resources for new construction.

Patient care is suffering while subsidizing excessive management costs and rising debt service payments—a diversion of hundreds of millions of dollars that could go towards direct patient care each year.
Evidence of significant deficiencies in patient care at UC Medical Centers is emerging from a variety of sources, including an independent evaluation by a healthcare buyers group, investigations by the California Department of Health, inpatient discharge data, and interviews with frontline care providers. Some of the incidents may be attributable, in whole or in part, to short staffing; others reflect a systemic breakdown of proper checks and balances. All call out for more oversight of the UC Health system.

When frontline care providers—members of AFSCME Local 3299—point out some of these problems, managers’ unsettling advice is to “just do your best.” UC management has responded with a mix of unfamiliarity, doubt, and at times, outright denial. To date, UC management has rejected all union proposals that UC take basic steps to improve staffing standards.

Frustrated, these workers are coming forward as whistleblowers to tell their story with the hope that it can bring about some corrective action.

Given UC’s unresponsiveness to its frontline employees, this report recommends more state oversight, and an audit of UC staffing, management, and financial practices before more taxpayer dollars are committed to the UC Health system. The goal should also be to ensure that UC not only utilize safe staffing standards but also exhibit the leadership expected of such a renowned and prestigious healthcare system. Without guarantees of safe staffing, UC’s drive for “efficiencies” could have far-reaching consequences that put care providers and patients at risk.

Independent reports and inpatient discharge data raise questions about the quality of care at UC Medical Centers.

- In November 2012, Ronald Regan UCLA Medical Center received an “F” for patient safety from the Leapfrog Group, a healthcare buyers organization that publishes an annual “Hospital Safety Score.”

- In 2012, the California Department of Public Health uncovered a systemic breakdown of internal checks and balances that contributed to two UC Davis Medical Center physicians engaging in a controversial experimental treatment for brain cancer patients, with tragic results.

- Since October 2008, the California Department of Public Health has made eleven formal findings of immediate jeopardy at two UC facilities: UC Irvine Medical Center and UCSF Medical Center.

- UC Irvine Medical Center has one of the highest rates for hospital-acquired pressure sores among elderly patients in the State of California.

- The California Department of Public Health found ten violations at UCSF related to hospital-acquired pressure sores.

- UC Irvine Medical Center has the worst rate of hospital-acquired Urinary Tract Infections among female patients in Orange County and the 10th worst in California after adjusting for case mix.
Frontline care providers give examples of how UC policies degrade safe staffing and patient care.

- Patients often fall trying to go to the bathroom by themselves because short staffing delays staff response times. In one instance, a patient classified with “altered mental status” did not receive one-on-one attention and was found standing on a windowsill.  

- Chronic short staffing creates excessive workloads and stress. One nurse’s aide reports being afraid to take breaks because it would increase the ratio of patients to CNAs from 10:1 to 20:1.

- Care providers are forced to give special treatment to VIPs—so-called because of their wealth or relationship to UC administrators—at the expense of other patients.

- The UC health system seeks to “re-align” Medicare and Medicaid patients to non-UC hospitals under the assumption that they often do not require the level of care UC provides.

- Care providers complain about dirty patient care areas. An operating room assistant sees dried blood and fluids in the crevices of an operating table month after month.

- Care providers complain that an emphasis on cutting costs undermines patient care quality. One operating room assistant frequently hears that she must “hustle” because the operating room “costs $260 a minute.”

- Profitable high-level procedures get overscheduled, causing stress and exhaustion for care providers and delays for patients.

Payroll data shows UC Medical Centers increasingly outsourcing patient care.

- UCSF increased its outsourcing of various classifications (including Sitters, Licensed Vocational Nurses, Sterile Processing Technicians, and Anesthesia Technicians) from 135 patient care hours in 2008 to over 75,000 patient care hours in 2011 — 500 times greater than in 2008.

- A patient care assistant at UCSF Medical Center describes “scary and stressful” situations when temporary employees work in an operating room but don’t know the protocol.

- UC Medical Centers are relying more on temporary workers and less on career patient care providers. Although just 13 percent of the patient care technical workforce, per diem appointments accounted for nearly a third of patient care positions added this last year.

Practices at UCLA Medical Center raise questions about UC’s commitment to charity care.

- Despite being the second most profitable hospital in the Los Angeles market, in 2011, UCLA Medical Center only dedicated 1.29 percent of operating expenses for charity care to low-income patients. Over 77 percent of hospitals in the market dedicated more. The average general acute care hospital in Los Angeles dedicated over four times more of their operating expenses for charity care to low-income patients than UCLA.

At the same time, patient care dollars are being diverted to pay for a skyrocketing number of managers and their exorbitant salaries.

