



# **Development of Staffing Quality Measures Phase I**

## **Stakeholder Meeting Summary Final Report: April 7, 2004**

Date of the Meeting: March 2, 2004

Time of the Meeting: 1:00 p.m. to 4:00 p.m.

Location of the Meeting: Centers for Medicare & Medicaid Services,  
Baltimore, Maryland

Submitted on April 7, 2004 to: Dr. Jean Scott, CMS, Government Task Leader  
and to Ms. Kathy Riley, CMS, Project Officer

Prepared by: The Colorado Foundation for Medical Care and  
The University of Colorado Health Sciences Center

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## **Development of Staffing Quality Measures - Phase I Stakeholder Meeting, March 2, 2004**

### **1. Introduction:**

On March 2, 2004 from 1:00 to 4:00 p.m., a stakeholder meeting was held at the Centers for Medicare & Medicaid Services in Baltimore, Maryland. The meeting was conducted for the Development of Staffing Quality Measures – Phase I project funded by the Centers for Medicare & Medicaid Services. Dr. Andrew Kramer, Professor of Medicine, and Head of the Division of Health Care Policy and Research at the University of Colorado Health Sciences Center, facilitated the meeting.

The purpose of the meeting was to consider:

- the aspects of nursing home staffing most important to the stakeholders and their constituencies,
- how improvements could be made to the measures of staffing information currently presented on Nursing Home Compare, and
- how staffing measures should be presented to the public (for example: as staffing levels, percentiles, ranks, thresholds, rating systems, or other).

The complete agenda for the stakeholder meeting can be found in Appendix A.

The stakeholders invited to the meeting represented a cross section of national and regional organizations extremely knowledgeable of staffing issues in nursing homes. The meeting was held at the Centers for Medicare & Medicaid Services headquarters in Baltimore, Maryland in order to maximize stakeholder participation, since many of the stakeholders are located in the Washington/Baltimore area.

Members of a separate technical expert panel (TEP) attended the stakeholder meeting to facilitate their appreciation for the positions and concerns of the stakeholder group and to inform the TEP's discussions at subsequent meetings.

Forty-two stakeholders attended the meeting, including twenty-seven national organizations, nine nursing home corporations (for-profit and not-for-profit) and six nursing facilities (for-profit and not-for-profit).

A list of all participants at the stakeholder meeting is provided in Appendix B.

A number of stakeholders provided written statements and these are included in Appendix C.

The following pages present the issues discussed and recommendations made by the stakeholders.

## **2. Summary of Issues Discussed:**

### *Consumer Comprehension and Ease of Use:*

There was substantial agreement that whatever measures are reported must be easy for the public to understand and use correctly. There were differences, however, over specific recommendations. Some stakeholders advocated providing highly detailed information, others preferred providing less detail, but allowing consumers interested in the details to access it via a drill-down process, and others argued that a simple ratings system is preferred. There was significant concern that if consumers are given only a specific number (for example, 3.76 nursing hours per resident-day), they will not be able to tell if that facility is different from other facilities with somewhat similar numbers (for example, 3.92 nursing hours per resident-day). Strategies for identifying similar facilities included providing helpful text to put the numbers in context, reporting the numbers with less precision, providing benchmark figures such as state and national averages or any recommended threshold for comparison, grouping sites into quartiles, or developing a star-based ratings system.

Other stakeholders maintained that consumers' needs for staffing information were much more basic. The three areas consumers are most concerned with are 1) whether there is enough staff to take care of residents' needs in a timely fashion, 2) whether the staff are respectful to residents, and 3) whether the specific personnel are consistent from day to day. Staffing measures should be chosen or reported in such a way as to address these concerns.

### *Accuracy of Data:*

Stakeholders were virtually unanimous in asserting that the data currently collected and stored in the Online Survey Certification and Reporting System (OSCAR) are not satisfactory for a number of reasons. Publicly reported staffing measures must be based on data that are accurate, auditable, valid, reliable, timely, and uniformly and consistently collected. If a staffing-resident ratio measure is used, it will require nursing home census data that are equally accurate, timely, reliable, etc. Some stakeholders specifically suggested that the time period the staffing measures refer to should be different from the time period immediately preceding the nursing home survey. Some stakeholders further stated that measures should have a demonstrated association with quality of care and resident quality of life. There was a suggestion that the accuracy of reported data may increase if facilities knew the data were being used for a specific purpose.

### *Acuity-Adjustment:*

Support for adjusting staffing measures to account for the differing care needs of residents was very strong. Most stakeholders argued that facilities with large numbers of very ill residents with significant care needs have to staff differently than facilities with fewer such residents. Many specifically suggested discriminating between the traditional long-stay nursing home resident, and the more acutely ill, short-term care (frequently Medicare) resident. When reporting measures, there was disagreement over whether the adjusted measure, the unadjusted measure, or both measures should be presented. Some stakeholders recommended providing the mechanics of the risk adjustment techniques in a separate area of the website for those (presumably professional researchers) who might be interested.

### Staffing Levels:

Many stakeholders expressed an interest in reporting staffing levels, commonly as a ratio of nursing hours per resident day, separately for different nursing staff (Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, and total). Others suggested that it would be preferable to report whether a facility falls above or below a particular staffing level threshold, or the number of days per month that a facility fell above or below a threshold. There was some support for reporting staffing levels separately by shift, and separately for weekends. Several stakeholders stressed, however, that measures of staffing quality should go beyond the simple concept of staffing levels. Furthermore, stakeholders cautioned that reliance on staffing levels alone may create unexpected incentives for providers to fill positions with "any warm body" simply to inflate their numbers, and that such an approach may discourage creative staffing solutions.

### Which Staff are Measured - Labor Efficiency and Substitution:

There was considerable interest in including or accounting for other care providers beyond nursing staff in any count of nursing staff levels. Many stakeholders provided examples of staffing strategies that allow them, in their view, to provide nursing care more efficiently. For example, by employing clerical staff to handle non-nursing duties that frequently fall to nursing staff to do (e.g., handling family complaints, ensuring facility doors are locked), a nursing home might employ fewer nurses, but those nurses are focused on direct nursing care. Similarly, a facility might invest in specialized equipment (such as a transfer machine) that allows resident care to be provided more efficiently by fewer staff. Similar arguments were made for making extensive use of therapy staff, hospice staff, specialized IV teams, clinical educators, respiratory therapists, advanced practice nurses, social workers, activity staff, personal helpers, housekeeping, and groundskeeping staff. These kinds of labor substitution strategies result in nursing homes requiring fewer nurses, and any measure of staffing levels would need to take this into account to avoid making such facilities appear poorly staffed. Recommendations for exactly how to account for such practices, however, were few. It is possible for an economist to create a sophisticated production function to accurately handle substitutions, but the result is an algorithm rather than a specific number, which will not be easily understood. Other stakeholders, however, maintained that nursing staff measures should be restricted to only nursing staff.

### Turnover and Retention:

There was broad support for reporting some measure of staff stability, with most stakeholders preferring a measure of retention rather than turnover. There was some interest in making a distinction between facility-wide turnover or retention rate and the rates for specific positions that may be particularly difficult to fill and retain. One stakeholder recommended including a statement explaining how turnover affects care, such as that used by the California Health Care Foundation on their website.

### Staff Competence and Training:

Many stakeholders mentioned the importance of considering the skills and training of nursing staff. Facilities where the nursing staff have had additional training in geriatric care or Alzheimer's care may provide better care. On-going CNA training and workshops are also important. Facilities that

invest in clinical educators for wound care, dementia, advanced directives, etc. should be "given credit" for such programs.

### Management Skills and Tenure:

A closely related topic was the importance of the leadership skills and tenure of the director of nursing, the nursing home administrator, and the medical director. Stakeholders maintained that good leadership is required for adequate training and supervision of nursing staff, and sets the tone for the entire facility. Good leadership fosters an environment for effective teamwork, influences staff retention, and ultimately results in better care.

### Quality of Life:

The quality of life of residents in a nursing home can be affected by staffing issues. A number of stakeholders recommended that there should be some measure of facility quality that captures residents' quality of life, though there were few specific suggestions for particular measures or measurement methods. A few stakeholders proposed measuring the quality of the workplace as a proxy for resident quality of life, or measuring the provision of services beyond the ordinary. On the other hand, there was concern expressed that capturing measures of staff kindness and resident dignity and quality of life, while noble, is extremely difficult to do in practice.

### Provider Burden:

Many stakeholders advised that any new data collection requirements placed on nursing homes should be minimally burdensome. There was some discussion about the conflicting messages of the desire for more complex measures of staffing and the reluctance to collect it. One stakeholder commented that collecting more complex data might be acceptable if it were done more efficiently than current practice. It was recommended that all the different requests for nursing home data be organized and requested only once, in a single format. Much time is wasted providing essentially the same information in slightly different ways to multiple agencies. There was further discussion regarding the usefulness of such staffing measures to the nursing homes themselves, and that investing in capturing such data might be beneficial in the long run.

### Other Topics:

Several stakeholders argued that it is important to include agency staff when counting nurse staffing levels. Others stressed the importance of restricting counts of nursing staff to strictly those providing direct patient care, to discourage facilities from adding nursing administrators instead of bed-side providers. Additional recommendations included considering the use of voluntary and mandatory over-time, frequency of staff floats, and the use of atypical schedules such as 12 hour shifts. Some organizations detailed their own data collection efforts and offered to share both their knowledge and their data.

### 3. Specific Stakeholder Recommendations:

This section lists the stakeholder recommendations that were specifically addressed at the stakeholder meeting or that were included in position papers.

#### Definitions:

- Develop clear, concise, understandable explanations of the quality measures.
- More evidenced-based research is needed before concluding and reporting a relationship between staffing levels and quality outcomes.
- Consider coming to a national definition of quality.
- An important first step to accomplish the development of common data elements and a national database and before any measures can be conceived with any degree of accuracy, is to reach consensus on the definition of nurse staffing. Does it include registered nurses, licensed practical nurses, certified nursing assistants, directors of nursing, assistant directors of nursing, staff development coordinators, feeding assistants, medication technicians, intravenous team nurses, etc.?
- Provide a definition of staffing that is driven by a resident's needs. Specifically, the definition should extend beyond registered nurses, licensed practical nurses, and certified nursing assistants, to activity coordinators, rehabilitation aides, and feeding assistants. Limiting the definition to nursing care may inadvertently give an incomplete picture of care in the facility.
- Measures should be clean, consistent, uniform, valid, reliable, and clinically meaningful to providers and consumers.
- Criteria that should be used to determine the appropriateness of any measure:
  - Should be in the public domain.
  - Be valid and reliable.
  - Relate to issues of high priority.
  - Be under the facility's ability to influence.
  - Be easily understood.
  - Not involve burdensome measurement.
  - Not create adverse incentives.
- We need studies that clearly demonstrate how staffing mix, nurse staff to resident ratios, staff qualifications, and training affect care quality outcomes.

#### Staffing Measures:

- Implement quality measures based on ratios expressed as hours of direct care per resident day. One set of measures would be disaggregated by type of direct care provider (RN, LPN, LVN, CNA). A separate quality measure would show these direct care staff as total nurse staffing hours per resident day. Feeding assistants, medication aides, and other non-nursing personnel should not be included.
- Quality measures need to distinguish between bedside and non-bedside care staff.
- Staffing quality measures need to include training, specifically training in geriatrics. Health care workers in all disciplines should be appropriately trained and credentialed in geriatric/gerontological care.

