REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH ON

NURSING FACILITY STAFFING GUIDELINES REPORT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 29

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Kay Coles James
Secretary of Health and Human Resources

January 6, 1995

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to House Joint Resolution 203, agreed to by the 1994 General Assembly.

This report constitutes the response of the Secretary of Health and Human Resources to this resolution and to review staffing guidelines for nursing facilities and to determine whether staffing requirements currently in effect in the Commonwealth adequately protect the health, safety and welfare of nursing facility residents.

Respectfully Submitted,

Kay Coles James
Secretary of Health and Human Resources

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EXECUTIVE SUMMARY

The 1994 General Assembly requested that the Secretary of Health and Human Resources review staffing guidelines for nursing facilities to determine whether staffing requirements currently in effect in the Commonwealth of Virginia adequately protect the health, welfare and safety of nursing facility residents.

The Virginia Department of Health is the designated State Agency responsible for assuring compliance with Federal regulations pertaining to nursing facility Medicare/Medicaid certification. The 1987 Omnibus Budget Reconciliation Act (OBRA) legislation mandated that nurse staffing in nursing facilities be "sufficient" to meet resident care needs, but specified only that each certified nursing facility have a registered nurse (RN) director of nursing, and a licensed nurse on duty at all times (including an RN eight hours a day). These few specific requirements may be waived in Medicaid facilities; however, Virginia does not allow waivers.

Chapter Five of Title 32.1 of the Code of Virginia requires nursing facilities to be licensed and the State Board of Health promulgates regulations for these facilities. State licensure law must conform to the federal law for certification regarding minimum nursing facility staffing requirements. The State may also require additional conditions for licensure of facilities. Virginia has no additional staffing requirements for licensure. The licensure requirements are the same as the Federal certification requirements.

A study conducted by the National Committee to preserve Social Security and Medicare (November, 1993) found that only 5 percent of the 15,043 federally certified nursing facilities meet a recommended minimum standard for staffing.

Staffing is the primary resource allocation issue in managing a nursing facility. It is also the vehicle for ensuring adequate care to a very vulnerable population.

Methodology

- Formation of a task force representing consumers, advocates, providers and interacting state agencies to review data and make recommendations.
- Survey of forty-four (44) identified states requiring additional nurse staffing. The survey requested information on specific resident outcomes as a result of additional staffing.
- Analysis of data provided by Department of Health Professions, Board of Nursing, regarding nursing staff availability by region and zip code.

- Analysis of Department of Medical Assistance Services' data on Nursing Facility Staffing Ratios for FY 1993 and Virginia Health Care Association's Annual Wage Survey and Nursing Hours Per Patient Day/Resident study.

- Conduct interviews with consumers, advocates, and providers.

- Review of current studies/literature addressing nursing facility staffing standards.

Analysis

- Additional nurse staffing requirements are not necessary to ensure the health, welfare and safety of residents. Current nursing facility staffing equals or exceeds staffing in states with mandated staffing requirements. Sixty-one percent (61%) of respondents interviewed believe current nursing facility staffing requirements ensure the health welfare and safety of residents.

- Complaints/adverse actions have no direct correlation to level of nurse staffing. Lack of a comprehensive employee orientation, which is facility specific, has a direct correlation to facility complaints.

- None of the forty-four (44) states surveyed have collected objective data on the impact of additional staffing on resident care outcomes.

- Seventy-seven percent (77%) of respondents interviewed believe additional nursing staff are available in the state.

- An increase of one Registered Nurse seven (7) days/week/24 hours/day/facility would increase the 258 providers cost a minimum of $32,659,704.

- Training programs in customer service addressing cultural diversity, stress management and communication skills are not offered to employees of all nursing facilities.

- The Congress of the United States, following 1993 hearings on the current state of staffing of nursing personnel in hospitals and nursing facilities, directed the Secretary of the Department of Health and Human Services to request a study from the Institute of Medicine, National Academy of Sciences, to determine whether and to what extent there is a need for an increase in the number of nurses in hospitals and nursing facilities in order to promote the quality of patient

care. The results will be available in 1996.

Recommendations

The Task Force recommends the following:

1. The Virginia Department of Health/Office of Health Facilities Regulation, Long Term Care Division Subgroup Two whose membership includes industry providers and advocates, responsible for review and revision of nursing facility regulations should:

   a. Consider requiring for all nursing facility staff a comprehensive facility-specific orientation to include, but not be limited to, life safety policies/procedure, patient rights, and dignity issues.

   b. Consider requiring a customer service program for all nursing facility employees regarding the aging process, cultural diversity, and mechanisms to cope with and avoid confrontational situations.

2. The Virginia Department of Health/Office of Health Facilities Regulation, should continue to collect and study, in cooperation with industry providers and advocates, available data on nursing facility staffing, and reconvene the Task Force to review the Institute of Medicine study on nurse staffing when it is published in 1996.

Introduction

House Joint Resolution Number 203 of the 1994 Legislative Session of the Virginia General Assembly requested the Secretary of Health and Human Resources to review staffing guidelines for nursing facilities.

The Resolution was based on the following concerns:

- elderly and disabled residents are very important to the Commonwealth and every effort should be made to ensure that they receive quality care in nursing facilities;

- Article 1 (Section 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia requires nursing facilities to be licensed and the State Board of Health promulgates regulations for these facilities; however, guidelines do not exist that dictate staffing requirements beyond meeting the medical needs of residents in nursing facilities;

- staffing is the vehicle for providing satisfactory care to a vulnerable group of the Commonwealth's population;

- a study by the National Committee to Preserve Social Security and Medicare found that only 5% of the 15,043 federally certified nursing facilities meet an expert recommended minimum standard for staffing;

- according to a 1989 survey of Virginia Hospitals and Nursing Facilities, the state of Virginia had a total of 212 nursing facilities with a cumulative total of 31,831 beds; this accounts for roughly 5% of the 664,000 residents of Virginia aged 65 years and over;

- the establishment of higher standards for staffing in nursing facilities would lead to higher quality care and would enable increased supervision for residents, thereby reducing the number of medical emergencies.

The Secretary of Health and Human Resources appointed the State Health Commissioner/Office of Health Facilities Regulation (OHFR) to design and direct the study. The Commissioner and the Director of the OHFR chose a multi-tiered study approach to assure that all concerns expressed in the Resolution were addressed, and that the views of a representative cross-section of interested organizations and individuals were reflected in any findings and recommendations.

Consistent with this approach, the Commissioner appointed interagency representatives to provide information and assistance to the study director. A network of expert organizations and providers as well as individuals with an interest in nurse staffing in nursing facilities were appointed to the Task Force.

The Virginia Department of Health (VDH) is the designated State Agency responsible for assuring compliance with Federal regulations pertaining to Nursing Home Medicare/Medicaid certification. The 1987 Omnibus Budget Reconciliation Act (OBRA) legislation mandated that nurse staffing in nursing facilities be "sufficient" to meet resident care needs, but specified only that each certified facility have a registered nurse director of nursing and a licensed nurse on duty at all times (including a registered nurse eight hours a day). These few specific requirements may be waived in Medicaid facilities; however, Virginia does not allow waivers.

Chapter 5 of Title 32.1 of the Code of Virginia requires nursing facilities to be licensed and the State Board of Health promulgates regulations for these facilities. State licensure law must conform to the federal law for certification regarding minimum nursing facility staffing requirements. The State may also require additional conditions for licensure of facilities. At the present time, the State has no additional staffing requirements for licensure. The licensure requirements for Virginia are the same as the Federal certification requirements.

Staffing is the primary resource allocation issue in managing a nursing facility. It also is the vehicle for ensuring adequate care to a very vulnerable population.

The Task Force developed the following objectives for the study:

- To evaluate the patient outcomes/impact of additional staffing requirements.
- To assess the efficacy of current state staffing requirements by comparing selected outcomes identified in the survey of states with additional staffing requirements.
- To estimate the financial impact of additional staffing requirements.
- To determine the availability of nursing staff for additional staffing requirements.
- To recommend staffing guidelines based on objective data resulting from the study.

The Task Force adopted the following study methods to meet the objectives. (See Work Plan Appendix)

- Formation of a task force representing consumers, advocates, providers and interacting state agencies to review data and make recommendations.

- Survey of forty-four (44) identified states requiring additional nurse staffing. The survey requested information on specific resident outcomes as a result of additional staffing.

- Analysis of data provided by the Department of Health Professions, Board of Nursing, regarding nursing staff availability by region and zip code.

- Analysis of the Department of Medical Assistance Services' data on Nursing Facility Staffing Ratios for FY 1993 and the Virginia Health Care Association's Annual Wage Survey and Nursing Hours Per Patient Day/resident study.