- Between 2008 and 2011, total UC workforce grew by 2 percent, faculty increased by 2 percent, but the number of managers and administrators grew by 9 percent. Twenty-eight percent of all new employee positions were for managers. And individuals earning more than $200,000 grew by 44 percent.
At UC Medical Centers, between 2009 and 2012, management growth swelled by 38 percent and payroll costs for managers grew by 50 percent. It is estimated this added $100 million to the annual cost of management, bringing total yearly salary costs for managers to an estimated $298 million.27

UCLA Medical Center doubled the number of its administrators between 2009 and 2012, adding 430 full-time managers at a cost of $62 million.28

UCSF Medical Center CEO Mark Laret received $300,000 in bonus pay in 2011, for nearly $1.2 million in total compensation.29

UCLA Hospital System CEO David Feinberg’s hourly rate grew from $354 to $431 between 2009 and 2012.30

UC Irvine Medical Center CEO Terry Belmont took home $775,000 in pay and bonuses in 2011, a 40% increase from his predecessor.31

Patient care dollars are being diverted to pay for ballooning debt loads to finance new construction, further squeezing UC Medical Centers’ operating budgets.

UC medical system’s total outstanding long-term debt and financing obligations increased from $1 billion in 2006 to $2.6 billion in 2012, overwhelmingly due to new construction.32

Between 2006 and 2011, outstanding hospital revenue bond debt tripled at UC Medical Centers—from $787 million to $2.4 billion. At UCSF alone, hospital revenue bond debt increased nearly 900 percent.33

At the same time, annual debt service to pay for these revenue bonds almost quadrupled, from $46.3 million to $175.9 million.34 These millions of dollars could be going to direct patient care.

**RECOMMENDATIONS**

The State of California provides significant funding for the University’s Health System. In the fiscal year 2012-2013, it will provide approximately $300 million in public dollars for health sciences instruction.35 In addition, UC is currently requesting another $15 million in taxpayer dollars in 2013-14 to support the new UC Riverside Medical School, as well as permanent core funding to support the school’s future needs.36 Before additional taxpayer dollars are committed to UC Health or its affiliated medical centers, AFSCME Local 3299 calls for an investigation into the following:

- **Legislative Hearings on Management “Efficiencies”:** California state legislators should question UC executives on current policies for cutting costs, reducing staff and maximizing revenue. This includes UC management’s admission that reductions of frontline staff are needed to pay for new expansion projects. As the Affordable Care Act comes online—which will give healthcare coverage to 7 million Californians for the first time—public hospitals should be expanding, not decreasing, their frontline workforce.

- **Audit Management Bloat & Salaries:** A State audit should examine the increasing number of administrator positions and their compensation at UC Medical Centers and UC campuses.

- **Investigate UC Staffing Practices:** The California Department of Public Health should audit current staffing practices at all five UC medical centers to identify potentially dangerous employment practices, such as workers’ inability to take breaks and worker fatigue.

- **Investigate Short Staffing of Non-Nurse Staff:** Investigate and assess hazards stemming from the absence of mandated staffing ratios and exam time standards* for non-nurse staff. These are two of the primary causes for workers not taking breaks and worker fatigue in a setting where being rushed and short staffing could cost lives.

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* There are currently no mandated standards for the amount of time non-nurse staff are to spend with patients.
Investigate UC Medical Centers’ Provision of Care to the Poor: Investigate the level of charity care provided by all five UC Medical Centers in their communities. The state legislature should explore whether the subsidies and related tax exemptions UC enjoys are justified, in particular by the level of charity care provided to the poor. At the very least, UC medical centers should be required to conduct a community needs assessment every three years like other non-profit hospitals in the state.

Reconsider UC’s Constitutional Immunity: The California State Legislature should reconsider the University of California’s constitutional status that grants the system autonomy from basic employment standards in the State Labor Code and local ordinances. This includes immunity from state law requirements governing overtime, missed meal and rest breaks, and prevailing wage requirements, as well as municipal ordinances that require employers to pay part-time workers sick pay.

Audit Increasing Debt Load at UC Medical Centers: The State should audit UC Medical Centers’ current and projected debt load to assess how increasing debt service to pay for new development and expansion relates to UC’s aggressive cost-cutting measures, as well as re-evaluate current and future new building projects.

Follow Safe Staffing Standards: UC Medical Centers should lead their peers in safe staffing, and not outsource essential services, rely on staff to work through breaks, ration care, or cut staff. UC has repeatedly rejected bargaining proposals that improve staffing standards. These include:

- Offer long-term per diem workers career positions after they meet a basic threshold of hours worked;
- Commit to keeping essential services in-house and insource those currently contracted out;
- Guarantee breaks or compensate frontline care providers when they miss their breaks; and
- Ensure frontline care providers have a real voice in staffing decisions through a staffing committee that includes a third party dispute resolution process.

Provide Health & Safety Training to Patient Care Providers: Care providers who frequently come into contact with hazardous chemicals used to prevent the spread of infectious diseases should receive adequate training, regardless of their classification. Temporary workers performing the same duties as career providers should also receive the same training.

UC workers are committed to providing the best care to their patients. Brave workers have come forward as whistleblowers to tell their story in the hope that they can bring about some positive change.

For more information, contact patientcare@afscme3299.org.