### Staffing Measures (cont.)

- Measure the quality and retention of staff and management. Measure census stability; staffing by shift including weekends; and recognize all disciplines.
- Measures must be adjusted for case-mix, accuracy, reliability, and have a demonstrated relationship to quality.
- Develop quality measures that include data on turnover and retention.
- Break down information to show both average licensed staff to resident ratios and average direct care to resident ratios on each shift, in addition to the current per resident day information available on the website. Include new information for consumers about the number of days per month/year on which staffing patterns fell above or below the established averages.
- Break information down by type of staff, by shift, and include data on turnover, wages, and expenditures for direct care. Data on feeding assistants, medication aides, and other non-nursing personnel should not be included in the same ratios or as part of the same quality measures.
- A quality measure should include at least 4.1 hours of direct nursing care per resident day as the minimum national benchmark.
- Adjust for variations in case-mix among facilities, broaden the definition of staff, and include consideration of the quality and efficiency of the workforce.
- Make 4.13 hours per resident (HPRD) a federal minimum for facilities participating in Medicare and Medicaid, even though higher staffing levels may be necessary for facilities with a higher acuity population.
- Minimum staffing levels must be federally mandated in tandem with reimbursement reform for both the Medicare and Medicaid programs.
- Consider if staff turnover is overall or just for a few hard-to-fill positions. Use of specialized equipment allows for greater safety and efficiency but requires fewer staff.
- Look beyond “one size fits all” staffing ratios and recognize new clinical services and resource support like facility-employed physician and nurse practitioners, IV nurses, wound care specialist, respiratory therapist, evening administrative managers, feeding assistants, to name a few. The question of what do we really need to do in today’s long term care facility to meet the clinical needs of our residents, needs to be asked. It’s more than nurses, nursing assistants and “old school” views of long term care staffing.
- Additional information related to nursing home staffing should be developed as soon as possible and include: staff turnover and retention, contract vs. payroll data, staff training, use of advanced practice nurses, tenure of the director of nursing and the administrator.
- Consider voluntary and mandatory overtime. Consider how often staff is floated to other units; flexibility in scheduling, such as twelve hour shifts and weekend staffing.
- Any meaningful measure must be based on accurate, audited staffing data from all of America’s nursing homes.
- Move forward immediately to implement a new, audited data collection system. Design a data collection system based on payroll records and invoices.
- Collect staffing data from payroll records and invoices that reflect two powerful indicators of quality, nursing staff turnover/retention and use of temporary agency personnel.



### Data Collection (cont.)

- Develop an audited data collection system to accurately measure staffing patterns in nursing homes.
- Establish a system for improving staffing data that is timely, generated quarterly, not related to timing of survey, acuity-adjusted and audited.
- The data collection mechanisms necessary to develop a staffing measure do not exist today. The current method – using the OSCAR 671 at time of survey - has yielded the invalid data we have today. Cost report data is too old and too infrequent. There is a significant question of CMS' readiness and willingness to resource adequately this initiative, for the agency itself and for the nursing homes of this country. And that is essential!
- Work in conjunction with the Department of Labor.
- Collect data over a longer period than two weeks.

### Risk Adjustment:

- Measures should be adjusted for the complexity of care, both acuity and dependency.
- Consider acuity.
- Consider incorporation of an acuity measure in the quality measure for staffing that reflects the impact of resident/patient acuity. Such a system could include a standard patient classification based on:
  - RUGs classifications
  - Disease Staging
  - Severity Illness Index
  - Patient Management Categories
  - Medical Illness Severity Grouping System
  - Acute Physiology and Chronic Health Evaluation, Simplified Version
- This acuity system should evaluate the acuity needs of an individual and prescribe an hours per patient day (HPPD) for an individual, a unit, and the facility.
- Consider the fact that staffing patterns in nursing facilities have stayed the same as acuity has risen. Current staffing standards are antiquated.

### Quality Measures:

- Measures must be adjusted for acuity. Taking care of residents with dementia requires a different skill set, training, and supervision.
- Focus attention on the adequacy of care processes in relation to the numbers of staff, instead of focusing on numbers alone.
- Measure(s) should consider the level of staff competence.
- Measure initial and annual training of certified nursing assistants, including mentoring and other non-classroom programs.
- Consider the leadership and tenure of the administrator and director of nurses.
- Do not let quality measures become an impediment to culture change and stifle creativity and performance.

### Quality Measures (cont.)

- Measure retention and stability instead of turnover. Competency, certification, leadership, and longevity are important.
- Focus on nurse staffing in all settings, not just nursing homes.
- The American Nurses Association recommended their Magnet Program for nurse credentialing.
- Consider nursing facilities that are organized into small communities and where all staff participate in resident care such as; groundskeepers, housekeepers, visiting children, and pets.
- More staff may not always equate to excellent customer outcome. A baseline for staff competence for each job category ought to be considered, otherwise any comparison between facilities is open to criticism.
- Looking at staffing levels is the wrong direction. Consider different types of staff. Look at good facilities, not poor ones, and learn from their successes. It's all about leadership and teamwork.

### Nursing Home Compare:

- Eliminate Nursing Home Compare staffing data.
- Include only audited information.
- Include nursing turnover rates.
- Include a comparison to the staffing hours identified by CMS in its Phase II report to Congress on the minimum number of direct care hours (4.1) that are necessary to provide care in compliance with federal standards.
- Make additional information available such as; CNA wages, "productive" hours of non-nursing staff per resident day, change in nursing staff, expenditures for direct care staff per resident day and numerical ratios of nursing staff to residents.
- Displays on the website are not of high quality. The importance or need to include a staffing measure is not the question; data validity and standardization is.

### Provider Burden:

- Consider the impact of regulation on the nursing facility. Consider the burden on the nursing facility to fill out additional forms. This takes staff away from resident care.
- Measure what the data gives you and what it costs you.
- Use the same format to report data to all agencies. I'd be happy to collect more complex data if I only had to do it once in one format.
- Consider the fact that with the implementation of the MDS, approximately 17,000 nurses were removed from direct (hands on) patient care in nursing homes. Though the MDS standardizes patient assessments and language, the tool's complexity, length, and survey/penalty focus has required full time attention by a nurse to help ensure MDS completion and accuracy.

Public Reporting:

- Staffing information presented to the public should meet three criteria.
  - It should allow the customer to answer the question “is it enough?”
  - It should convey meaningful differences – those that are empirically based and statistically significant.
  - It should be presented in a way that allows the average user to readily understand and accurately interpret the information.
- Conduct objective, robust consumer testing, regarding language, format, and ability to interpret correctly, to determine how to present the information in an understandable way prior to initiating reporting of any additional measures.
- Case-mix adjustment should be done “behind the scenes” (with methods available for those interested) and not presented to the public. Perhaps observed and expected rates, perhaps group similar nursing homes together.
- Report audited, accurate direct care nursing staff levels, annual nursing staff turnover rates, and numbers of agency nurses.
- Report the quality measures in both case-mix adjusted and unadjusted formats. The 4.1 hours of direct care per resident day should be the baseline for the standard.
- Give the public the evidence between quality and staffing.
- Do a pilot first. Go to poorly performing nursing homes (as measured by survey outcomes), look at the data and see if there is a relationship with staffing. Get an idea of validity and reliability before rolling out nationally.
- Have measures tested by residents and families.
- We must consider how the family looks at the measures. They must be useful and meaningful.

## **Appendix A: Stakeholder Meeting Agenda**



## Development of Staffing Quality Measures – Phase I

### Stakeholder Meeting

**Date:** March 2, 2004

**Time:** 1:00 p.m. to 4:00 p.m. ET

**Place:** Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1859  
Multipurpose Room – First Floor

**Dial-in Number and Instructions:** Call 410 786-5504. This is a direct number to “Nursing Home Staffing.” This should place you directly into the Stakeholder Meeting. If you experience any difficulty call 410 786-3090 and tell the conference operator that you wish to join the “Nursing Home Staffing” Stakeholder Meeting.

### Agenda

**Facilitator:** Dr. Andrew Kramer, Development of Staffing Quality Measures Project Team

<b>Agenda Topics:</b>	<b>Welcome and Introductions</b>	<b>1:00 – 1:10 p.m.</b>
	<i>Dr. Jean Scott, Centers for Medicare &amp; Medicaid Services</i>	
	<b>Project Overview/Meeting Objectives</b>	<b>1:10 – 1:40 p.m.</b>
	<i>Dr. Andrew Kramer</i>	
	<b>Stakeholder Discussion</b>	<b>1:40 – 3:45 p.m.</b>

**Questions to be considered by the Stakeholders:**

- What aspects of nursing home staffing are most important to you and your constituency?
- How can we improve on the measures on staffing information currently represented on Nursing Home Compare?
- How should staffing measures be presented to the public (for example: as staffing levels, percentiles, ranks, thresholds, levels of complexity, rating systems, or other)?

<b>Ending Remarks</b>	<b>3:45 – 4:00 p.m.</b>
<i>Drs. Scott and Kramer</i>	

## **Appendix B: Stakeholder Meeting Participants**

## **List of Participants Attending the March 2, 2004, Stakeholder Meeting for the Development of Staffing Quality Measures – Phase I Project**

### **Organizations**

Alliance for Quality Nursing Home Care  
Alzheimer's Association  
American Association of Homes and Services for the Aging  
American Association of Retired Persons  
American Health Care Association  
American Health Quality Association  
American Hospital Association  
American Medical Directors' Association  
American Nurses Association  
Association of Health Facility Survey Agencies  
Center for Medicare Advocacy  
Eden Alternative – Homewood at Williamsport  
Friends of Residents in Long -Term Care  
Joint Commission on Accreditation of Healthcare Organizations  
National Association of Directors of Nursing Administration in Long Term Care  
National Association of Subacute/Post Acute Care  
National Citizens Coalition for Nursing Home Reform  
National Gerontological Nurses Association  
National Hospice and Palliative Care Organization  
National Long Term Care Ombudsman Organization  
National Network of Career Nursing Assistants  
Paraprofessional Healthcare Institute  
Pioneer Network – Providence Mount St. Vincent  
Quality Improvement Organization - Delmarva Foundation for Medical Care  
Service Employees International Union  
The Commonwealth Fund  
Wellspring Innovative Solutions for Integrated Health Care – Good Shepherd Services

### **Nursing Home Corporations**

Beverly Enterprises  
Extencicare Health Services  
Genesis HealthCare  
HCR, Manor Care  
Kindred Healthcare  
Mariner Health Care  
SunBridge Healthcare  
The Evangelical Lutheran Good Samaritan Society  
Trans Health Incorporated

## **Nursing Homes**

Diakon Lutheran Social Ministries  
Friendship Village of Dublin  
Glade Valley Nursing and Rehabilitation Center  
Good Samaritan Nursing Center  
Gurwin Jewish Geriatric Center  
Kendal-Crosslands Communities

## **Centers for Medicare & Medicaid Services**

Robert Connolly  
Marvin Feuerberg  
Judy Goldfarb  
Yael Harris  
Trent Haywood  
Lisa Hines  
Zhoowan Jackson  
Susan Joslin  
Pauline Karikari-Martin  
Sandy Khoury  
Rosemary Lee  
Paul McGann  
Edward Mortimore  
Mary Pratt  
Karen Schoeneman  
Jean Scott

## **Technical Expert Panel Members**

Irene Fleshner, Genesis HealthCare Corporation  
David Jackson, Jackson and Associates  
Beth Klitch, Survey Solutions  
David Mehr, University of Missouri – Columbia  
Dana Mukamel, University of California – Irvine  
Jack Schnelle, UCLA Borum Center  
Janet Specht, University of Iowa  
Robyn Stone, Institute for the Future of Aging Services  
Mary Zwygart-Stauffacher, University of Wisconsin – Eau Claire

## **Development of Staffing Quality Measures – Phase I Project Team**

Terry Eilertsen, University of Colorado Health Sciences Center, Division of Health Care Policy and Research  
Donna Hurd, Abt Associates  
Andrew Kramer, University of Colorado Health Sciences Center, Division of Health Care Policy and Research



**Development of Staffing Quality Measures – Phase I Project Team (cont.)**

Kris Mattivi, Colorado Foundation for Medical Care

Alan White, Abt Associates

Laura Palmer, Colorado Foundation for Medical Care

Marilyn Rantz, University of Missouri, Sinclair School of Nursing

Ann Romaglia, Colorado Foundation for Medical Care

Alan White, Abt Associates

## **Appendix C: Stakeholder Position Statements**

## **Statement**

### **American Association of Homes and Services For the Aging (AAHSA)**

**To:**

**The Centers for Medicare and Medicaid Services  
Colorado Foundation for Medical Care**

### **Development of Staffing Quality Measures – Phase I Stakeholder Meeting**

**March 2, 2003**

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit this statement for the CMS Stakeholder Meeting on the development of staffing quality measures. AAHSA represents more than 5,600 mission-driven, not-for-profit members providing affordable senior housing, assisted living, nursing home care, continuing care retirement communities, and community services. Every day, our members serve more than one million older persons across the country. AAHSA is committed to advancing the vision of healthy, affordable, and ethical aging services for America.