State agencies which contributed to the study through data collection/presentation were the Department of Medical Assistance Services (DMAS) for reimbursement considerations and Fulltime Equivalent (FTE) per nursing facility bed analysis in collaboration with the Health Services Cost Review Council. The Department of Health Professions contributed the distribution of licensed/certified nursing staff by geographical region. The Department of Aging's State Ombudsman Program and the OHFR presented an analysis of complaints received for nursing facilities. In addition, forty-four (44) agencies in other states, identified through the Preserve Social Security and Medicare Study (1993) as having additional state mandated staffing requirements, were surveyed. The Task Force also conducted 100 interviews with consumers, providers and advocates regarding adequacy of nursing facility staffing.

An analysis of nursing hours per patient day (nhppd)/resident was presented using data collected by Ernst and Young for the Virginia Health Care Association.

The state survey, interviews, staffing and financial data provided the information to respond to the objectives of the study.

CURRENT NURSE STAFFING IN VIRGINIA NURSING HOMES

The National Committee to Preserve Social Security and Medicare study (November, 1993) found that only 5 percent of the 15,043 federally certified nursing facilities meet a recommended minimum standard for staffing. The study also identified forty-four (44) states that currently have state mandates for additional nurse staffing requirements in nursing facilities.

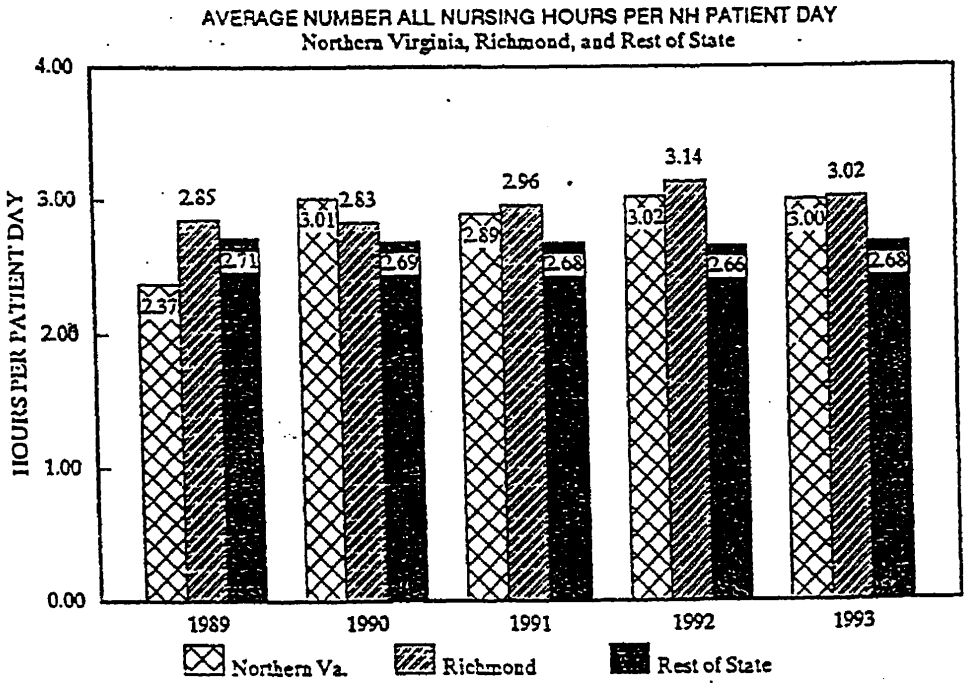
The Task Force surveyed the forty-four (44) states requesting their staffing guidelines, the impact/outcome of additional staffing and whether additional funding was provided for the increased staffing requirements. There was a 71 percent return rate for the survey questionnaire. Six (6) of the states, (14 percent), replied they did not pass regulations requiring additional staffing. One reason given was the high cost associated with increasing staff. The majority of states responded that they based their staffing on nursing hours patient per day (nhppd)/resident. The range of required nhppd/resident was 1.0-3.0. The average required was 2.2 nhppd/resident. Only 7 percent of the states used a caregiver:resident ratio. Increased reimbursement through Medicaid occurred in 25 percent of the surveyed states. None of the states had collected data regarding the impact/outcome of additional staff or quality of life and care issues for residents. Nor could they provide data regarding the impact on patient/family complaints, incidence of patient restraints or staff attrition. Forty-one percent of the states surveyed did not participate in sub-acute programs for nursing facilities, 12 percent did and 7 percent were considering pilot programs.

There are currently no national standards for nhppd/resident for nursing facilities and no definitive studies have been done on this issue. However, the Task Force believed it was important to learn the current staffing standards employed throughout Virginia.

The Virginia DMAS, Quality Care Assurance Division, completed nursing facility staffing ratios for FY 1993 from information reported to the Virginia Health Services Cost Review Council (VHSCRC). In addition, the Virginia Health Care Association contracted with Ernst and Young to complete an annual wage survey which provided data regarding nhppd/resident from 1989 through 1993. The data from these studies demonstrates that Virginia nursing facility staffing currently equals or exceeds the required mandated nhppd in other states. Virginia statewide averages 2.76 nhppd/resident, with a range of 2.68 - 3.02 nhppd (Bar Graph 3). The surveyed states had not collected data on the impact/outcomes of mandated staffing requirements, nor does Virginia have data regarding impact/outcomes of current staffing. The current lack of national staffing standards and the impact of staffing on resident outcomes will be addressed in a study the 1994 Congress authorized

the federal Institute of Medicine to undertake. A provision of the 1993 law authorized the Institute of Medicine, an arm of the National Academy of Sciences, to conduct a study to determine "to what extent there is a need for an increase in the number of nurses in hospitals and nursing facilities in order to promote the quality of patient care and reduce the incidence among nurses of work-related injuries and stress: The Institute of Medicine and an appointed committee of fifteen (15) healthcare experts will undertake a twenty-two (22) month study regarding the overall adequacy and skill mix of nurses in hospitals and nursing facilities. This study is being undertaken in response to concerns by the American Nurses Association and Service Employees International Union. Study results will be available in 1996.

NURSE STAFFING IN VIRGINIA NURSING HOMES
Graph 3



Base data from VHCA Annual Wage Surveys by Ernst & Young.
Average hours per patient day computed by VHCA. Excludes DON.

This graph shows the average number of all nursing personnel hours provided per patient day in Virginia nursing homes. The data is organized and displayed here according to nursing home location by "peer group" for Medicaid reimbursement.

These results were computed by VHCA from data provided in VHCA's Annual Wage Surveys, conducted for VHCA by Ernst & Young. VHCA's Annual Wage Surveys typically cover more than 60% of Virginia's nursing home beds.

The VHCA survey collects data on the number of FTE (full-time-equivalent--2000 hours per year) personnel in most occupational categories in nursing homes. The survey includes all categories of nursing personnel--RNs, LPNs, and CNAs (certified nurse aides/nurse assistants). The VHCA Wage Survey and this data omit the Director of Nursing in each facility.

Conversion of the number of nursing personnel FTEs into nursing personnel hours per patient day incorporates the fact that Virginia nursing home beds are in the aggregate 93% occupied.

Availability Of Staff

The Task Force requested the Department of Health Professions, Board of Nursing to collect data regarding the distribution of licensed and certified nursing staff throughout the state by region and zip code. The total current Virginia licensees are : Registered Nurses (RN) 55,981; Licensed Practical Nurses (LPN) 22,388; Certified Nurse Assistants (CNA's)30,855. The Task Force's interviews with consumers, advocates and providers found that 77 percent of respondents believe additional nursing staff are available in the state.

However, the Task Force was concerned that there was a perception that nursing facilities used an excessive amount of temporary staff, especially CNA's who had not been properly oriented to the specific facilities and individual residents. Virginia's current licensing regulations, Section 14.2.6, require "When temporary personnel are used by the nursing home each such temporary employee shall receive sufficient orientation in the nursing care and emergency policies and procedures of the home." The DMAS/VHSCRC study of "Nursing Facility Staffing Ratio's for Fiscal year 1993" demonstrated that utilization of temporary staff by all nursing facilities for FY 93 was 0-0.1 Full Time Equivalent (FTE)/year (Figure 6). This means overall that few of the available temporary staff were utilized.

Correlation Between Staffing Levels And Facility Complaints

This study was undertaken to ensure that current nursing facility staffing was adequate to ensure the health, welfare and safety of residents. The Task Force requested data from the Department for the Aging, State Ombudsman and OHFR regarding complaints received about nursing facilities to determine if there was any correlation to staffing levels. The Office of the State Long Term Care Ombudsman received a total of 1052 complaints during FY 93. Seventy-five percent of these complaints were directed towards nursing facilities. The number of complaints per nursing facility ranged from one to forty-five. Thirty-three percent of all complaints received involved only eight nursing facilities. Fifty-five percent of all complaints received involved twenty-one (21) nursing facilities or 8 percent of the total nursing facilities in Virginia. The majority of complaints received (60 percent) involved resident care. Approximately 41 percent of complaints closed were verified. To determine if there was any correlation between staffing levels and complaints received, the DMAS Quality Assurance Division studied the FTE/bed ratios for those twenty (20) selected nursing facilities with high levels of complaints filed by residents or their representatives. The facilities ranged from 56 beds to 230 beds. Total FTE's per bed ranged from 0.520 to 1.293. The distribution by facility of total

FTE's to number of beds, with selected high complaint facilities, was compared to the distribution by facility of total FTE's to number of beds and no significant difference was found. One of the facilities with the highest number of complaints also had the highest staffing levels (Figure 8, 9).

