About the Consumer Voice

*The leading national voice representing consumers in issues related to long-term care*

▸ **Advocate for public policies** that support quality of care and quality of life responsive to consumers’ needs in all long-term care settings.

▸ **Empower and educate** consumers and families with the knowledge and tools they need to advocate for themselves.

▸ **Train and support** individuals and groups that empower and advocate for consumers of long-term care.

▸ **Promote the critical role** of direct-care workers and best practices in quality care delivery.
Welcome

- The program is being recorded
- Use the Q&A feature for questions for the speakers
- Use the chat feature to submit comments or respond to questions from speakers or other attendees
- Please complete the evaluation questionnaire when the webinar is over.
- Links to resources will be posted in the chat box and will be posted to the Consumer Voice website – theconsumervoice.org
Speakers

Lori Smetanka  
Executive Director  
National Consumer Voice for Quality  
Long-Term Care

Sam Brooks  
Director, Public Policy  
National Consumer Voice for Quality  
Long-Term Care

Charlene Harrington  
Professor Emerita  
Department of Social & Behavioral Sciences, University of California San Francisco
Agenda

1) How we got here.
2) What is in the Notice of Proposed Rulemaking (NPRM)?
3) 2022 Staffing Study Conducted by Abt and Associates
4) Next Steps
5) Questions
How We Got Here

- Decades of inadequate staffing in nursing homes
- Culminated in over 200,000 deaths of residents and workers during COVID-19 pandemic
- Homes with better staffing did better during the pandemic
- Brought attention to the poor care and conditions in many nursing homes
- Increased interest from the press, Congress, and the public.
President Biden’s Historic Announcement

► On February 28, 2022, President Biden issued a list of historic nursing home reforms focusing on staffing, transparency and accountability.

► Central to the reforms was the creation of a minimum staffing standard in nursing homes.

► For the first time, nursing home residents would be entitled to, at a minimum, a certain amount of care each day.

► Residents, families, and advocates rejoiced.
In 2001, CMS issued a staffing study report that was the product of years of research.

Study found that to avoid compromised care residents needed, at least, 4.1 hours of direct care per day (hprd).

- .75 hprd Registered Nurse (RN)
- 0.55 hprd Licensed Practical Nurse (LPN)
- 2.8 hprd Certified Nursing Assistant (CAN)

This number is a minimum. Residents with more needs would require more care.

Since 2001, the 4.1 hprd has been “gold standard” for minimum staffing.
4.1 is Over Twenty Years Old

- Residents have higher care needs now.
  - More individuals staying at home longer and receiving Home and Community Based Services (HCBS)
  - More residents with mental health issues
  - More residents with cognitive impairments requiring more care
CMS Regulatory Process

- Issued a Request for Information in April 2022.
  - Consumer Voice along with hundreds of others commentors expressed overwhelming support for minimum standard

- Staffing Study
  - Literature Review
  - Qualitative
  - Quantitative
What has CMS proposed?

- .55 hours or RN care per day (hprd)
- 2.45 hprd of CNA care
- No minimum for LPN
- Total minimum standard of 3.0 hprd
- Must still staff to residents’ needs (acuity levels)
- Registered nurse required 24/7
Nursing facilities must have a registered nurse (RN) “on site” 24 hours per day, 7 days a week. (42 C.F.R. § 483.35(b)(1))

“Available to provide direct resident care”

Current regulations only require an RN to be present eight hours per day.

What does available mean?
Waivers

- CMS will allow some facilities not to comply with minimum staffing standard. (42 C.F.R. § 483.35(g) et seq.)

- Waivers are one year long. No limit on number of waivers

- Four criteria for waivers and all must be met:
  - Location
  - Good faith efforts to hire
  - Demonstrated financial commitment
  - Certain exclusions from eligibility for waiver
Location

- Supply of health staff not sufficient
  - Must show that provider-population ratio is 20% or 40% below national average.
  - Multi-step calculation using data from Bureaus of Labor and Statistics
- OR, the next closest long term care facility is 20 or more miles away.
- More on rurality later
Good faith effort to hire

- Must have recruitment and retention plan in accordance with 42 C.F.R. § 483.71(b)(5)
- Diligent efforts to hire
  - Offering jobs at PREVAILING wages
  - Job listings in common recruitment forums, etc.
Demonstrated Financial Commitment

- Vague requirement that a facility must document the financial resources it expends annually on nurse staffing relative to revenue
Exclusions from Waivers

- Cannot be Special Focus Facility
  - Only 88 SFF in the country out of roughly 15,000 nursing homes
- Cannot have been cited in previous 12 months for:
  - Widespread insufficient staffing with actual resident harm; or
  - Pattern of insufficient staffing with actual harm; or
  - Immediate jeopardy related to staffing
- Failed to submit staffing data (Payroll Based Journal)
Waivers Cont’d