*What aspects of nursing home staffing are most important to you and your constituency?*

Virtually every aspect of the decisions facility leaders make regarding staffing is extremely important to AAHSA members. Critical issues identified repeatedly by researchers, providers, and consumers as impacting quality include: sufficient staff to meet resident needs, turnover and retention rates, adequate training, effective supervision, staff empowerment, use of innovative care delivery models, permanent assignment, and the roles non-nursing staff, such as activities personnel, therapists, and many others, play in resident care and quality of life.

The key question for this study, however, is not merely, “what aspects of staffing are most important,” but rather, “what aspects of staffing are valid and reliable as measures of nursing home quality.” The answer must come from objective research, not from a collection of opinions or anecdotes. It is not feasible, nor necessarily desirable, to attempt to report on all of the elements of staffing that we would all likely agree are important. The elements previously listed, and many more, go into creating facility-level systems that either do or do not result in high quality of care and optimum quality of life for nursing home residents.

From our perspective, then, the most important aspects of staffing for the purpose of developing a quality measure are those that can be objectively measured uniformly across all facilities and that empirical research demonstrates can be used to make meaningful distinctions across facilities with regard to the quality of care and quality of life for residents. While other aspects of staffing may be interesting, and may very well be things we would encourage prospective residents and their families to discuss with facility staff and residents at length before making a placement decision, they may never lend themselves to use as quality measures.

*How can we improve on the measures on staffing information currently represented on Nursing Home Compare?*

The current staffing data on Nursing Home Compare provide consumers with virtually no truly meaningful information for two primary reasons: questionable data and the absence of any reference to variations in resident acuity. As CMS states in the just-published proposed rule on posting of nurse staffing information, "...data submitted through the only national data source of nursing home staffing for individual facilities, the Online Survey Certification and Reporting (OSCAR) system, can be less than accurate, and as such, *is misleading when used as the sole data source for public reporting.*"

CMS staff has recently asserted that these data can be "refined" to improve their overall accuracy, without undertaking a whole-scale redesign of the data collection approach. We question the ability to refine this database in a way that will sufficiently improve accuracy at the facility level. Approaches that have generally been discussed to improving the database have centered on removing outliers and out-of-range values. This may improve accuracy of averages, but does not adequately ensure that facility-level data are correct.

Furthermore, even if we could ensure that all data were sufficiently accurate at the time they were collected, a significant problem would remain because they are not timely. Given survey timing and significant lags in data entry at the state level, data in the OSCAR system can be over 15 months old. As CMS also states in the above-mentioned proposed rule, "The Phase I study also indicated that nurse staffing could vary considerably during the course of a year." This is likely to be particularly true for the very facilities we might be most concerned about – those with excessive rates of employee turnover.

The second fatal flaw in these data is the lack of any reference point to resident acuity. Absent this information, there is no way for the data to be meaningful. A number of "hours per resident day" does not tell a consumer what he or she really wants to know – is that sufficient to meet the needs of the residents? Without relating staffing to acuity, the data may seriously misinform consumers. Two facilities with identical staffing but very different populations may in fact be at opposite ends of the spectrum with regard to quality. A facility with a staffing ratio that appears higher than average may, in fact, be understaffed, if they serve a very dependent or highly medically complex group of residents. The bottom line is, at present, there is no way for the consumer to know this based on the data presented – no way to determine, "is it enough?"

*How should staffing measures be presented to the public (for example: as staffing levels, percentiles, ranks, thresholds, levels of complexity, rating systems, or other)?*

In keeping with the points made thus far, the form in which staffing information is presented to the public should meet three criteria. First, it should allow the consumer to answer the question, "is it enough?" Second, it should convey meaningful differences – those that are empirically based and statistically significant. Finally, it should be presented in a way that allows the average user to readily understand and accurately interpret the information.

With regard to the first point, it is essential that a measure of acuity/resident needs be developed and that staffing be reported in relationship to that measure – i.e., what is the observed staffing relative to what would be expected/sufficient for this facility given the needs of the residents? The facility-level

measure might be a simple yes/no – is the staffing sufficient? Another option might be to report meaningful deviations from the expected – does the facility have significantly more or less staff than would be expected, given resident needs? Any comparative information – percentiles, rankings, etc. – must also be relative to acuity, rather than unadjusted numbers or staff-to-resident ratios.

With regard to potential measures of other aspects of staffing, the research needed to arrive at valid and reliable measures should also provide a basis for determining the appropriate reporting format. Reporting for all quality measures should provide consumers with information about meaningful, significant differences across facilities. Data used to validate any potential measures should also be used to determine the appropriate groupings, thresholds, ranking schemes, or other categorizations for purposes of reporting.

Finally, we urge you to conduct objective, robust consumer testing to determine how to present the information in an understandable way, prior to initiating reporting of any additional measures. This testing should not be limited to determining what language and formats consumers prefer, but should also incorporate testing to ensure that consumers' understanding from data presented in any proposed reporting format is an accurate interpretation of the information those data actually convey.

**Development of Staffing Quality Measures – Phase I**  
**Stakeholder Meeting, March 2, 2004**  
**Comments to CMS by the American Health Care Association**  
**Sandra Fitzler, Senior Director of Clinical Services**

The American Health Care Association (AHCA) is a federation of state affiliations representing over 10,000 not-for-profit and for-profit nursing care facilities, assisted living centers and residential services for the mentally retarded and developmentally disabled. AHCA has aggressively engaged in finding solutions to the long term care workforce shortages. In 2003 and after 6-AHCA sponsored seminars listening to the experts discuss the issues impacting nursing workforce, we established the National Commission on Nursing Workforce for Long Term Care. The commission is coordinated by George Washington University and its' goal is to develop a plan that describes practical steps to develop a skilled and dedicated nursing workforce and to develop partnerships that will work to implement best approaches to recruit and retain workers. Experts in nursing workforce issues, educational institutions, providers, advocates, professional organizations and representatives from the federal and state government and workforce system represent the commission.

From the work of the commission, we have learned that the national nursing shortage has been identified and extensively studied and reported.

- According to a 2002 state survey conducted by the Center for Health Workforce Studies at the University of Albany, 86% of the states indicated a shortage in registered nurses (RNs), and 64% in Certified Nursing Assistants (CNAs) across all settings.
- The RN population is aging rapidly. In 2001, the average age of nursing staff in nursing homes was 45-years for RNs, 44-years for Licensed Practical Nurses (LPNs) and 38-years for CNAs.
- In the July 2002 national survey data on nursing school faculty shortage released by U.S. Department of Health & Human Services, 39% of the schools responding to the survey indicated that faculty shortages have prohibited them from enrolling qualified applicants.
- Last year, over 11,000 qualified applicants were turned away from nursing programs.
- More than 70% of the current faculty is over the age of 50 years and the average age of faculty retirement is 62 years.
- In 2002, AHCA completed a *Survey of Nursing Staff Vacancy and Turnover in Nursing Homes* and found 52,000 CNA vacancies, 13,900 RN vacancies and 25,100 LPN vacancies.
- And for the first time, RNs top the U.S. Bureau of Labor Statistics list of occupations with the largest projected 10-year job growth.

Considering this information, it is puzzling why the goal of this project is limited to only developing measures for staffing in nursing homes for public reporting. What is to be accomplished by publicly reporting known staff shortages in one sector of healthcare when all sectors are affected as well as the educational pipeline?

AHCA believes that measuring staffing is important. We have learned from the Commission experts that in order to improve nursing workforce and staffing, new thinking is required. The experts recommend:

- The establishment of common data elements to forecast supply and demand changes, and
- The development of a national database that includes workforce data across all provider settings for use in trend analysis and to create a pipeline/educational model to forecast workforce needs.

The findings of the American Hospital Association (AHA) commission report *In Our Hands: How Hospitals Leaders Can Build a Thriving Workforce*, also recommends the establishment of a consistent resource for workforce data collection, analysis and publication to avoid future shortages and oversupply.

In considering the expert and commission findings, the goal of this project would more appropriately be to develop staffing data elements that are consistently applied and common to all provider settings.

An important first step to accomplish the development of common data elements and a national database and before any measure can be conceived with any degree of accuracy, is to reach consensus on the definition of nurse staffing. Does nurse staffing only include RNs, LPNs, and CNAs? How about other nursing professionals providing hands-on or contributing to direct care like DNS, ADNS, SDC, facility-based and paid APNs, feeding assistants, medication techs, nursing consultants, intravenous nurses, etc? Are students and nursing assistant apprentices considered in staffing? If not all these disciplines are to be considered: why not?

One of the specific goals of the staffing quality measure(s) project is to complete an analysis of the relationship of draft measures with quality outcomes using existing data. Organizations define quality based on their own interpretation of criteria they see as important. Considering this, whose definition of quality will be used for this project? There is no nationally accepted definition of quality that encompasses the totality of services, outcomes and expectations that are associated with high-level performance. Thus any attempt to draw a relationship between staffing and quality will fall short.

A better goal in looking at the correlation between staffing data and specific measures would be to do so without reference to quality. Our recommendation is further supported by two CMS reports.

- The first report is the Abt 2001 study *Identification & Evaluation of Existing Quality Indicators That Are Appropriate for Use in Long Term Care Settings*, Section: Technical Appendix B: A Modest Proposal for Benchmarking QIs To Identify “Good” and “Bad” Facilities. This study found that “conceptually any QI derived from LTC does not necessarily characterize the overall quality performance of a facility and generalizing from a single measure is likely to result in an incorrect interpretation.” The study provided an example and identified “that facilities with higher staffing had higher rates of pressure ulcers and that facilities admitting a high proportion of residents with pressure ulcers had high incident rates in the long stay population 9 months later.”
- The second CMS study, Phase II, Final Report: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Executive Summary, found “no substantial evidence exists that there exists a relationship between levels of staff and resident outcomes.”

More evidence-based research is needed before concluding and reporting a relationship between staffing levels and quality outcomes.

Earlier I mention that currently there is no nationally accepted definition of health care quality. In parting, AHCA wishes to publicly offer the following definition as the first step toward developing national consensus on a definition for healthcare quality: **The totality of features and characteristics of a service to meet and exceed customer expectations.**

AHCA wishes to thank CMS for this opportunity to comment on the Development of Staffing Quality Measures(s) project.

A Proposed Definition for Quality in Long Term Care  
Bernie Dana, Assistant Professor of Business at Evangel University

“The totality of features and characteristics of a service to meet and exceed customer expectations”

This definition combines the key elements of two other definitions of quality<sup>1</sup>:

- The American National Standards Institute (ANSI) and the American Society for Quality (ASQ) define quality as “the totality of features and characteristics of a product or service that bears on its ability to satisfy given needs.”
- In highly competitive markets, merely satisfying customer needs will not achieve success. To beat the competition, organizations often must exceed customer expectations. Thus, one of the most popular definitions of quality is “meeting or exceeding customer expectations.”