The OHFR Complaint Unit receives approximately 1600 complaints each year. Ninety percent of those received are regarding nursing facilities. Sixty percent of the complaints are made by family members of nursing facility residents and 40 percent are facility reported incidents as required by regulation. These complaints were reviewed for correlation between staffing issues and adverse actions to staffing levels.

The OHFR used the methodology of random sample (representative sampling) for this data analysis. The samples were chosen that were considered to be typical or representative of the complaints received in this office between October 1992 and September 1993. A list of facilities with twenty (20) or more complaints was submitted to this office from the Office of the State Long-Term Care Ombudsman. These were included in this data analysis. This office reviewed all facility adverse actions initiated during this same time period to determine if there was a correlation between the number and type of complaints and initiated facility adverse actions. An adverse action is initiated when the facility is significantly out of compliance with program requirements. If the facility does not achieve compliance within a mandated time frame their participation in Medicare and/or Medicaid may be terminated.

The complaint log for this time period was reviewed. Data from this log was then organized into sections which identified the facility and the numbers of complaints received during the above time period. The number of complaints per facility ranged from one (1) to forty-three (43). Thirteen facilities with twenty or more complaints were then selected for manual review. These facilities ranged from 90 beds to 385 beds.

The manual review was done to determine what type of staffing issues were involved in the complaints. The following data was obtained:

1. Inadequate staffing and training (Certified Nurse Assistants) 18

2. Inadequate training 10

3. Temporary agency staffing issues (training) five

The majority of the complaints dealt with other issues in the nursing facility setting, i.e., dietary/food, medication, residents' rights and environmental issues.

The facilities with twenty (20) or more complaints were compared with the initiated adverse action list for this same time period. Two of the thirteen (13) were involved in initiated adverse actions. A manual review of the nine facilities involved in initiated adverse actions was conducted. This review disclosed that there was no correlation between the number of complaints (staffing or otherwise) and facility-initiated adverse actions. A further review was undertaken to determine the types of staffing issues involved in initiated adverse actions. Six of the ten facilities had citations for not complying with federally- mandated training/staffing requirements of personnel, particularly CNA's.

It was determined from these two data sources (complaints and initiated adverse actions) that inadequate training for nursing facility employees, particularly CNA's, in the nursing facility industry may impact on the quality care for the residents.

Financial Impact of Additional Staffing

Nursing facilities are a labor intensive industry with over 50 percent of the direct costs attributed to nursing staff salaries. The Task Force was concerned regarding the cost impact versus benefit of additional staffing requirements.

The Committee to Preserve Social Security and Medicare Study (1993) identified forty-four (44) states that had state mandated additional staffing requirements. However this study's state survey found that six (6) (Nevada, Iowa, Arizona, Wyoming, South Dakota, and Missouri) had not passed legislation requiring additional staffing. Missouri reported that its governor would not adopt legislation recommending an increase of 1.73 nhppd due to the cost. The state survey respondents indicated only 25 percent of those states that had increased staffing requirements increased Medicaid reimbursement to facilities to assist in the increased cost of additional staff. None of the states surveyed had collected objective data to determine the impact/outcomes of additional staff. Therefore, no data has been provided through the state survey to determine the benefit or outcomes of additional nursing staff. The cost of proposed additional nurse staffing did deter legislation in some states considering mandating additional staffing requirements.

In Virginia, DMAS has budgeted $404,240,000 for FY 95 directed to the reimbursement for nursing facility care. FY 96 is budgeted for $434,113,000 which is a 7.4 percent increase in funds. This amount was determined by DMAS base budget and adjusted to reflect legislative amendments and utilization/inflation trends. Approximately 70 percent of nursing facility residents in non-profit, proprietary and state/local nursing facilities receive services through Medicaid funding. The total number of Medicaid enrolled nursing facilities is 258. The total number of Medicaid

reimbursed nursing facility days is 6,949,941. The average Medicaid reimbursement per day is $63.57 or $23,263 per year. The 1993 average reimbursement/recipient was $12,827. The approximate average daily number of Medicaid recipients receiving nursing facility services is 19,041. Medicaid reimbursement to nursing facilities is based on the sum of three (3) components: direct costs; in-direct costs; and capital costs. The direct costs are modified by the facility's service intensity index (SII) score which is determined by the patient intensity rating system (PIRS). A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the established ceiling (ceiling is not applied toward capital cost). The rates, which are determined on a facility-by-facility basis, are based on annual cost reports filed by each provider and on peer-group ceiling rates.

On an average, approximately 44 percent of the facility's rate is determined by direct costs, of which nurse staff is primary; approximately 42 percent by in-direct costs and approximately 14 percent for capital costs.

The PIRS system is based on budget neutrality. Reimbursement is made to a nursing facility based on the facility's service intensity index score (determined by a compilation of individual resident intensity levels) relationship to the state norm (determined by a compilation of all facility services intensity index scores).

Nursing facility residents are each scored as belonging to one of three classifications. Ratings are based on formulas incorporating resident functional limitations (determined by level of independence in activities of daily living [ADL]) and medical nursing needs. Class A residents (ADL score of six (6) or less and no medical/nursing needs) are the most independent residents. Class B residents have an ADL score of seven (7) to twelve (12) with no medical/nursing needs. Class C residents are the most dependent and require medical nursing needs (ADL score of nine to twelve with medical/nursing needs).

The Task Force's interviews with advocates, consumers, and providers resulted in 23 percent of the respondents stating that Medicaid would provide additional funding for increased staff. Twenty percent believe additional funding would be provided by increasing charges to private pay residents and 19 percent did not know where additional funding would be generated.

The VHCA contracts with Ernst and Young to conduct an annual wage survey of Virginia Nursing Facilities. The 1993 survey findings were statewide: current year average hourly wage rate for all Registered Nurses $14.49; current year average hourly wage rate for Licensed Practical Nurses' $10.66; current year average hourly

wage rate for all CNA's is $5.86. The study findings do not warrant additional nurse staffing requirements; however, the Task Force reviewed the cost of requiring an additional registered nurse 24 hours/day, seven days a week. The minimum direct costs of salary would be $126,588/facility for additional nurse staff requirements. This does not include benefits which would be an additional 20-25 percent of base salary of $30,140/nurse/yr. There are currently 258 nursing facilities in Virginia. The total cost for mandating an additional RN 24 hours/day/seven days a week would be $32,659,704. Eleven (11) nursing facilities are owned/operated by cities/counties. The costs to these localities would be $1,392,468. Mandating additional staff is not warranted nor can a cost/benefit be demonstrated. However, based on interviews with advocates, consumers and providers there is a need for all nursing facility staff to become more aware of customer service needs. The cultural diversity of staff and residents should be discussed in orientation and on an ongoing basis. Staff development addressing coping skills and stress management should also be addressed. The cost to providers would be minimal as orientation and staff development costs are already in place. A new focus for existing orientation and staff development would be required.

The Task Force also found through interviewing advocates, consumers and providers that facility orientation for all staff should include but not be limited to : patient rights, patient dignity, quality of life issues and life safety issues.

Sixty-one percent of the interview respondents believe current nursing facility staffing requirements ensure the health, welfare, and safety of residents. The Task Force concurs with the interview respondents and the study, that the findings do not demonstrate that additional mandated nurse staffing is required through the promulgation of state regulations.

RECOMMENDATIONS

The Task Force was guided in its review by statutory and administrative policies that restrain the use of the regulatory authority of the Commonwealth, unless it can be clearly demonstrated that regulation is required to ensure the health, welfare, and safety of the citizens of the Commonwealth.

It was also clear to the Task Force that problems identified in nursing facilities in the decade of the 80's have been addressed by voluntary private sector quality assurance initiatives. These initiatives were prompted by the 1987 OBRA legislation and by marketplace evolution.

Those states that have implemented regulatory approaches to the resolution of concerns related to nursing facility staffing have no objective data that they have been any more effective in improving nursing facility resident patient care outcomes to warrant regulatory costs. Several of these states have abandoned or withdrawn their initiatives regarding nursing facility staffing.

However, the Commonwealth of Virginia will continue to monitor nursing facility staffing standards to ensure the health, welfare and safety of nursing facility residents.

The Task Force recommends the following:

1. The VDH/OHFR Long Term Care Divison Subgroup Two, whose membership includes industry providers and advocates, responsible for the review and revision of nursing facility regulations to be promulgated in 1995 should:

   a. Consider requiring for all nursing facility staff, a comprehensive facility-specific orientation to include, but not be limited to, life safety policies/procedures, patient rights, quality of life and dignity issues.

After reviewing complaints and adverse actions, the Task Force found that many employees were not thoroughly oriented to the nursing facility policies and procedures.

   b. Consider the establishment of a customer service program regarding the aging process, mechanisms to cope with and avoid confrontational situations, and cultural diversity.