- Consumer Voice opposes all waivers. All residents, regardless of geographical location, are entitled to safe and high-quality care

- Facilities still allowed to accept new residents, despite failure to be able to safely care for current residents

- No requirement that facility create better jobs or invest in staff

- Turnover not a factor
Timeframes

- 24/7 RN
  - Urban: 2 years from date of final publication of rule
  - Rural: 3 years from final publication of rule

- Minimum Staffing Standard
  - Urban: 3 years from final publication of rule
  - Rural: 5 years from final publication of rule
Unacceptable Timeframes

- Could be seven years before this proposed rule goes into effect in rural areas

- Abt study found that staffing is almost identical in rural and urban facilities, yet CMS is still proceeding with prolonged rural phase in

- Only sizeable difference in staffing is LPN, the staffing category CMS is not including in its minimum staffing standard

<table>
<thead>
<tr>
<th></th>
<th># of Facilities</th>
<th>RN</th>
<th>LPN</th>
<th>CNA</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Urban</td>
<td>10,973</td>
<td>0.67</td>
<td>0.91</td>
<td>2.21</td>
<td>3.80</td>
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<tr>
<td>Rural</td>
<td>4,174</td>
<td>0.64</td>
<td>0.80</td>
<td>2.23</td>
<td>3.66</td>
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</tbody>
</table>
Abt Nursing Home Staffing Study 2023

Charlene Harrington, Professor Emerita
University of California San Francisco
September 2023
Abt NH Staffing Study Showed Positive Results of Higher Staffing

- NHs with higher staffing perform better on quality and safety measures with no ceiling on improvement.
- RN staffing has the strongest effect of quality and safety while LPN staffing did not have a consistent relationship.
- Nursing Aides (NA)s had a strong relationship with quality and safety only at 2.44 hprd to 2.93 hprd or higher.
- The results show a potential role for minimum staffing requirements
Abt NH Study Analyses of Quality Outcomes Were Flawed

- Abt quantitative analysis used unreliable data
  - Quality: Quality Measure ratings from Care Compare included self-reported measures (e.g. pressure ulcers) known to be inflated by NHs to improve their scores
  - Safety: Health Inspection ratings from Care Compare
    - Survey dates were from Oct 2020-2022, when surveys were infrequent. 34% of NHs were not surveyed within the two previous years by Dec. 2021 and 16% not surveyed by Dec. 2022. Should have used 2019 data
- All measures were based on how homes perform compared to each other, and not indicative of high-quality care.
Abt NH Study Examined Nurse Staffing

- Study used PBJ data from Q3 of 2021 through Q2 of 2022.
- Abt examined the full range of staffing levels across facilities for RNs, LPNs, NAs, and Total Nursing.
- Abt found that the higher the staffing the higher the quality and safety across all facilities.
Abt NH Study Examined Only 4 Nurse Staffing Scenarios – excluded high staffing options

Exhibit 4.10 Scenarios
(In Deciles)

<table>
<thead>
<tr>
<th>Minimum Required Staffing Level (in HPRD)</th>
<th>RNs</th>
<th>LPNs</th>
<th>Nurse Aides</th>
<th>Licensed (RN/LPN) Total Nursing</th>
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</thead>
<tbody>
<tr>
<td>Low/4th</td>
<td>0.45</td>
<td>0.7</td>
<td>2.15</td>
<td>1.15</td>
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<tr>
<td>Medium/5th</td>
<td>0.52</td>
<td>0.71</td>
<td>2.25</td>
<td>1.23</td>
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<tr>
<td>Higher/6th</td>
<td>0.60</td>
<td>0.72</td>
<td>2.35</td>
<td>1.32</td>
</tr>
<tr>
<td>Highest/7th</td>
<td>0.70</td>
<td>0.73</td>
<td>2.45</td>
<td>1.43</td>
</tr>
<tr>
<td>Excluded</td>
<td>0.82</td>
<td>1.04</td>
<td>2.44</td>
<td>1.84</td>
</tr>
<tr>
<td>8th</td>
<td>1.00</td>
<td>1.14</td>
<td>2.62</td>
<td>2.14</td>
</tr>
<tr>
<td>9th</td>
<td>1.28</td>
<td>1.3</td>
<td>2.93</td>
<td>2.58</td>
</tr>
</tbody>
</table>
Abt Focused on Four Nurse Staffing Options for RNs, LPNs, NAs, and Total