Some may argue that long-term care is not in highly competitive markets. Even so, everyone will agree that it is a service that is highly scrutinized by its individual customer. Because of the nature of our service to a frail and elderly people, many providers and consumers view the need to meet and exceed each customer’s expectations as a moral obligations as well as a business strategy. We often delegate whether the expectations of our customers are reasonable. While there are some exceptions, most of us who have been in the customer role would say that the greater burden on this issue lies with the providers.

It is also important to recognize that this definition says that it is the combination (totality) of both the feature (everything from the building to choices, dignity and respect, etc.) and characteristics (the reliability and acceptability of the systems and processes to deliver clinical care and other services) be sustained at a high level of performance. This calls for an organizational commitment to performance excellence and for continuous assessment, improvement, and alignment of its systems and outcomes to achieve those results.

The definition also requires that providers recognize long-term care residents as a heterogeneous rather than homogeneous market. Providers must more effectively recognize the individual needs and expectations of the market based on segments and profiles (i.e., cognitive, ambulatory, fragile, hospice) that differentiate the type of services and delivery methods that best meet their needs and expectations.



## Position of the American Health Care Association on Staffing Standards in Nursing Facilities

**Our Position:** The American Health Care Association (AHCA) supports the creation of an aggregate optimal staffing standard. Government, consumer advocates and providers must join together to create a fully funded aggregate optimal staffing standard for nursing facility patients. We offer these guiding principles on the creation and maintenance of nursing facility staffing standards:

**1. AHCA supports a fully funded aggregate optimal staffing standard to provide quality care for our patients.** Government, consumer advocates and providers continue the debate over the "right" staffing number that no one really knows. We support an aggregate optimal staffing standard based on acuity to provide quality care to our patients. We commit to working with government and consumer advocates to establish this aggregate optimal staffing standard and method. We will accept and support the "right" number concurrent with a public policy to fully fund this quality level to ensure that the long term care profession recruits, retains and rewards qualified people.

**2. AHCA calls upon the Clinton Administration and the Congress to partner with us in a national crusade to establish a goal of attracting more than 60,000 Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) and 250,000 Certified Nursing Assistants (CNAs) to the profession by January 1, 2002.** Our CNAs are the long term care profession's critically important first line of safety and service for our patients. Accordingly, a national initiative on the order of President Clinton's call for 100,000 new police officers and 100,000 new teachers is necessary.

AHCA proposes the following steps to assist in accomplishing this initiative:

- a. The Clinton and successor administrations must lead and exhort the public to action. The employment environment in the profession is in critical condition. It requires an immediate, aggressive and effective response.
- b. Our immigration laws must be liberalized to attract qualified professional and para-professional help to the long term care profession from outside the country.
- c. Congress and the Administration must help to reduce the use of a temporary work force for the profession. Nationally, the profession has had to use temporary employees because it has been unable to attract and keep a permanent work force. The use of temporary employees is unnecessarily expensive and, more importantly, interrupts the continuity of long term care delivery which is so critical to successful patient outcomes.
- d. Funding must be provided for training grants to providers and organizations that represent them so that the profession can keep its qualified people and establish rewarding career paths for them.
- e. A national criminal background check registry must be created to ensure the safety of long term care patients and personnel.
- f. Medicare and Medicaid funding systems must be fully funded to give the long term care profession the resources to attract and keep qualified people.

**3. Any standard enacted by legislation or adopted by regulation must impact all patients, regardless of payor source. Specifically, for the purpose of the legislative discussions that will take place for the remainder of the 106<sup>th</sup> Congress, any staffing standard cannot be "Medicare specific."** Such a narrowly focused standard would be disastrous for dually certified providers and the patients they serve by inappropriately skewing upward the staffing standard on beds occupied by Medicaid recipients without the concomitant funding to support these standards. The Congress will reexamine the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 this fall. If policy makers conclude that the infusion of additional funding will only be forthcoming to the profession if tied to a staffing standard, such a standard and the funding that follows must apply to both Medicaid and Medicare providers and recipients.

**4. States must fully fund any staffing standard in their Medicaid reimbursement methodologies.** Any federal legislation enacted or regulation adopted must require the states, in their state plans, to fully fund the standard for their Medicaid nursing facility providers and recipients. HCFA must be vigilant in its oversight and state plan review and approval responsibilities. Furthermore, the federal directive must prohibit states from funding the staffing standard by reducing one or more non-nursing components of the rate. "Robbing Peter to pay Paul" cannot be tolerated.

**5. The profession and policy makers must work together to develop dependable and defensible data collection systems to establish appropriate staffing standards and to monitor them.** Phase II of the HCFA study creates an excellent opportunity for HCFA and the long term care profession to joint venture an initiative to conduct the research that is necessary to develop the data collection infrastructure to establish present and future profession staffing standards and to monitor the impact of such standards on long term care costs, *quality of* and *access to care*.

**Statement of the American Medical Directors Association**  
to CMS and the Colorado Foundation for Medical Care  
on the Development of Staffing Quality Measure(s) Project

March 2, 2004



A national organization of  
long term care physicians  
committed to quality care

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The American Medical Directors Association is pleased to provide this written statement to CMS and the Colorado Foundation for Medical Care on the Development of Staffing Quality Measure(s) Project. We recognize a priority of this Administration is to provide information to consumers, so that they can make informed choices about nursing home placement for themselves or their family. In order to make Nursing Home Compare a useful resource, AMDA members urge CMS to adjust for variations in case mix among facilities, broaden the definition of staff, and include consideration of the quality and efficiency of the workforce.

### *Case Mix Adjustment*

AMDA's primary concern with the development of a staffing quality measure is how to configure staffing information for each facility in a way that is helpful to consumers. We believe that any staffing measure must be able to compare equally staffed facilities that have the same hours-per-resident stay, yet have different care needs. If that is not done, one facility may be poorly staffed and the other relatively well staffed, but appear the same. Similarly, if one facility has 3.5 nursing staff hours per day and another has 3.7, some consumers may judge one facility as relatively higher in quality than the other when, in fact, they may have patient populations that warrant more or fewer staff.

### *Definition of Staff Driven by Resident Needs*

Staffing measures based only on resident-to-worker ratios are simplistic and will not adequately assess or meet resident needs. Instead, medical acuity, complexity of

medical illness, a patient's ADL status, and cognitive status all require different staffing and must be taken into account when developing a measurement system. AMDA recommends that CMS provide a definition of staffing that is driven by a resident's needs. Specifically, the definition should extend beyond the registered nurse (RN), licensed practical nurse, and certified nursing assistant (CNA) to include other qualified staff who provide services to residents, such as activity coordinators, rehabilitation aides, and feeding assistants. Limiting the definition to nursing care may inadvertently give an incomplete picture of care in the facility. Take for example a facility that has a dementia floor with residents that have behavior issues, but do not need toileting or feeding assistance. The facility may staff the unit with less CNAs or RNs and more activity workers who can facilitate group activities to prevent behavior problems. However, a consumer, looking at the categories under the current staff posting requirement, may think the facility is poorly staffed, when in reality, there are additional activity people meeting the needs of the residents.

### *Quality and Efficiency of Facility Staff*

Finally, AMDA cautions CMS to remember that a quality measure should not penalize those facilities that operate with less staff but provide a sufficient level of care for each resident to maintain their highest practicable physical, mental and psychosocial well-being. Numbers alone cannot reflect the adequacy of care processes in the facility. We encourage CMS to focus more attention to the adequacy of care processes in relation to the numbers of staff, instead of focusing on numbers alone.

In sum, AMDA recognizes that the public reporting system is an important step in helping consumers become better informed about the care of their loved ones. But, consumers need a measure that fairly represents the facility's quality. Adjusting for the case mix, instituting a definition of staffing based on resident needs, and taking into account the efficiency of the workforce, are important components of a measure that will make Nursing Home Compare a more useful resource.

attachments: *AMDA Position on Direct Care Staffing in Nursing Home*  
*AMDA Position on Minimum Staffing Standards in Nursing Homes*

# Resolutions, Policy Papers, and Position Statements

## Position on Minimum Staffing Standards In Nursing Homes

Statement A00

Becomes Policy August 1999

### Background

Provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) specifically require nursing facilities to have registered nurse coverage for at least 8 hours per day and 24-hour licensed nurse coverage per day. The general requirement is that staffing must be sufficient to meet the needs of nursing home residents.

Recently, HCFA contracted with Abt Associates to collect quantitative data that will decide whether or not regulations on staffing levels or ratios in nursing homes are warranted. Unlike the Institute of Medicines' report in 1996<sup>1</sup> and the National Citizens' Coalition for Nursing Home Reform's staffing guidelines<sup>2</sup>, Abt is looking for empirical staffing and outcomes data to determine if there is a level for which--if you fall below it--residents are at risk for poor outcomes. If a threshold is found and HCFA recommends staffing levels, then Abt will perform a cost analysis of what it will take to staff at that level. In addition to looking at dollars for the cost analysis, Abt will look at availability of staff.

### Positions

Excluding the specific and general staffing requirements outlined in the OBRA '87 provisions, AMDA withholds its support of staffing standards for nursing homes until the Abt Associates nursing home staffing project provides empirical data on the justification for or against staffing standards and their affect on patient outcomes. While too little staffing may lead to poor outcomes, there currently is no proven correlation between higher staffing levels and improved outcomes.

Until the scientific and clinical data is defensible, the development of staffing levels or ratios should be approached with an appropriate level of caution. AMDA recognizes that if one must develop guidelines, the following points should be taken into account:

- the complexity of the patient population;
- the functional level of the patient and the services required;
- the existence of staffing shortages for some types of staff in some geographic locations, and, for temporary staffing shortages due to such events as employee illness or termination; and
- the quality, education, and training of the staff.

1. Wunderlich GS, Sloan F, et al. (1996). Nursing Staff in Hospitals and Nursing Homes: Is it Adequate? Washington, D.C.: National Academy Press.

2. National Citizens Coalition for Nursing Home Reform. (1998). Proposed Minimum Staffing Standards for Nursing Homes. Washington, D.C.: National Citizens Coalition for Nursing Home Reform.

**Resolutions and Position Statements**  
**Position on Direct Care Staffing in Nursing Homes**  
Statement H02  
Becomes Policy March 2002

## Summary

The primary focus of this statement is to:

- Expand upon AMDA's 2000 position on minimum staffing standards in nursing homes ([AMDA House of Delegates Resolution A00](#));
- Affirm the value of direct caregivers in the long term care continuum; and
- Encourage the Centers for Medicare and Medicaid Services (CMS) to provide funding increases for any federally mandated staffing levels.

The intent of this statement is to expand [AMDA's 2000 position on minimum staffing levels](#), which dealt primarily with the lack of scientific and clinical data to support the implementation of federal staffing mandates. In the interest of improving the quality of patient care in long-term care, AMDA believes that it is necessary to examine the broader issues surrounding nursing home staffing.

## Background

In recent years, workforce dynamics along with a growing elder population have resulted in nurse staffing shortages across the long-term care continuum. Nurse staff shortages are particularly endemic to America's nursing homes and extend to registered nurses (RN), licensed practical nurses (LPN), as well as certified nursing assistants (CNA). Adequate nurse staffing is critical to providing quality patient care. In this context, adequate nursing staff can be defined as the appropriate number of well trained, properly supervised individuals who meet the personal [direct] care needs of nursing home residents.<sup>1</sup> Presently, nursing assistants provide 80 to 90 percent of direct patient care.<sup>2</sup> Direct patient care includes assisting the patient with feeding, drinking, ambulating, grooming, toileting, dressing, and socializing.