The literature review by task force members demonstrated that the majority of nursing facility staff do not have special geriatric training or experience. Those nursing facilities that educate staff in customer service programs have improved resident/staff communication and services.

2. The VDH/OHFR should continue to collect and study in cooperation with industry providers and advocates, available data on nursing facility staffing, and reconvene the Task Force to review the Institute of Medicine Study when it is published in 1996.

The Task Force found there are no national standards for nursing facility staffing available. The data collected for this study is the initial review of current staffing in Virginia. Virginia nhppd/resident equal or excel other states practices. The Institute of Medicine study will be the first national initiative to review nursing facility staffing.

Nursing facility staffing ratios for fiscal year 1993

Virginia Department of Medical Assistance Services
Quality Care Assurance Division
August 1994

This document was compiled from information reported to the Virginia Health Services Cost Review Council by nursing facilities about the numbers and types of paid full time equivalents in their facilities during fiscal year 1993, and the number of licensed beds in these facilities as reported by the Virginia Department of Health.

Tables

Figures

Table 1: Distribution of FTEs per bed categories among 276 nursing facilities for fiscal year 1993 by types of facility staff

Category of number of FTEs per bed	RN FTEs	LPN FTEs	Nurse Aide FTEs	Contract FTEs	Other FTEs	Total FTEs	Total RN, LPN, Nurse Aide FTEs
0.0 < 0.1	252	94	8	269	9	0	0
0.1 < 0.2	17	165	6	7	12	5	7
0.2 < 0.3	7	9	59	0	107	1	2
0.3 < 0.4	0	3	132	0	90	2	19
0.4 < 0.5	0	1	51	0	31	1	123
0.5 < 0.6	0	1	15	0	5	3	62
0.6 < 0.7	0	1	3	0	4	32	35
0.7 < 0.8	0	1	0	0	4	80	12
0.8 < 0.9	0	0	0	0	3	56	4
0.9 < 1.0	0	0	0	0	5	39	4
1.0 < 1.1	0	0	1	0	2	17	4
1.1 < 1.2	0	0	0	0	0	11	1
1.2 < 1.3	0	0	0	0	1	9	1
1.3 < 1.4	0	0	0	0	0	5	1
1.4 < 1.5	0	0	0	0	0	0	0
1.5 < 1.6	0	0	0	0	0	2	0
1.6 < 1.7	0	1	0	0	0	2	0
1.7 < 1.8	0	0	0	0	0	0	0
1.8 < 1.9	0	0	0	0	0	0	0
1.9 < 2.0	0	0	0	0	1	3	0
2 or more	0	0	1	0	2	8	1

Table 2: FTE per bed ratios for 20 selected facilities with high levels of complaints filed by residents or their representatives

Facility	Number of beds	RN FTEs per bed	LPN FTEs per bed	Nurse Aide FTEs per bed	Contract FTEs per bed	Other FTEs per bed	Total FTEs per bed	Combined RN, LPN, Nurse Aide FTEs per bed	Contract FTEs as percentage of total FTEs
A	230	0.091	0.070	0.347	0.040	0.269	0.818	0.509	4.944
B	225	0.044	0.120	0.404	0.000	0.262	0.831	0.569	0.000
C	180	0.022	0.161	0.367	0.061	0.233	0.844	0.550	7.237
D	180	0.012	0.114	0.369	0.000	0.224	0.719	0.495	0.000
E	180	0.026	0.118	0.295	0.000	0.259	0.699	0.439	0.000
F	180	0.024	0.124	0.305	0.000	0.233	0.686	0.453	0.000
G	173	0.012	0.092	0.266	0.000	0.150	0.520	0.370	0.000
H	145	0.037	0.086	0.295	0.000	0.235	0.654	0.419	0.000
I	143	0.041	0.090	0.343	0.042	0.258	0.773	0.473	5.425
J	141	0.016	0.106	0.298	0.000	0.289	0.709	0.420	0.000
K	120	0.022	0.150	0.351	0.000	0.267	0.789	0.523	0.000
L	120	0.025	0.124	0.320	0.003	0.308	0.781	0.469	0.427
M	120	0.028	0.122	0.333	0.008	0.266	0.757	0.483	1.101
N	120	0.018	0.107	0.273	0.000	0.255	0.653	0.398	0.000
O	109	0.034	0.119	0.329	0.000	0.301	0.783	0.483	0.000
P	60	0.071	0.296	0.530	0.093	0.403	1.393	0.897	6.657
Q	60	0.042	0.108	0.338	0.002	0.343	0.833	0.488	0.200
R	56	0.045	0.105	0.311	0.000	0.341	0.802	0.461	0.000