- The four options were not based on clinical outcomes but based on cost considerations.
- Four options were all below 4.1 total nursing hprd that the 2001 minimum staffing level found to prevent harm or jeopardy.
  - RN levels were all below the 2001 level of .75 RN hprd.
  - NA levels were all below the 2001 level of 2.8 NA hprd.
  - RN levels were below the .67 RN hprd national average.
  - NA levels of 2.45 is slightly above the national average 2.22 NA hprd.
Abt NH Study Options for Setting Nurse Staffing Minimums

**Abt Options**

1. Setting minimums for RNs, Licensed Nurses, and Total Nursing
2. Setting minimums for RNs, LPNs, NA, and Total Nursing
3. Setting minimums for RNs and NAs

**CMS regulations arbitrarily propose:**

1. Setting minimums for RNs and NAs
2. Alternative for Setting Minimums for RNs, NAs, and Total Nursing at 3.48 hprd – was not an Abt option
3. CMS should have selected Abt option 1 or option 2
CMS Proposed Regulations Fail to Set Licensed Nursing Minimum Staffing

- RN levels of .55 hprd are not sufficient to meet the care needs of residents.

- Because LPNs (licensed practical nurses) substitute for RNs, they are needed to provide medications and treatments.

- The Abt study and CMS regulations assume that NHs will retain their existing LPNs and will add RNs and NAs to meet the new requirement

  - Many NHs will convert LPNs to RNs and reduce their total LPN staffing to save money if there is no minimum licensed nurse requirement

  - Some NHs will convert LPNs to NAs to reduce costs if there is no minimum licensed nurse requirement

- CMS must set minimum standards for both licensed nurses and total nursing staff to prevent potential dangerous reductions in licensed nursing
Abt Study Failed to Use its Own Simulation Model for Licensed Nurses

- Abt conducted a limited simulation model for licensed nurses (RNs and LPNs) to determine the effect of staffing levels on omitted care. The model only estimated 5 tasks out of dozens of tasks and did not estimate the interruptions of care caused by urgent problems and emergencies.

- Abt’s simulation estimated at least 1.4 to 1.7 licensed (RN and LPN) nursing hours were needed to reduce delayed & omitted tasks to less than 5 percent

- CMS ignored the simulation model findings in developing its regulations

A previous version of this PowerPoint incorrectly stated that the Abt study found that 1 hprd would result in 19% omitted care. 1 hprd would result in 19% delayed care, not omitted care.
Abt Study Noted Previous Simulation Models for Nursing Assistants

- Schnelle et al. conducted NH simulation research in 2001 and 2016 and found that to keep omitted care below 10% daily, facilities needed:
  - 2.8 CNA hours/resident/day with a low workload to
  - 3.6 NA hours per resident day for a high workload – based on resident acuity (care needs)

- Under the proposed CNA standard of 2.45 hprd, facilities would omit over 20% of care daily in each facility.

Simulation Models Show A Need for Higher Total Nursing Minimums

- The Abt Simulation Model found a need for
  - 1.4 to 1.7 licensed nursing hours

- The Schnelle Simulation model found
  - 2.8 to 3.6 NA hrpd depending on acuity

- Combining these simulation totals, the minimum total nursing hours were:
  - 4.2 to 5.3 total nursing hprd

- This is more consistent with expert recommendations for higher minimums than the CMS recommended regulations
Abt and CMS Cost Estimates

- Abt used Medicare cost report data using 2021 data
  - Estimated wages/benefits at $44 for RNs, $35 for LPNs, and $21 for NAs

- Abt total costs for setting a standard for Total Nursing, Licensed Nursing and RN hours was $1.5 to $5.3 billion

- Abt and CMS RN costs are over estimated because they assume NHs will maintain all the existing nursing staff and add staff.

- However, most NHs will substitute RNs for LPNs (only $9 more per hr) rather than adding new RNs at $44 per hour

- NHs do not need additional funding for staffing. NHs receive over $100 billion from Medicare and Medicaid, but often divert money into profits and real estate rather than spending money on resident care
States will be required to report annual Medicaid spending on direct care workers and support staff. (42 C.F.R. § 442.43, et. seq.)

- Very broad definitions of direct care workers and support staff.
  - Must be broken down by staff type

- Accessible to the public on state run website.

- Simple reporting requirement

- NPRM states it did not have enough information to implement a direct spending requirement, despite implementing one in the Medicaid HCBS setting.
Facility Assessment

- Adds requirements to existing facility assessment regulations at 42 C.F.R. § 483.71
- Annual assessments that require facilities to assess resident needs
  - Staffing plans
  - Resource allocations
  - Emergency planning
- Would go into effect 1 year after publication of final rule
Comments are due on November 6, 2023

Consumer Voice will be providing template comments and more materials empowering folks to comment.

More webinars and events to come

Questions
Connect with us!

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