Studies show that residents and their families directly relate the interaction between the nursing assistant and the resident to the level of satisfaction experienced in the nursing home. Clearly, well-trained CNAs have an important role in providing direct patient care in nursing homes. Similarly, published studies positively correlate RN participation in direct care giving, providing hands-on guidance to CNAs, and improvements in the quality of patient care.<sup>3</sup> As licensed nursing professionals, RNs and LPNs are crucial in providing guidance and supervision in the nursing home environment.

## Staffing Levels

Current federal law requires facilities to have an adequate number of licensed and qualified staff to provide care and services to residents. The level of care must be sufficient for each resident to attain or maintain their highest practicable physical, mental and psychosocial well being.<sup>4</sup> In addition to the federal government's general requirement for adequate staffing, some state laws explicitly mandate staffing levels by requiring a minimum number of nursing staff for a specific number of residents.



State staffing mandates vary.<sup>5</sup> In some states, the staff-to-resident ratio is solely based on the number of residents in a facility. In other states, the ratio depends upon the case-mix of a facility's residents. Until recently, there has been little quantitative data to suggest specific ratios at which quality is either compromised or significantly enhanced.<sup>6</sup> Ongoing research to collect clinical and scientific data purposes to determine staffing levels that will best achieve desired outcomes as well as to develop recommendations that are sensitive to changes in case-mix and acuity. AMDA recognizes that if federal staffing guidelines are developed, the following points should be taken into account:

- The acuity of the patient population;
- The functional level of the patient and the services provided;
- The existence of staffing shortages for some types of staff in some geographic locations, and, for temporary staffing shortages due to such events as employee illness or termination; and
- The quality, education, and training of the staff.<sup>7</sup>

## Training Standards

Minimum training standards for nursing assistants were codified in the Omnibus Reconciliation Act of 1987 (OBRA '87). Seventy-five hours of training in specifically designated areas are mandated for CNAs who work in long term care facilities receiving Medicare or Medicaid funding. In addition, 12 hours per year of continuing education must be provided by the facility. Approximately, one third of states have additional nursing assistant training requirements. Required curriculum content varies substantially between the states. There is very limited research that defines the specific number of hours and curriculum content that will produce the most competent paid caregiver.<sup>8</sup> Both the paucity of formal training hours and the variability of curriculum content are felt to be inadequate by consumer and professional organizations including the National Citizens Coalition for Nursing Home Reform, the Certified Nursing Assistant Program, and the Direct Care Alliance.

AMDA is dedicated to the education, training, and professional development of those practicing in the long term care continuum. AMDA encourages continued research and demonstration projects that will define the relationship between expanded training hours and standardized curriculum content for CNAs and higher quality resident care. AMDA also recognizes that adequate supervision by licensed staff is critical to the continuing education process for CNAs and that "best practices" for ratios of licensed to unlicensed staff need to be established to promote the highest quality of patient care.

## Supply of Caregivers

Many solutions have been proposed to increase adequate staffing in nursing facilities. They include:

- Hiring of single task workers;
- Mandating federal staffing levels or ratios; and
- Changing federal immigration laws to permit the use of foreign workers.

However, AMDA cautions against the implementation of the any one recommendation without consideration of the broader issues mentioned in the Institute of Medicine's (IOM) March 2001 report.

Several groups have suggested that "single task workers" be employed by nursing homes to enable facilities to provide care without hiring additional CNAs. Presently, federal regulation does not allow this practice.<sup>9</sup> Historically, AMDA has expressed concern about the utilization of single task workers in nursing homes. To date, there is insufficient evidence to determine the impact of single task workers on the overall quality of patient care in nursing facilities. In the absence of such evidence,

AMDA has been reluctant to endorse the use of the single task workers in the care continuum. A lack of training relative to other direct care providers and the potential to undermine the spirit of professionalism among CNAs are additional areas of concern. AMDA encourages CMS to address the complex marketplace dynamics affecting nursing home staffing and would support a small-scale demonstration research project to study the impact of single task workers on care quality in nursing homes.

AMDA recognizes that policymakers may begin looking outside of the United States for nursing staff to help ease the staffing shortages in nursing homes and other places of care. If this strategy is implemented, AMDA encourages state and federal policy makers to remain committed to current educational requirements for nursing staff.

## Federally Mandated Staffing Levels

Federally mandated minimum staffing and training levels do have the potential to raise the quality of care for nursing home residents, a goal that AMDA has consistently promoted. However, the overall impact of new federal mandates is far from clear and could result in unintended consequences. For example, a shortage of available workers in the labor force may make compliance with federal mandates difficult. A consensus statement widely endorsed across the care continuum delineates the multiple interrelated factors that contribute to the current staffing shortage. These factors include:

- Inadequate Medicare and Medicaid payment systems;
- Job image and quality;
- Wages and benefits;
- Education;
- Workload and the facility's management philosophy;
- Workplace safety;
- Advancement opportunities;
- External and personal issues for the low income worker; and
- Public perception.<sup>10</sup>

Post-baby boom demographics over the next 30 years reveal a widening care gap between the rapidly growing population of long term care consumers and the shrinking supply of direct care workers.<sup>11</sup> Clearly, any federal mandates to improve staffing levels in nursing homes will need to address the broader systemic issues that limit the availability of trained and qualified nursing staff.

## AMDA's Recommendations

The conclusions outlined in the IOM in the report entitled, "Improving the Quality of Long Term Care," published in March 2001, specifically examine the relationship between the quality of nursing home care and staffing levels. AMDA endorses many of their recommendations as outlined below.

- AMDA highly values direct caregivers in our nation's nursing homes. Their hands-on care determines whether a resident's care plan will achieve its goal: the highest possible functional level. Our daily experience as physicians affirms that the quality of a resident's life is profoundly affected by whether they are treated in a competent, compassionate manner by the nurses and nursing assistants who are responsible for their care.
- AMDA supports the continued research regarding mandated staffing levels (number and skill mix) for direct care based on case-mix-adjusted standards that will optimally meet the needs of residents in nursing homes. Staffing levels based only on resident-to-worker ratios are simplistic and will not adequately assess or meet resident needs. Workforce issues including wages and benefits, job

design, quality of training and supervision, career development and workplace safety must be addressed before a labor pool of adequately trained licensed and unlicensed staff will be available to allow facilities to comply with staffing mandates.

- AMDA agrees with the IOM's conclusion that "the amounts and ways we pay for long term care are probably inadequate to support a work force sufficient in numbers, skills, stability, and commitment to provide adequate clinical and personal services for the increasingly frail or complex populations using long term care."<sup>12</sup> Any mandated changes in staffing levels and training requirements must be accompanied by federal and state funding increases specifically targeted to achieve these goals.

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1. Wunderlich, G.S., Kohler, P.O. (2001). *Improving the Quality of Long-Term Care*. Washington, D.C.: National Academy Press.
2. Committee on Nursing Home Regulation. (1986). *Improving the Quality of Care in Nursing Homes*. Washington, D.C.: National Academy Press. See also "Sharing the caring: Family caregivers views of their relationships with nursing home staff" by M. Duncan & D. Morgan, from the *Gerontologist* (34) 1994: 235-244; as well as "Infopack: Staffing Issues in Long Term Care" published by the American Health Care Association in 1998.
3. Wunderlich, G.S., Sloan, F. et al. (1996). *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Washington, D.C.: National Academy Press.
4. Social Security Act of 1935. U.S.C.A. §1395i-3 et seq. ([www4.law.cornell.edu/uscode/](http://www4.law.cornell.edu/uscode/)).
5. See "Nursing Homes Staffing Standards in State Statutes and Regulations", a report prepared by Charlene Harrington in conjunction with the National Citizens' Coalition for Nursing Home Reform, May 2001.
6. Health Care Financing Administration. (2000). *Report to Congress: The Appropriateness of Minimum Staffing Ratios in Nursing Homes, Phase I*. (Department of Health and Human Services). Washington, D.C.: Government Printing Office.
7. American Medical Directors Association. (2000). [House of Delegate Resolution A00](#).
8. Noel, MA, Pearce GL, et al. (2000). *Frontline Workers in Long-Term Care: The Effect of Educational Interventions and Stabilization of Staffing Ratios on Turnover and Absenteeism*. Journal of the American Medical Directors Association, 1(6), 241-247.
9. On June 28, 2001, the Secretary of the Department of Health and Human Services, Tommy Thompson indicated in testimony before the Senate Special Committee on Aging that CMS, formerly the Health Care Financing Administration (HCFA), will offer assistance to states to allow greater utilization of single task workers.
10. Campaign for Quality Care. (March, 2001). *Staffing Crisis in Nursing Homes: A Consensus Statement*. Washington, D.C.: Author.
11. Dawson, Steven L., Surpin, R. (2001) *Direct Care Health Workers: The Unnecessary Crisis in Long Term Care*. Washington, D.C.: Domestic Strategy Group of the Aspen Institute.
12. Wunderlich, G.S., Kohler, P.O. (2001).

## **American Nurses Association**

### ***Testimony to the Colorado Foundation for Medical Care On the Development of Staffing Quality Measures***

#### ***Center for Medicare and Medicaid Services***

**Tuesday, March 2, 2004**

It is the American Nurses Association's (ANA) pleasure to provide this group with testimony on the development of nursing home staffing measures. ANA has been working on the development of indicators sensitive to the input of nursing practice for over ten years. Our experience is extensive. To date, ANA's National Database of Nursing Quality Indicators (NDNQI) has over 510 acute care hospitals currently submitting data. Although long term care facilities are not currently involved in NDNQI, the database has experience with the indicators' use in nursing homes. During the development phase of these indicators and the database, data were collected from long term care facilities in a project funded by ANA and conducted by the North Dakota State Nurses Association (NDSNA). All of the NDNQI indicators were found to be applicable in the long term care setting. It is ANA's commitment to move data collection and indicator development into other places where nursing care is provided in the not too distant future. Long term care facilities and home care are the first two settings to be addressed in this next phase.

The principle reason a person is in a nursing home is to receive nursing care. When an individual can not care for him/herself or needs extensive assistance with rehabilitation, (s)he usually seeks care in a long term care facility. In other words, nursing services are the principle product of the nursing home.

If there is interest in the quality of care, residents of long term care facilities receive, measures of nursing care are imperative to collect and assess. This requires that clearly and consistently defined indicators be used; data are uniformly collected; as well as the use of valid and reliable methods. These data must also clinically meaningful to providers and consumers.

ANA developed and tested, National Quality Forum endorsed, long term care staffing measures, skill mix and nursing hours per patient day, have proven to be related to selected outcome measures in a number of care settings.

Nursing skill mix indicators include:

- Percent of RNs providing direct patient care greater than 50% of their time;
- Percent of LPN/LVNs providing direct patient care greater than 50% of their time;
- Percent of Unlicensed assistive personnel (UAP) providing direct patient care greater than 50% of their time;
- Registered nursing hours per patient days;
- LPN/LVN nursing hours per patient day; and
- UAP nursing hours per patient day.

Research has shown that the mix of RNs, LPNs and UAPs does affect the incidence of selected outcomes in patient care. (Zimmerman, et al. 2002; Feuerberg, M. 2001; Harrington 2001; Hendrix and Foreman, 2001; Anderson, Hsieh, Su, 1998). Such granularity of the indicators assists in understanding the impact of each level of nursing personnel on patient outcomes. In addition, it provides information which is essential in quality improvement efforts. These data are not only useful in reporting but critical for improving.

## **Data collection**

NDNQI has developed each of its indicators based upon a thorough review of the empirical literature; expert panel review; and feasibility testing. The value of NDNQI is not only that it is the only database containing nation-wide nursing-sensitive indicator data for over 500 acute care facilities, but that all of the indicators are collected uniformly using a standardized definition; and all instruments used in data collection have established validity and reliability. This allows for comparability among facilities and confidence that each facility is measuring the same thing. All data collection methods have been pilot tested and refined as needed.