Figure 1: Distribution of the number of facilities by total FTEs per bed

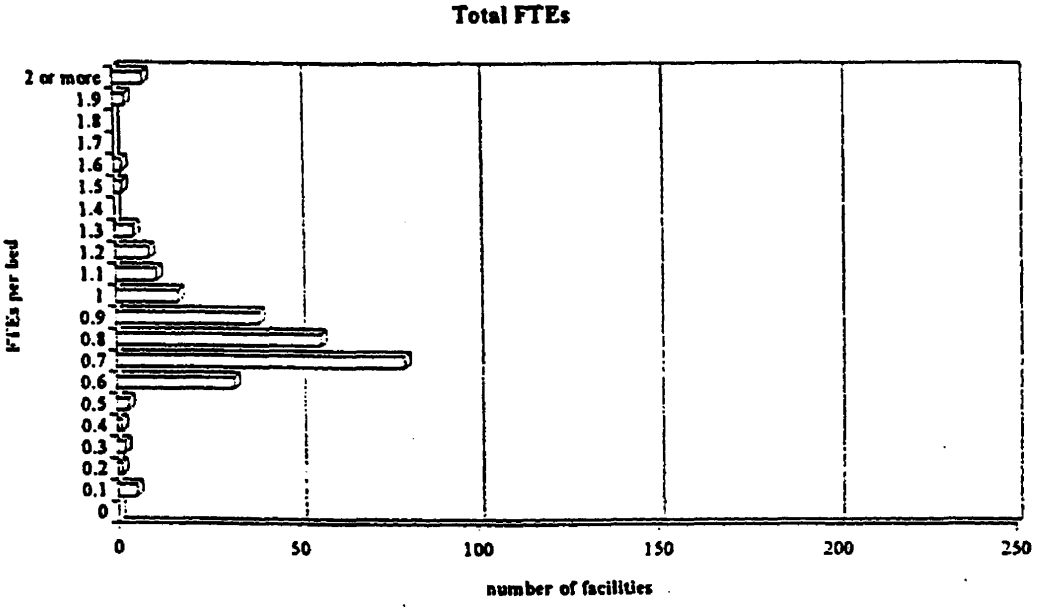


Figure 2: Distribution of the number of facilities by RN FTEs per bed

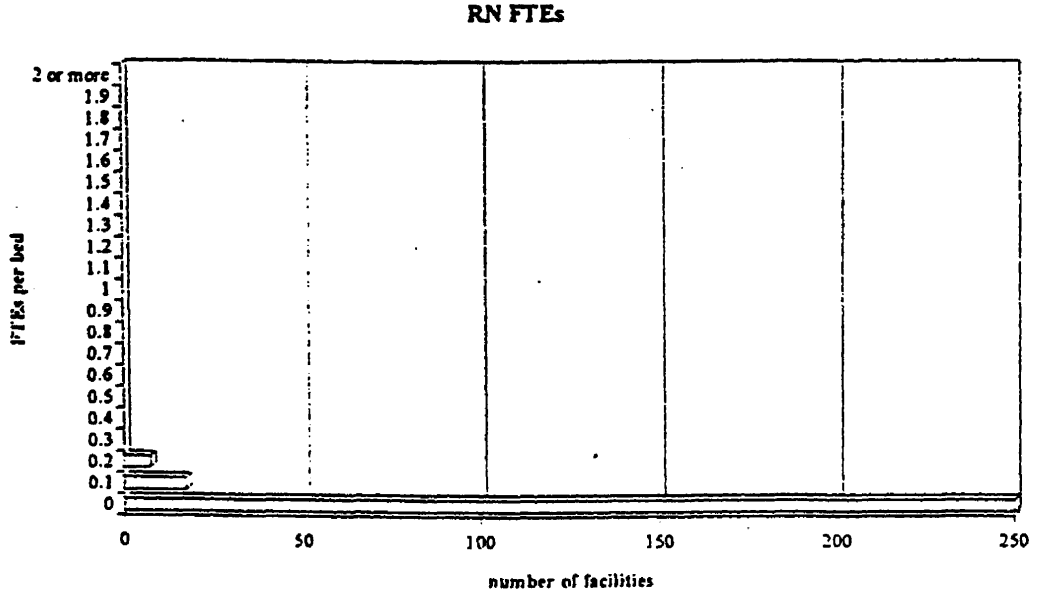


Figure 3: Distribution of the number of facilities by LPN FTEs per bed

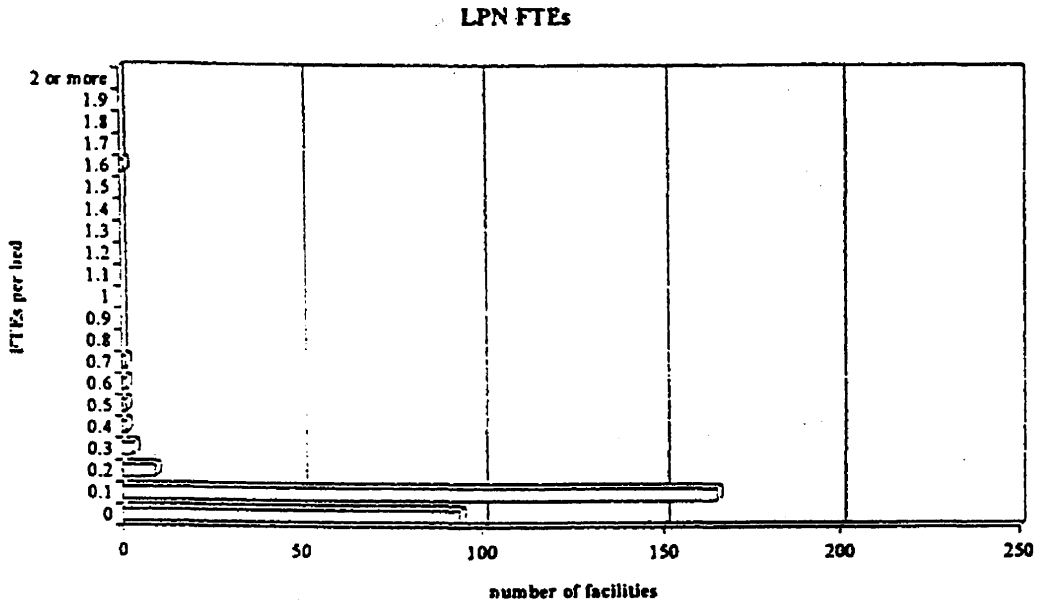


Figure 4: Distribution of the number of facilities by Nurse Aide FTEs per bed

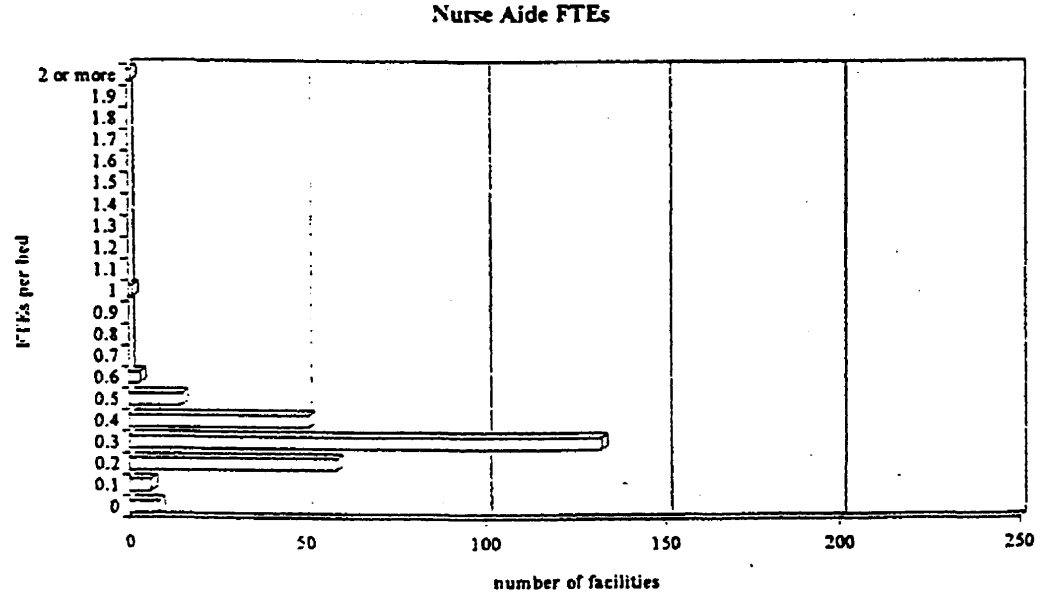


Figure 5: Distribution of the number of facilities by combined RN, LPN, and Nurse Aide FTEs per bed

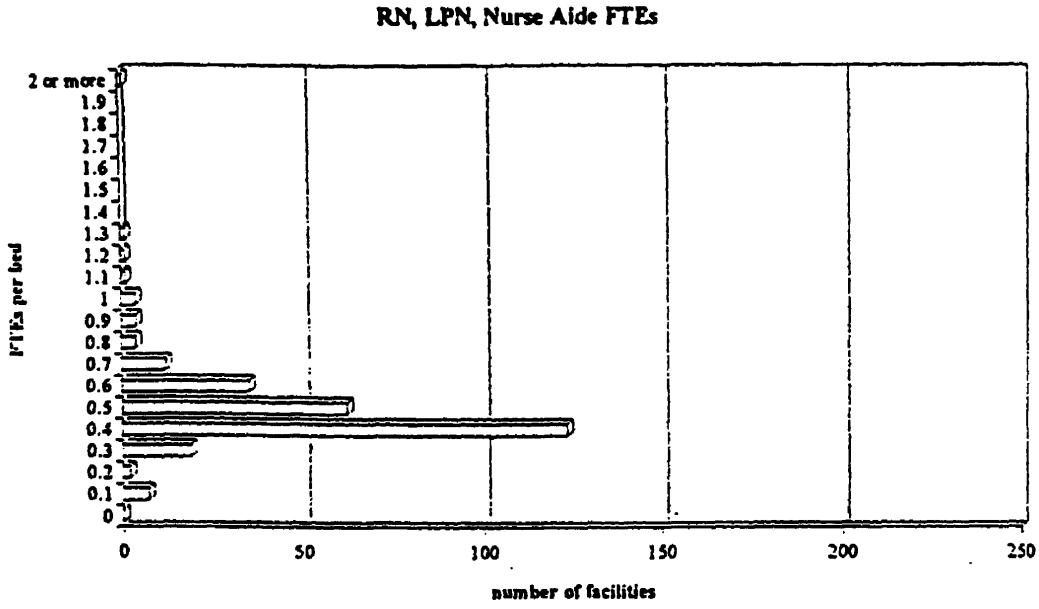


Figure 6: Distribution of the number of facilities by Contract FTEs per bed

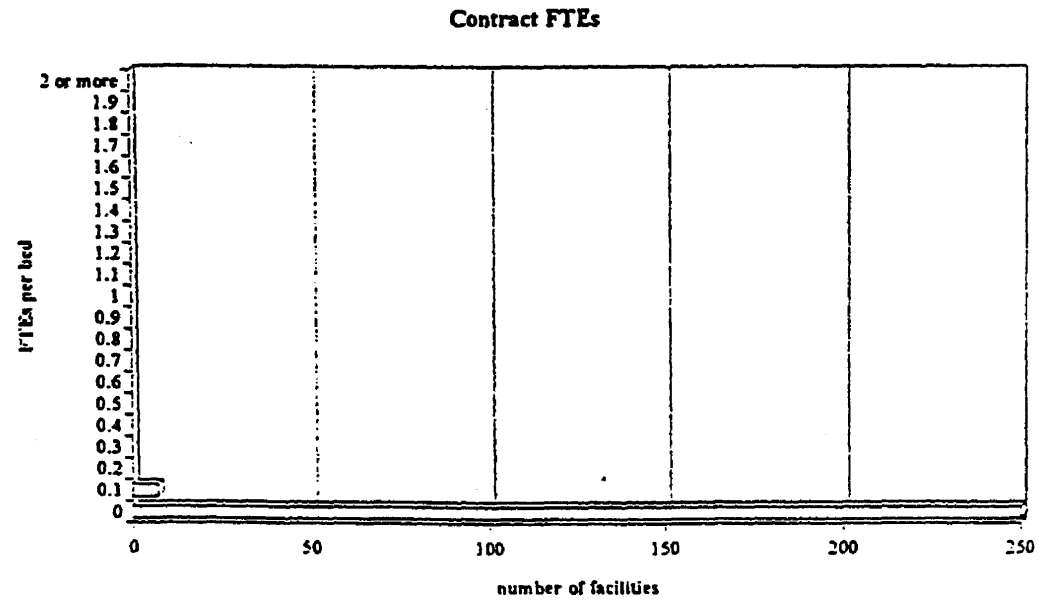


Figure 7: Distribution of the number of facilities by Other FTEs per bed

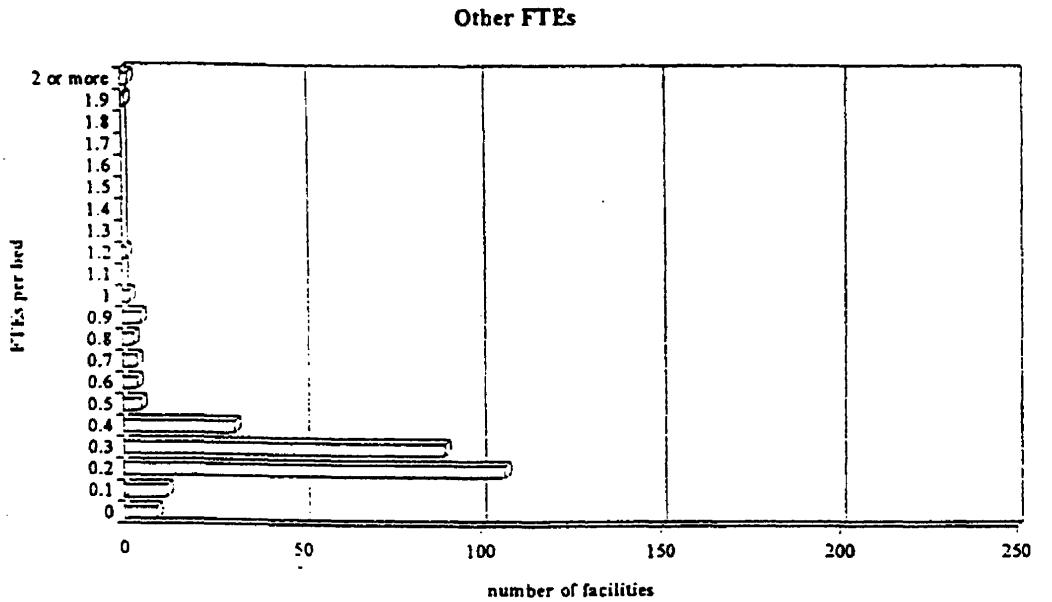


Figure 8: Distribution by facility of total FTEs to number of beds

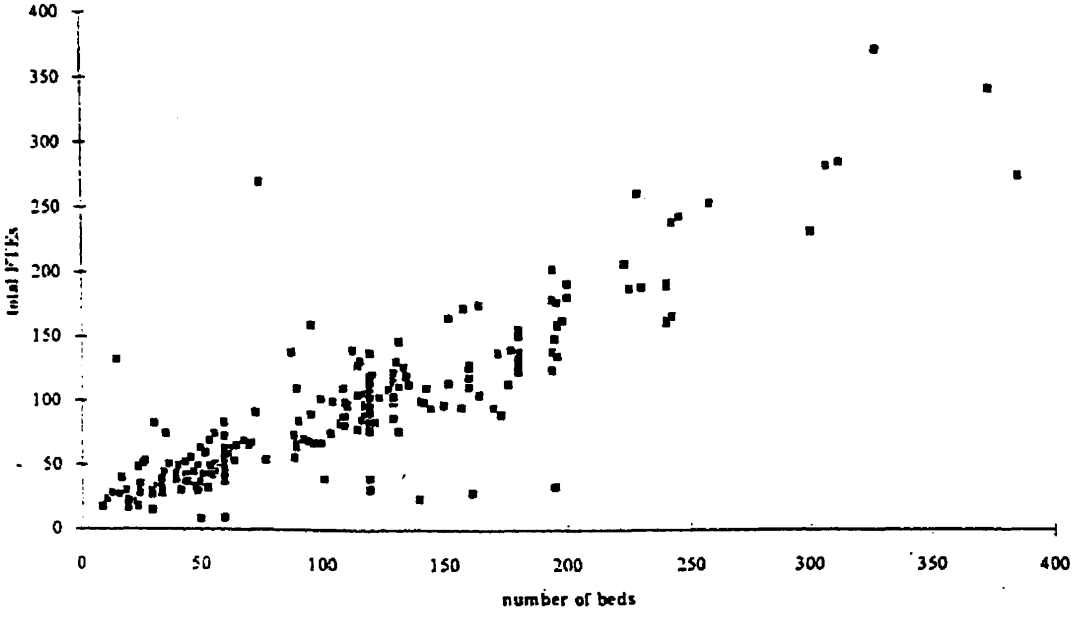
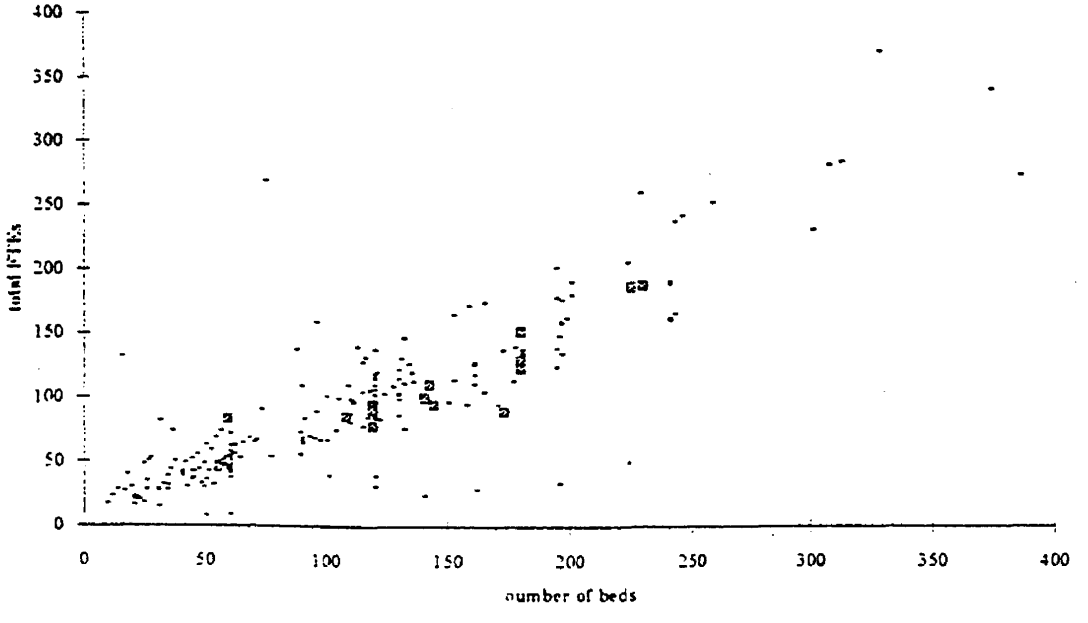
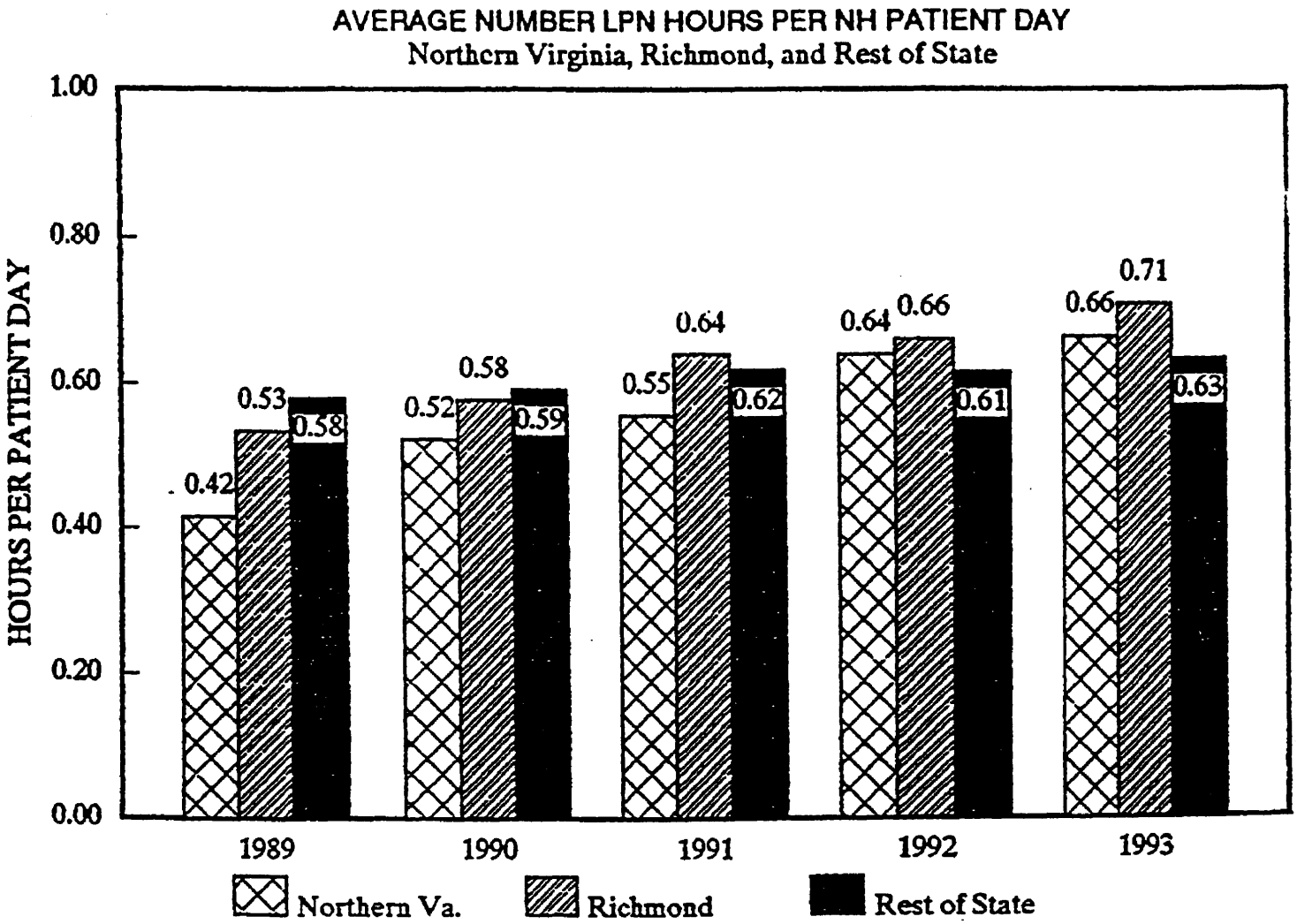