Issues which must be considered in collecting staffing data are the quality of the data. NDNQI's experience has shown that hospitals vary greatly in their ability to retrieve staffing data; define their work period differently; and vary in their definitions of who is care providing staff. NDNQI has learned that if there is commitment on the part of the facility internal challenges regarding collecting data in the correct way can fairly easily be overcome. Supportive database staff and free and open communication between the database and the facilities is imperative.

As I speak, NDNQI is in the process of putting online a web-based data abstraction tutorial which is also used for re-testing of data obtaining staff and an online mode of data submission. Already available are a chat room for facility liaisons, a bulletin board for participating facilities and NDNQI nurse liaison e-mail for questions.

Not meaning to "toot ANA's horn", but pleased to do so, I believe it is important to convey the need for training and continued oversight to assure the data are accurate. I am sure we are all aware of the variable quality of data being collected in a broad array of projects - both past and present - which contribute little to our exploration of the complex nature of health care delivery. We encourage the Foundation and CMS to focus on methods which can improve the quality of data collected.

The American Nurses Association is very pleased that this effort to identify staffing quality measures in the long term care environment is wide based and inclusive. With the residents and their needs (social, physical, emotional, spiritual, etc) as our focus, this effort at identifying begins a much needed and longed for process for long term care and its residents and their families.

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## Beverly Healthcare

Good afternoon, and thank you for the opportunity to speak on behalf of this project. My name is Dave Devereaux, and I am the President of Beverly Healthcare. I've had the privilege to work in the skilled nursing profession since the late 1970's, starting as a housekeeper while in high school, working as a dietary aide in college, and as a caregiver while in graduate school. I have an additional privilege in that my mother, who is a registered nurse of over 45 years, also spent the majority of her career in skilled nursing.

At year-end 2003, Beverly operated 373 skilled nursing facilities, as well as 20 assisted living centers, and 23 hospice and home care centers. Through AEGIS Therapies, we also offer rehabilitative services on a contract basis to nursing facilities operated by other care providers. We offer services of one type or another in 36 states across the nation.

Beverly believes that measuring staffing is important. It is one of many measures that provides a view toward a skilled nursing facility's performance. As a singular indicator, it does have limitations. If viewed as a barometer of quality, this measure can over- or understate the capabilities of any facility. In combination with others, it helps create a comprehensive picture for one to evaluate.

Providing care is a total team effort. There are critical elements, in addition to those common in the traditional evaluation of nurse staffing, that contribute to the overall patient care experience. With the environment as it exists today in the profession, each are noteworthy and should be considered in the establishment of a staffing standard. I'd like to highlight a few at this point:

- \* Stability and competence of facility leadership, specifically the facility Administrator and Director of Nursing. It is the common denominator among those facilities delivering excellence in care and customer service, and influences staff retention and team play.
- \* Staff Competence. More staff may not always equate to excellent customer outcome. A baseline for staff competence for each job category ought to be considered, otherwise any comparison between facilities is open to criticism.
- \* Staff Retention. This is a very important aspect, needing careful examination. What's most important is that the impact to care delivered differs among each provider. For example, for a facility experiencing 30% turnover, does it mean that 30% of the entire staff changes annually, or a few tough-to-fill positions turn over rapidly, creating the same statistical outcome? Arguably, one situation is preferable to the other.

\* Equipment. The introduction of improving bathing, transfer, and lifting equipment provides a safer and more efficient care environment for the customer and caregivers. At the same time, providers differ in their level of investment in each of these areas, creating a difference in the methods in which care is delivered. It is possible that facilities investing in these areas could be penalized, as they may have less nursing staff in terms of hours reported, yet provide a safer environment.

\* Therapy Staffing. The dimension that Physical, Occupational, and Speech Therapy adds to any provider is considerable. Each is an assist to Nursing, and provides expertise to those customers with special and intense needs. Though the availability of therapies is a condition for participation in Medicare and Medicaid, providers differ in the structure and intensity of their therapy programs, as it relates to on-staff vs. contract therapies, number of days/week and hours/day each discipline is available.

\* Hospice Services. Though the statistics may be invisible in the staffing documentation, the contribution of hospice staff to any provider delivering care to an individual at the end of their life is considerable, additive, and highly valued. As the profession continues to mature, hospice will grow in its prevalence and value, and become an even larger part of the daily routine among the provider community.

\* Patient Acuity. While all providers care for very sick people, there are differences in the population each serves. Equating care needs and staffing is a part of each provider's daily responsibility, though not all providers and their respective customers are alike. We'd ask that consideration be given to acuity in this project.

Finding an answer that is satisfactory to all interested parties is likely impossible. At the same time, we all benefit from a more educated customer, and this effort represents another step in how far we've come over the last four decades. On behalf of Beverly, I'd like to thank CMS for this opportunity to comment on the Staffing Quality Measures(s) project.



## Staffing Quality Measures

What information should be reported to the public:

- Audited, accurate direct care nursing staff levels, by day (and by shift), classified by registered nurse, licensed vocational/practical nurse, and certified nurse assistant, with comparison to statewide averages, national averages, and the staffing hours identified by CMS in its Phase II report to Congress on the minimum number of direct care hours (4.1) that are necessary to provide care in compliance with federal standards.;
- Audited, accurate direct care annual nursing staff turnover rates, classified by registered nurse, licensed vocational/practical nurse, and certified nurse assistant, with comparison to statewide and national averages; and
- Identification of numbers of agency nurses, classified by registered nurse, licensed vocational/practical nurse, and certified nurse assistant, with comparison to statewide and national averages.

How the information should be displayed for the public:

- As numbers of hours (i.e., number of hours of registered nurses per resident per day; number of hours of certified nurse assistants per resident per day);
- As percentiles;
- With a comparison to the staffing hours identified by CMS in its report to Congress on the minimum number of direct care hours (4.1) that are necessary to provide care in compliance with federal standards; and
- With a simple, straightforward narrative explanation, as included in the California Health Care Foundation's website.

The California Health Care Foundation reports nursing staff on its website for Nursing Home Search, <http://www.calnhs.org>, using two measures

- Total Nursing Staff: total nursing hours per resident day and, by a system of one to three stars, whether the facility does not meet, meets,

or exceeds the state minimum standard staffing ratio. Includes the statement, "Facilities that meet the nurse staffing goal recommended by experts have three stars;"

- Change in Nursing Staff: turnover rates, expressed as a percentage, and, by a system of one to three stars, whether the facility's turnover rate is lower than average, average, or higher than average. Includes the statements, "Low turnover may reflect better management, wages and benefits or other enhanced employment conditions. Facilities with lower than average turnover may provide better care."

To improve the staffing information on Nursing Home Compare:

- Include only audited information;
- Until only audited information is reported, state clearly that the information is self-reported and not audited;
- Include nursing staff turnover rates; and
- Include a comparison to the staffing hours identified by CMS in its Phase II report to Congress on the minimum number of direct care hours (4.1) that are necessary to provide care in compliance with federal standards.

Toby S. Edelman  
March 1, 2004

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## Evangelical Lutheran Good Samaritan Society

I would like to thank CMS and the Colorado Foundation for Medical Care for the opportunity to comment here today. I speak on behalf of the Evangelical Lutheran Good Samaritan Society of Sioux Falls, South Dakota serving residents in over 250 locations in 25 states. I also speak out of my experience as a member of the National Quality Forum's Steering Committee that was charged by CMS to recommend a core set of performance measures for long term and short term residents in nursing homes.

What has helped frame my thoughts for this meeting is referring back to some of the documents of that Steering Committee work. The principles established and agreed to at that time, while perhaps intuitive and clearly understood, are important to reiterate and help inform the beginning of this important work of developing a staffing quality measure. I also think these principles have been affirmed by some of the other comments already expressed today.

The NQF Steering Committee identified several domains of quality:

- Clinical care
- Functional Status
- Structural characteristics (including staffing)
- Quality of life
- Satisfaction
- Participation in care management
- External measures of quality

Staffing was recognized then as an important component of a core set of measures. Further, the measures currently on the CMS website represent only a few of these domains.

We went further and identified criteria that should be used to determine the appropriateness of any measure:

- Should be in the public domain
- Valid and reliable
- Relate to issues of high priority
- Be under the facility's ability to influence
- Easily understood
- Not involve burdensome measurement
- Not create adverse incentives

The Committee talked a lot about a staffing measure oftentimes with spirited discussion. Through it all, two consistent themes emerged:

- By CMS' own admission, the staffing data it displays on its web site is not of high quality; and
- The importance or need to include a staffing measure is not the question; data validity and standardization is.

Even as the NQF ultimately recommended a staffing measure for adoption, earlier Steering Committee discussion yielded the following recommendations which relate directly to the issues being lifted up today:

- CMS should establish a system for improving staffing data that is timely, generated quarterly, not related to timing of survey, acuity-adjusted and audited.
- Additional information related to nursing home staffing should be developed ASAP: staff turnover and retention, contract vs. payroll data, staff training, use of advanced practice nurses, tenure of the DNS and the Administrator.

Every one of these items has been affirmed time and again in today's comments.

Finally, I would share one other observation. Perhaps this is self-evident but I would assume that the data collection mechanisms necessary to develop a staffing measure fitting these criteria do not exist today. The current method – using the OSCAR 671 at time of survey - has yielded the invalid data we have today. Cost report data is too old and too infrequent. There is a significant question of CMS' readiness and willingness to resource adequately this initiative, for the agency itself and for the nursing homes of this country. And that is essential!

Thank you, once again, for the opportunity to provide comment and please know that the Good Samaritan Society stands ready to participate in any way possible in the development of these important measures.

Bill Kubat  
Vice President for Care Management, Clinical & Quality Affairs  
Ev. Lutheran Good Samaritan Society  
Sioux Falls, South Dakota

## Genesis HealthCare

### Staffing Quality Measure Phase I Stakeholder Meeting Comments

Traditionally, when people speak of staffing in a nursing home, they think of nursing personnel. Specifically, nurses and nursing assistants. This definition may have been adequate in years past, but recently the nursing home industry has significantly changed. As hospitals reduce their length of stay by discharging patients earlier, nursing homes have watched the acuity of the patients they care for increase. Today, nursing homes are caring for individuals who traditionally were cared for in acute care settings.

We conducted a survey of 1,500 admissions over a 30 day time period in 41 Genesis Centers in Maryland, Delaware and Virginia. The results showed that 34% of all patients discharged from hospitals to nursing homes had wounds, 18% needed IV therapy and 5% had a history of substance abuse. The impact of these types of admissions on nursing homes creates new clinical and operational issues for us to deal with.

This survey also revealed other interesting admission information. Most notably, 60.3% of all admissions came after 3:00PM and 36.7% of all admissions came after 5:00PM. Weekend admissions accounted for nearly 11% of all admissions and not surprisingly nearly one quarter of all admissions occurred on Fridays. Five to ten years ago, almost all admissions arrived before 3:00PM from Monday to Friday. Additionally 52.8% of all admissions went home and 73.4% had a length of stay of less than 30 days. Only 26.6% were long term care admissions. This would validate the fact that the types of patients LTC facilities are caring for today versus 10 to 20 years ago has radically changed.

The reason for pointing out these facts is that we are in a time of significant change in long term care. We believe that the traditional staffing model with nurse to patient ratios is an antiquated way of defining how to staff facilities. Looking strictly at nursing personnel in how we staff nursing homes is also shortsighted. Our patients require additional resources and expertise due to their changing clinical needs.