Figure 9: Distribution by facility of total FTEs to number of beds, with selected high complaint facilities highlighted



NURSE STAFFING IN VIRGINIA NURSING HOMES
Graph 1



Base data from VHCA Annual Wage Surveys by Ernst & Young.
Average hours per patient day computed by VHCA.

This graph shows the average number of licensed practical nurse (LPN) hours provided per patient day in Virginia nursing homes. The data is organized and displayed here according to nursing home location by "peer group" for Medicaid reimbursement.

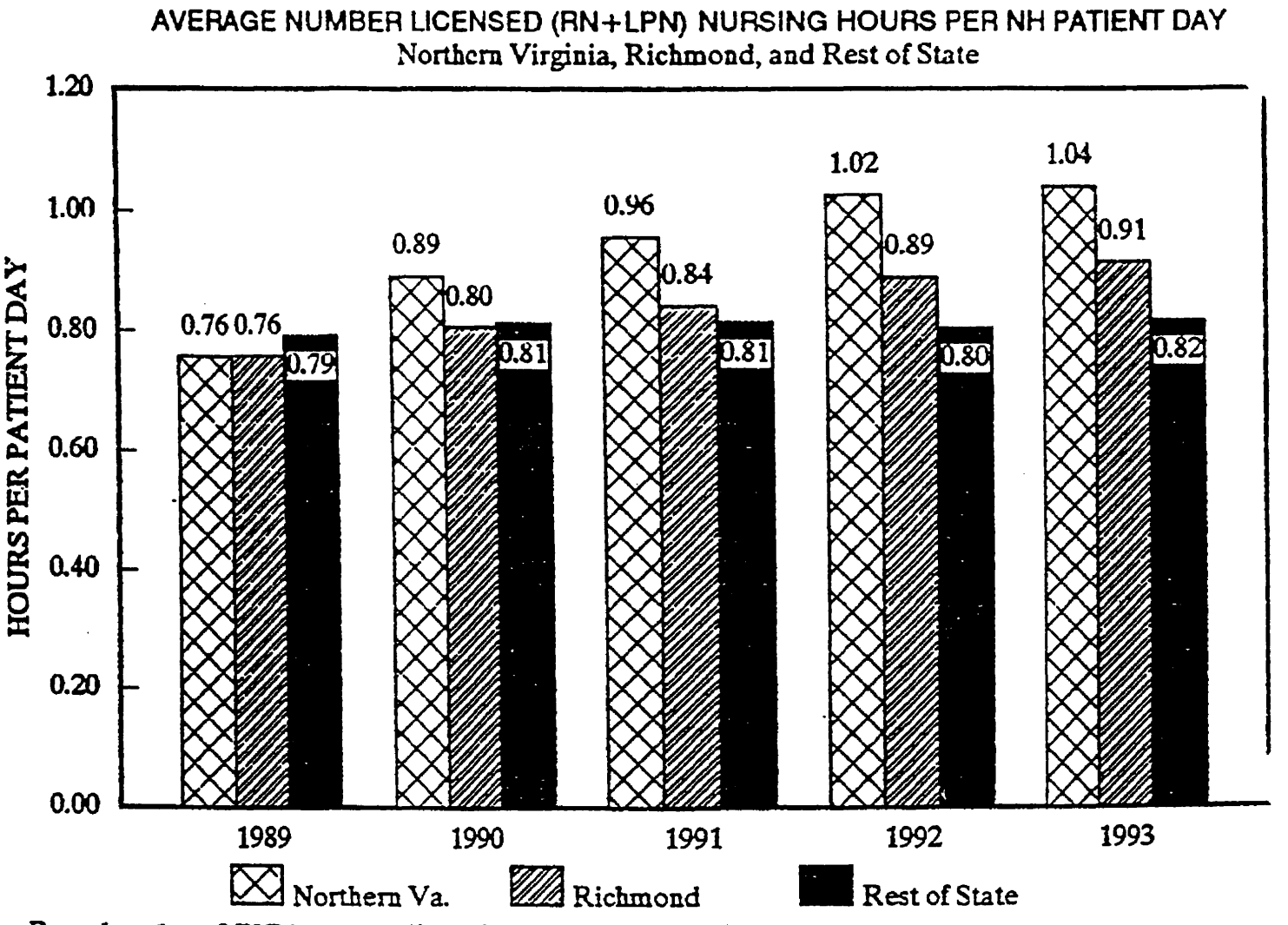
These results were computed by VHCA from data provided in VHCA's Annual Wage Surveys, conducted for VHCA by Ernst & Young. VHCA's Annual Wage Surveys typically cover more than 60% of Virginia's nursing home beds.

The VHCA survey collects data on the number of FTE (full-time-equivalent--2000 hours per year) personnel in most occupational categories in nursing homes. The survey includes all categories of nursing personnel--RNs, LPNs, and CNAs (certified nurse aides/nurse assistants). The VHCA Wage Survey and this data omit the Director of Nursing in each facility.

Conversion of the number of LPN FTEs into LPN hours per patient day incorporates the fact that Virginia nursing home beds are in the aggregate 93% occupied.

VHCA, 8/94

NURSE STAFFING IN VIRGINIA NURSING HOMES
Graph 2



Base data from VHCA Annual Wage Surveys by Ernst & Young.
Average hours per patient day computed by VHCA. Excludes DON.

This graph shows the average number of licensed nurse (RN+LPN) hours provided per patient day in Virginia nursing homes. The data is organized and displayed here according to nursing home location by "peer group" for Medicaid reimbursement.

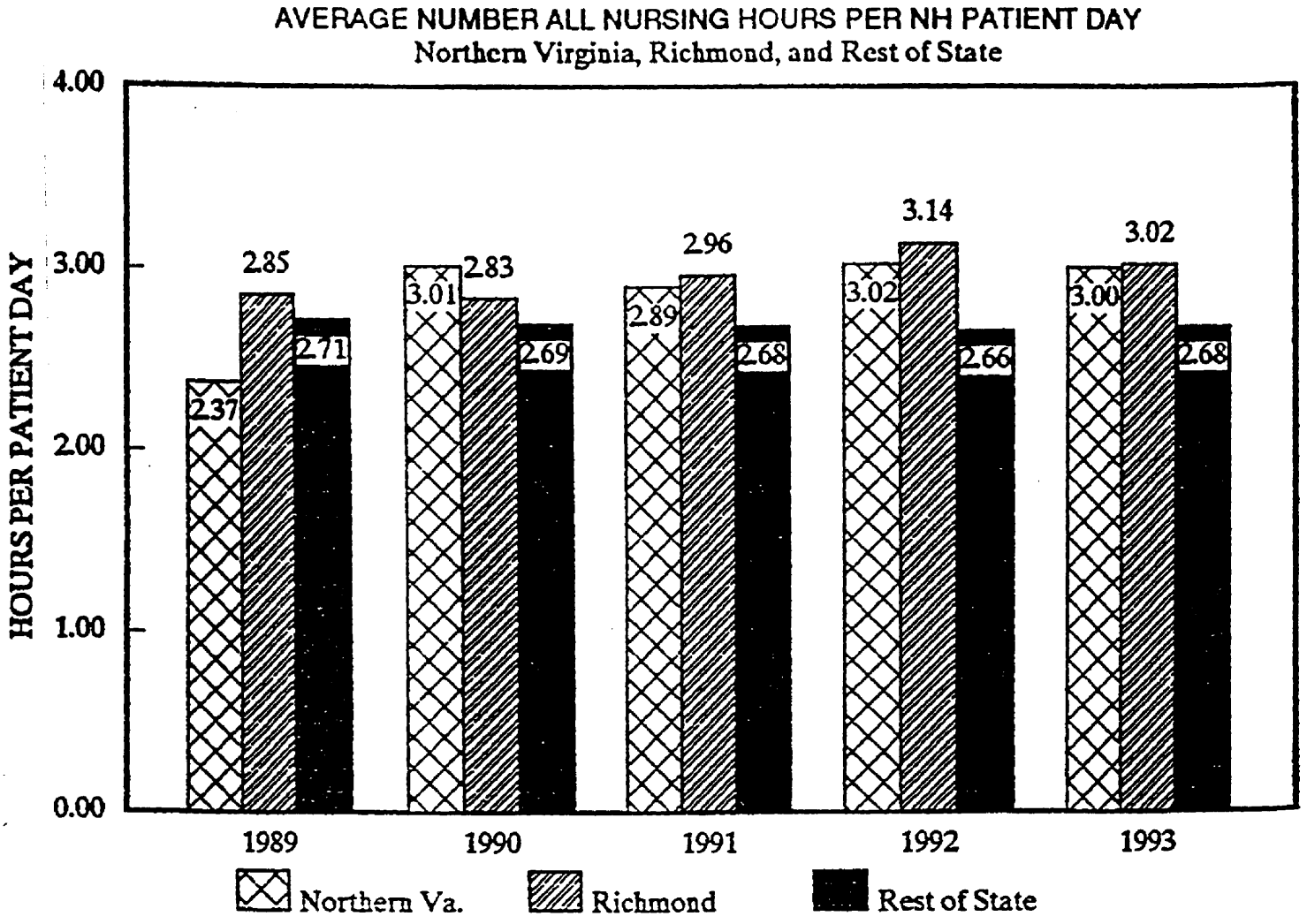
These results were computed by VHCA from data provided in VHCA's Annual Wage Surveys, conducted for VHCA by Ernst & Young. VHCA's Annual Wage Surveys typically cover more than 60% of Virginia's nursing home beds.