Though we do not oppose minimum nursing PPD staffing levels, as long as they are adequately reimbursed, we do oppose staffing ratios. In a rapidly changing environment, nursing homes need to have the flexibility to staff where and when their needs are greatest. One size does not fit all when it comes to staffing a nursing home. For instance, if I have a center admitting 60-100 patients a month, do we staff it the same as a facility doing 10 admissions a month? If 60% of the people are being admitted to a nursing home after 3:00PM, it will require additional resources on the 3-11 shift that were not there in years past. What should these resources be? These issues, as you can see, are complex and need to be carefully thought through to allow LTC facilities to care for patients adequately.

Let me briefly summarize additional positions and resources we have added to our nursing homes to improve the care and services to our residents over the past 3-4 years as a result of our changing industry.

1. At Genesis, we added an evening Administrative Manager to take the burden off the evening nursing supervisor of handling non clinical tasks (i.e. staff call-outs, assisting and admissions,

monitor staff performance, etc.). This allows the evening nursing supervisor to focus their time more on clinical nursing, where it is needed and not on non-clinical administrative duties. This model has not only benefited the clinical care of our residents but also improved customer satisfaction, even though it is not counted as a part of our nursing staffing model. Thus, we do not get credit for this position even though the nursing staff and patients benefit from it.

2. As we care for more patients with wounds and IVs, we added a roving IV team and wound specialist to assist centers in caring for these patients with a greater number. They support our centers 24 hours/7 days per week. It has added significant and measured positive clinical outcomes, yet these critical services are not counted in the traditional nurse staffing models
3. With greater numbers of highly complex patients, the need to have an active Medical Director and physician staff becomes critical. At the same time, many nursing homes have too many doctors with too little interest and too little time to care for nursing home residents. As a result, in my 41 Maryland, Delaware and Virginia centers, Genesis has hired 34 full-time and part-time physicians and 9 nurse practitioners to care for approximately 60% of the 4,000 patients in these centers. This assures that we provide our residents with attentive, responsive and quality medical care. The benefit of adding a strong medical component to our centers is obvious. Yet, these services, though necessary, are not recognized in the traditional staffing models for LTC.
4. To have improved training for our facility nursing staff, we hired a group of 12 highly skilled clinical educators who visit our 41 nursing centers to provide high quality, consistent training programs that are driven by facility needs. They spend all their time training our staff in the various centers. Why did we do this? It's simple. Many times, facility staff development positions are assigned a number of tasks within a nursing center that have little to do with developing staff (employee health, infection control etc.). Other times, the facility staff development people are conducting Certified Nursing Assistant classes and have little time to train staff in other areas. Five of the clinical educator group conduct centralized CNA training. The other 7 specialize in other clinical areas that need to be addressed in our LTC facilities. Yet this model, though proven to be very effective, is not counted in traditional nursing staff models.
5. To provide better care for tracheotomy patients, our centers utilize respiratory therapists. This frees up the nurse to perform other clinical tasks and while another discipline cares for the tracheotomy residents. If we didn't utilize respiratory therapists, the nurses' time would be taken away from other residents or in some cases, we would not be able to admit such types of patients into our centers. We also are not reimbursed for respiratory therapist, even though their services are necessary. Respiratory therapists are not counted in the traditional nursing staff models.
6. Today, 72% of all our residents receive rehab services. Ten years ago, this number was around 20%. Ten years ago, we had 1-2 therapists in a facility. Today, we have anywhere from 4-20 therapists in a typical nursing center. These added resources are not considered when looking at nursing home staffing needs.

These are a few examples of what Genesis is doing to care for our patients. As our business changes, we must change how we provide care. As our acuity increases, the need for increased clinical, medical resources and support is paramount to our success as an industry. When we think of staffing, we need to think beyond our traditional view of nursing home staffing as being made up of only nurses and nursing assistants. We need to look at the bigger picture. We believe CMS should look beyond "one size fits all" staffing ratios and recognize new clinical

services and resource support like employed physician and nurse practitioners, IV nurses, wound care specialist, respiratory therapist, evening administrative managers, feeding assistants, to name a few. The question of what do we really need to do in today's LTC facility to meet the clinical needs of our residents, needs to be asked. It's more than nurses, nursing assistants and "old school" views of LTC staffing.

# HCR Manor Care

February 27, 2004

Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850  
Attention: Ann Romaglia, CFMC Project Manager

Centers for Medicare and Medicaid Services:

HCR Manor Care's continuing commitment to quality care is the foundation on which the clinical and other service needs of residents/patients are determined (i.e. "acuity" or work load assessment). To support the ongoing research and the important public debate on the impact of various aspects of workforce and staffing on overall quality in long term care, HCR Manor Care is pleased to submit the following observations and comments as a response to CMS's request for input as the organization works to develop a valid and meaningful Quality Measure for staffing:

There are a number of complex issues that must be included in the development of any meaningful staffing/workforce related quality measure. First, we feel strongly that one must consider the impact of resident/patient case mix acuity on the appropriate staffing required to deliver quality services. We urge CMS to consider incorporation of an acuity measure in the quality measure for staffing that reflects the impact of resident/patient acuity. Such a system could include a standard patient classification based on:

- RUGs classifications
- Disease Staging
- Severity Illness Index
- Patient Management Categories
- Medical Illness Severity Grouping System
- Acute Physiology and Chronic Health Evaluation, Simplified Version

This acuity system should evaluate the acuity needs for an individual and prescribe an HPPD for an individual, a unit, and the facility. The system should also consider both direct and indirect time requirements, the facility structural complexities, and the impact of average length of stay (ALOS) on work load and quality. Since the work load on the first weeks of admission and last day are clearly greater than the work load on other days (on average), and in certain situations more intense services can actually decrease length of stay required to achieve rehabilitation goals, a facility that achieves excellent clinical outcomes and a shorter length of stay, may require higher staffing than a facility that provides less intense services and requires a longer ALOS to achieve the same clinical outcomes.



## **Distribution**

Another consideration is not merely to define overall HPPD requirements for a center, but to use the acuity system to define workload distribution of staffing by job category (RN, LPN, CNA), by shift, and by unit for each day of the week. An optimal staffing/workforce measure should include some reflection of the consistency of staffing and workload distribution throughout all shifts and on the weekends, based on the accepted resident/patient acuity system. Such a system should also incorporate:

- Consistent use of Hours Per Patient Day methodology by all providers
- Consistent calculation of HPPD per unit, rather than an aggregate HPPD for the center to identify units in need of a higher HPPD to provide care

## **Competency/Skill**

HCR Manor Care also strongly believes that the level of training and competencies/skill levels of the staff at any facility can substantially influence quality of care and caring. Any comprehensive measure of the role of staffing/workforce issues on quality should include some assessment of this aspect of workforce competencies. Such a measure could include consideration of the use of Advanced Practice Nurses, the numbers of hours of experienced Licensed R.N.'s, the use of new R.N. graduates, the hours of care provided by L.P.N.'s/L.V.N.'s, and the hours of care from Nursing Assistants. This measure should include some consideration of the quantity and content of the orientation program and any on-going training of staff, as well as the presence of a formal, documented competency evaluation program.

## **Tenure**

The influence of staff retention and turn over are well documented and should also be utilized in a comprehensive workforce –quality measure. In this important arena, there is a need to develop and implement consistent methodologies for the reporting of staff retention and turnover rates. There is some evidence in early studies that the tenure of clinical leadership (e.g. Director of Nursing Services) has a significant impact on quality. Inclusion of this data element in any final quality measurement system should be evaluated and included or substantiated as an important component of overall quality.

## **Outcomes**

To make this area optimally useful as a component of quality measures for public communications and to facilitate its use in internal facility and organization quality improvement efforts, there needs to be a consistent methodology adopted for the overall correlation of staffing/workforce issues and clinical and satisfaction/quality of life outcomes. Only when the data is uniformly measured and reported across all providers can we all achieve the goals of the Quality Measures initiative.

Sincerely,  
Joyce Smith, V.P., Director of Clinical Services



**National Association of Directors of  
Nursing Administration in Long Term Care**

**Statement of the National Association of Directors of Nursing Administration in Long Term  
Care to CMS and the Colorado Foundation for Medical Care on the Development of Staffing  
Quality Measure(s) Project**

**March 2, 2004**

The National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) is pleased to comment on the Development of Staffing Quality Measure(s) on behalf of our 5000 members and 40 State Chapters. The issue of quality of care and quality of life for residents as it relates to adequate staffing has long been of interest to our association and to our members. We believe, however, that “staffing quality” is of a broader scope than can be determined or communicated to consumers by comparing an individual nursing home’s FTEs to the daily resident census. Further more, measuring those numbers against data from other nursing homes results in inequalities that will not be obvious to the untrained reader.

**Case Mix**

To expect that a consumer can select a nursing home based on posted data regarding nursing FTEs and daily census is to leave out an absolutely key factor: case mix acuity level of the residents who reside there. Nursing home residents present a broad range of needs on the care spectrum, all the way from the person who only needs supervision to the person receiving mechanical ventilation, significant wound care, enteral and parenteral feedings, and more. Included in caring for these

residents is a range of personnel beyond the proposed RNs, LPNs, and CNAs. Some homes employ feeding assistants, some have non-clinical valets who perform many tasks such as bed making, passing of water, meals, and nourishments, preparation and clean-up of bathing areas, and much more, all designed to remove the task burden from CNAs so that they can give all their attention to the resident, not to those non-clinical tasks. Other homes require the CNAs to perform all tasks themselves. To compare these homes by numbers of FTEs and census, one would miss the reality that one home may be giving far better personal attention to their residents than the other. The posting of FTEs and census data that cannot factor in Case Mix or contribution of other support staff does not adequately compare the homes, and may in fact mislead consumers seeking information.

### **Competence of Nursing Staff**

An additional missing ingredient is the level of training provided in the individual homes. Nursing homes that embrace the belief that investing in staff development and competence is an investment in quality for their residents will be overlooked. It is not possible for a consumer to determine the competence of staff by reviewing FTE postings. Numbers alone do not reflect the level of expertise of the nursing staff.

**In summary**, NADONA supports the belief that the public should have information available to help them make informed choices about nursing homes. However, to base it on ratios of FTEs to resident census will give an inaccurate picture. There are other factors to consider, including case mix of residents and competence of nursing and support staff.

*For further information, contact NADONA President Betty MacLaughlin Frandsen, RN, NHA, CDONA/LTC at 607-689-0261, 607-738-7720 (cell), or [bmacfran@stny.rr.com](mailto:bmacfran@stny.rr.com).*

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## Statement of Alice H. Hedt, Executive Director, For the CMS Staffing Quality Measures Project March 2, 2004

11/16/04 Erica Bloom

Since its founding in 1975, the National Citizens' Coalition for Nursing Home Reform has consistently identified an adequate, well-trained workforce as the primary key to good nursing home care. As a member of the National Quality Forum steering committee that developed recommendations for the nursing home Quality Measures (QMs), NCCNHR strongly advocated for a measure on nurse staffing. Although the other measures that the NQF recommended to CMS are indicators of quality, if we could select only one identifier of a good nursing home, nurse staffing is the one we would choose.

Most of the neglect and abuse that plague so much of the nursing home industry could be eliminated if nursing homes were required to meet the minimum standards identified by Andrew Kramer and John Schnelle in HHS's study of the appropriateness of requiring minimum nurse staffing ratios. NCCNHR is extremely pleased that Dr. Kramer is now engaged in this project to develop Quality Measures on nurse staffing so that consumers at least can judge for themselves whether or not facilities are adequately staffed.

Following are NCCNHR's recommendations:

- Quality Measures for nurse staffing cannot be developed without accurate data on the total number of residents and total number of direct care nursing staff (RNs, LPNs/ LVNs, and CNAs) in every certified facility. While we understand that CMS is considering ways to improve the current, self-reported data on OSCAR, we urge it to move forward immediately to implement a new, audited data collection system. Research begun during Phase II of the staffing ratio study and completed last year should enable CMS to design a data collection system based on payroll records and invoices. This new system should be developed as quickly as possible and be put in place no later than the completion of this project to develop Quality Measures for staffing.
- NCCNHR recommends reporting the QMs in both case-mix adjusted and unadjusted formats. Although staffing measures may be case mix-adjusted, the minimum staffing level identified in the Phase II report -- 4.1 hours of direct care per resident day -- should be the baseline for the standard. This level of staffing is essential to perform the minimum tasks of nursing home

care and to prevent adverse events, such as loss of functioning, pressure sores, and avoidable hospitalizations. This was the conclusion of a

distinguished panel of experts convened by the John A. Hartford Institute for Geriatric Nursing that evaluated the staffing standards adopted by NCCNHR members in 1998; it was confirmed by the research of Dr. Kramer and Dr. Schnelle in the HHS study. Some nursing homes may require more hours of nurse staffing, but few if any could provide good care with fewer hours of care.

- NCCNHR supports implementation of Quality Measures based on ratios expressed as hours of direct care per resident day. (1) One set of measures would be disaggregated by type of direct care provider (RN, LPN/LVN, or nurse aide). (2) A separate Quality Measure would show these direct care staff as total nurse staffing hours per resident day. Feeding assistants, medication aides, and other non-nursing personnel should not be included.
- The collection of staffing data from payroll records and invoices will enable CMS to develop Quality Measures that reflect two other powerful indicators of quality: (1) nursing staff turnover/retention, and (2) use of temporary agency personnel. NCCNHR strongly supports the development of Quality Measures that incorporate turnover/retention and use of agency staff.
- In addition to the Quality Measures, NCCNHR recommends that Nursing Home Compare make additional information available. Currently, other consumer Web sites, both public and private, publish information such as CNA wages, “productive” hours of non-nursing staff per resident day, change in nursing staff, expenditures for direct care staff per resident day, and numerical ratios of nursing staff to residents. Consumers continue to tell us that this other staffing information is essential.

Finally, we urge that the contractors develop clear, concise, understandable explanations of the Quality Measures.

NCCNHR welcomes the opportunity to work with and make recommendations to CMS and the researchers for this important project.

## National Gerontological Nursing Association (NGNA)

### CMS Stakeholders Meeting on the Development of Staffing Quality Measures Project Statement on What Matters to the National Gerontological Association in the Development of Staffing Quality Indicators

March 2, 2004

The mission of the National Gerontological Nursing Association (NGNA) is to improve the clinical care of older adults across care settings. We are the only national organization to give voice to more than 10,000 nurses certified in geriatrics and gerontology. Among our members are clinicians, administrators, educators, and applied researchers whose work regularly places them on the front lines of Medicare and Medicaid reimbursed programs for our nation's older adults. We bring to this CMS stakeholders meeting what matters to NGNA in the development of staffing quality measures.

**First**, staffing quality measures must be more than merely bean counting. Quality indicators reflecting a one-size fits all staffing-ratio can result in desperate attempts by nursing homes to fill vacancies with “any warm body” and will not improve care outcomes. Having an adequately trained and stable staff is as important to care quality as is achieving a particular staffing ratio. Will facilities think about staffing indicators before they terminate someone who is chronically late or lazy in order to meet the any warm body requirement? If so, what does that say about the quality of staff we will have in long-term care? Staffing quality measures also must take into account use of agency staff. Many facilities use temporary staff to meet quotas. Accountability for care provided, as well as

monitoring ongoing training and skill competency, are major concerns. These issues of agency staffing must be factored into staffing quality measures.

**Second,** staffing quality measures need to distinguish between bedside and non-beside care staff. In the past additional regulation and oversight has led to additional administrative overhead. MDS coordinators, quality review personnel, infection control nurses, staff educators, and other administrative staff have no doubt made significant contributions to care quality. It is important, however, to distinguish between staff who fulfill a supportive function and those who provide direct care.

**Third,** staffing quality measures need to include training, specifically training in geriatrics. Health care workers at all levels and in all disciplines who care for older people should be appropriately trained and credentialed in geriatric/gerontological care. Quality measures need to include both basic and ongoing training to assure that older adults are receiving evidence-based, state of the art clinical care.

**Fourth,** 80-90% of care in nursing homes is delivered by unlicensed staff (CNAs). Consequently, supervision of bedside care giving staff is essential. Adequate numbers of unlicensed staff are necessary but not sufficient to ensure care quality. All new staff members need adequate orientation to be able to function safely and effectively. Oversight and management of direct care giving staff is critical to assure that resources are used effectively, care plans are implemented, and outcomes are monitored.

**Fifth,** A growing body of evidence shows that qualifications, training, and tenure of key personnel such as Medical Directors, Administrators, and Directors of Nursing are equally important in the link between staffing and care quality. These key figures create the organizational culture and must be included as CMS develops staffing quality measures.

**Sixth,** staffing quality measures must be understandable. Measures that split care giving staff into pieces or parts (e.g., 3.6 FTEs) leads to confusion among residents and families. Incremental changes in values not associated with significant differences in care quality will only create unnecessary anxiety among the public.

**Finally,** more research is needed. LTC professionals and the public need more information (evidence) and documentation on how staffing affects care quality. We need studies that clearly demonstrate how staffing mix, nurse staff to resident ratios, and staff qualifications and training affect care quality and outcomes.

**In summary,** NGNA supports and applauds CMS' efforts to develop staffing quality measures and stands ready to work with you to develop measures that truly reflect care quality and resident outcomes. And most importantly NGNA stands ready to assist the public in obtaining high quality long-term care for their family and loved ones.



## CMS Staffing Quality Measure Project

Statement of Sharon C. Wilder, N.C. State Long Term Care Ombudsman  
Representing  
The National Association of Long Term Care Ombudsmen Programs.  
March 2, 2004

Long Term Care Ombudsmen Programs are mandated to advocate individually and systemically on behalf of residents in long term care facilities. Program representatives spend many hours in long term care facilities providing direct assistance to residents, training staff about Residents' Rights, attending resident's council meetings and family council meetings.

### **Q: What aspects of nursing home staffing are most important to you and your constituency?**

**Residents/families want staffing information that will help them determine whether:**

- ⇒ Individual resident care needs will be met timely by nursing facility staff on a daily basis in a manner that respects rights of autonomy, privacy, and dignity.
- ⇒ Timely responses will be available when they ring their call bell (within 3-5 minutes) or verbal request by courteous staff ready to assist them as needed.
- ⇒ Prescribed medications will be administered on time, adequate help will be available for assistance eating their meals (when this is needed) along with their fellow residents, and not after watching others eat for up to an hour.
- ⇒ Residents want staff to treat them as whole persons with histories, not just tasks that need to be completed hurriedly. Residents want staff to listen respectfully and seriously when concerns/requests are being voiced and respond appropriately.

### **Q: How can we improve on the measures on staffing information currently represented on Nursing Home Compare?**

Development of an enhanced Staffing Quality Measure should include at least 4.1 hours of direct nursing care per patient day as the minimum national benchmark required to meet residents care needs in nursing facilities.

Any meaningful staffing quality measure must be based on accurate, audited staffing data from all of America's nursing homes. Development of an audited data collection system would improve CMS's ability to accurately measure staffing patterns in nursing homes for incorporation into a national quality measure.

### **Q: How should staffing measures be presented to the public?**

Consumer information on Nursing Home Compare should be broken down to show both average licensed staff to resident ratios and average direct care staff to resident ratios on each shift, in addition to the current per patient day information available on the website.

With the development of an audited data collection system, CMS could include new information for consumers about the number of days per month/year; staffing patterns fell above or below the established averages.



## Development of Staffing Quality Measures – Phase I

### Statement of Lee Goldberg, Long Term Care Policy Manager, March 2, 2004

The Service Employees Union International has approximately 1.6 million members – more than 300,000 of whom are on the front lines of providing long term care in nursing homes. The quality of care provided to the elderly and the disabled in long term care to a great extent determined by the quality and the quantity of this work force.

SEIU believes that poor staffing levels are the single most important factor contributing to poor quality of nursing home care in the United States. We applaud the work of Dr. Andrew Kramer, Dr. Charlene Harrington, Dr. John Schnelle and others on the correlation between staffing levels and quality of care. We strongly support the staffing standards developed by the John A. Hartford Institute on behalf of the National Citizens Coalition for Nursing Home Reform and believe that CMS should make 4.13 hours per resident per day (hprd) a federal minimum for facilities participating in Medicare and Medicaid, even though higher staffing levels may be necessary for facilities with a higher acuity population. As CMS noted, staffing levels below 4.1 hprd may seriously impair the quality of care. SEIU supported the National Quality Forum’s recent adoption of staffing as a quality indicator for long term care. With more than 97 percent of facilities operating below that level of staffing, SEIU believes that ultimately minimum staffing levels must be federally mandated in tandem with reimbursement reform for both the Medicare and the Medicaid programs.

A major problem in staffing is worker retention. AHCA data from 2002 indicate that the turnover rate for certified nurse assistants remained high, approximately 71 percent, and this has a negative impact on quality of care. Some nursing home residents do not have surviving family and many never receive a visit from a family member. Residents forge strong bonds with their care providers and a break in the relationship can be highly stressful, especially for residents with difficulty communicating. Repeating this break two and three times a year can be harmful to continuity and quality of care. SEIU supports the development of quality measures that include data on turnover/retention.

There are many reasons for the high turnover rate, but for many of our members, the number one complaint is the work load. In many facilities, the responsibilities of licensed and unlicensed staff have expanded as the percentage of residents with complex mental, physical and psychosocial care needs have increased. Workers may be assigned

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to ten or twelve residents on the day shift and as many as thirty or forty at night. It is simply impossible, physically, mentally and emotionally to provide quality care to that many people at once.

A key contributing factor to the high turnover rate is wages. Most recent census data indicate that much of the long term care work force lives in poverty. One in three aides working in nursing homes earned less than \$10,000 a year and thirty-eight percent reported family incomes less than \$20,000. Aides working in nursing homes were twice as likely as other workers to be receiving food stamps and Medicaid and they were more likely to lack health insurance. Low wages are caused primarily by low state Medicaid rates. A recent CMS study found that CNAs wages and benefits need to be raised 17-22 percent to retain employees in long stay facilities.

SEIU is also concerned about recent efforts to expand the use of unlicensed staff as feeding assistants. Although many geographic areas face a chronic shortage of people willing to work as CNAs at prevailing wage rates, SEIU believes that efforts to expand the pool of available workers by diluting state and federal training requirements run contrary to the recommendations of the Institute of Medicine on stabilizing the workforce. Efforts to solve the staffing shortage by reducing the overall skill level of the direct care work force will be harmful to patients, workers and the quality of care.

Information on staffing can be presented to the public in many ways, but ratios of nursing staff to residents are in fact the easiest for most consumers to monitor on a regular basis. Families making a difficult decision of placing a relative in a nursing home and trying to assess the likely quality of care at a facility would benefit greatly from knowing that facility's average staffing ratios. Residents and family members are simply unlikely to be able to determine aggregate staffing hours per resident per day.

Additional information such as ranking, percentiles and rating systems may be helpful, but are not substitutes for staffing ratios. While the data on CMS's Nursing Home Compare website is useful, we suggest not only breaking it down by type of staff but also by shift and including data on turnover, wages and expenditures for direct care. Data on feeding assistants, medication aides, and other non-nursing personnel should not be included in the same ratios or as part of the same quality measures.

The development of quality measures depends on accurate data on staffing at the facility level. SEIU supports changes to the current self-reported data on OSCAR, including the implementation of a new audited data collection system. SEIU fully supports the recommendations advanced by consumer groups such as the National Citizens Coalition for Nursing Home Reform to more accurately assess data on the direct care work force through payroll data and other means.