The VHCA survey collects data on the number of FTE (full-time-equivalent--2000 hours per year) personnel in most occupational categories in nursing homes. The survey includes all categories of nursing personnel--RNs, LPNs, and CNAs (certified nurse aides/nurse assistants). The VHCA Wage Survey and this data omit the Director of Nursing in each facility.

Conversion of the number of licensed nurse FTEs into licensed nurse hours per patient day incorporates the fact that Virginia nursing home beds are in the aggregate 93% occupied.

VHCA, 8/94

NURSE STAFFING IN VIRGINIA NURSING HOMES
Graph 3



Base data from VHCA Annual Wage Surveys by Ernst & Young.
Average hours per patient day computed by VHCA. Excludes DON.

This graph shows the average number of all nursing personnel hours provided per patient day in Virginia nursing homes. The data is organized and displayed here according to nursing home location by "peer group" for Medicaid reimbursement.

These results were computed by VHCA from data provided in VHCA's Annual Wage Surveys, conducted for VHCA by Ernst & Young. VHCA's Annual Wage Surveys typically cover more than 60% of Virginia's nursing home beds.

The VHCA survey collects data on the number of FTE (full-time-equivalent--2000 hours per year) personnel in most occupational categories in nursing homes. The survey includes all categories of nursing personnel--RNs, LPNs, and CNAs (certified nurse aides/nurse assistants). The VHCA Wage Survey and this data omit the Director of Nursing in each facility.

Conversion of the number of nursing personnel FTEs into nursing personnel hours per patient day incorporates the fact that Virginia nursing home beds are in the aggregate 93% occupied.

VHCA, 8/94

STATE SURVEY ON MANDATED ADDITIONAL STAFFING REQUIREMENTS IN LONG TERM CARE FACILITIES RESPONSE FORM

The state of Virginia is conducting a survey to determine the impact on patient outcomes due to state mandated additional staffing requirements for nursing facilities.

This multiple choice questionnaire is devised to obtain opinions from other state agencies, on this increasingly important issue.

Please mark the appropriate answer with an "X" and use the space provided for additional comments. If you mark increase or decrease for an answer, please include the number or percentage, if available. Please return the questionnaire no later than July 29, 1994, in the provided self-addressed envelope and thank you for your time and interest in completing this form.

****

1a. When did your state implement mandated additional staffing requirements for nursing services in long term care facilities?

b. What was the reason for implementation of this requirement?

c. Did your state have an increase in monetary reimbursement for the additional staffing requirements?

2. Do your state regulations mandate additional staffing for the following: (a) Licensed personnel (b) Unlicensed personnel (c) Both (d) Nursing hours per resident day?

3. Have the mandated additional staffing standards had any noticeable impact on staff stability (attrition) in long term care facilities ?
(a) Yes (b) No (c) No change

4. Have the mandated additional staffing standards had any impact on complaints of abuse (of any type) or citations in abuse ? (a) Increase (b) Decrease (c) No change

5a. Has your state discovered, due to the mandated additional staffing standards, an increased use of "temporary staff" in lieu of permanent staff? (a) Yes (b) No (c) No change

b. If yes to 5a., has your state found the "temporary staff" trained and knowledgeable regarding care of the aging ?

6. Have the mandated additional staffing standards had any impact on the number of complaints and/or citations regarding the use of patient restraints: (a) Increase (b) Decrease (c) No change

7. Have the mandated additional staffing standards had any impact on the number of complaints and/or citations regarding quality of life issues? (a) Increase (b) Decrease (c) No change

8. Have the mandated additional staffing standards had any impact on the number of complaints and/or citations on quality of care issues? (a) Increase (b) Decrease (c) No change

9. Have the mandated additional staffing standards caused a decrease in resident/family complaints vs complaints generated prior to mandated additional staffing ratios ? (a) Yes (b) No (c) No change

10a. Does your state participate in a specialized/sub-acute programs?

b. If yes to 10a., has your state mandated any additional staffing requirements for this program.

NURSING FACILITY STAFFING GUIDELINES

Interview Guide:

1. Do the current NH staffing requirements ensure the health welfare and safety of residents?

2. How would additional staffing requirements impact patient outcomes?

3. How would you recommend structuring additional staffing requirement?

   a) Increasing RN to 24 hour/7 day per week
   b) Ratio - RN: resident
   c) Ratio - Caregivers (RN/LPN/CNA) : resident
   d) Patient assessment to facility judgment

STAFFING GUIDELINES FOR NURISNG FACILITIES - HJR 203
WORK PLAN
FOR DISCUSSION PURPOSES ONLY

Objective #1: To evaluate the patient outcomes/impact of additional staffing requirements in states with such requirements. Responsibility: Ann Adkins

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1A. Identify states with additional staffing requirements.	1.A-1-Analyze 1993 study National Committee to preserve Social Security and Medicare.	Ann Adkins, OHFR	Study Information	05/30/94	06/09/94
	1.A-2-Develop list of targeted study states.		State Listing	05/30/94	06/09/94
1B. Determine impact/outcome of additional staffing requirements.	1.B-1-Develop survey form to be sent to each state identified in Step 1.A. Survey will identify objective outcome indicators and evaluation studies conducted.	Ann Adkins, OHFR	Survey letter to states	06/20/94	08/15/94
	1.B-2-Analyze data received from 1B-1 survey.	Study Group	Summary sheet of data	07/18/94	08/15/94
	1.B-3-Identify key common components of staffing requirements and outcomes.	Ann Adkins, OHFR	Components identified	07/18/94	08/15/94

Objective #2: To assess the efficacy of current state staffing requirements by comparing selected outcomes identified in the survey of states with additional staffing requirements.

Responsibility: Nancy R. Hofheimer

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
2.A. Determine efficacy of current state staffing requirements.	2.A-1-Conduct structured interviews with key actors/stakeholders.	Nancy Hofheimer	Interviews	06/20/94	07/30/94
	2.A-2-Analyze and categorize the results of interviews conducted in 2A-1.	Nancy Hofheimer Study Group	Interview Summaries	07/30/94	08/15/94
	2.A-3-Review of current literature/studies addressing nursing facility staffing standards	Nancy Hofheimer Study Group	Study summaries	06/01/94	08/01/94
2.B. Review specific outcomes of survey.	2.B-1-Analyze survey results of specific outcomes compared to state outcomes.	Nancy Hofheimer	Comparative data	07/30/94	08/15/94

Objective #3: To determine the availability of nursing staff for additional staffing requirements.

Responsibility: Nancy Durette

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
3. Determine availability of nursing staff for additional staffing requirements.	3A. Analyze current availability of nursing staff by state/region.	Nancy Durette	Summary of active nurses licensed/ certified	06/20/94	07/30/94

Objective #4: To estimate financial impact of additional staffing requirements. **Responsibility:** Mary Chiles/VHCA/VANPHA

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
4.A. Identify number of additional FTE's required for increased staffing requirments.	4-A-Review survey results of 1B. to determine additional FTE's in survey states required.	VHCA VANPHA	Analysis of data Data Base	07/18/94	08/01/94
4.B. Determine additional FTE's required by skill mix.	4-B-Review survey results of 2C to determine required skill mix.	VHCA VANPHA	Data Base	07/18/94	08/15/94
4.C. Determine financial impact of additional staffing requirements.	4-C-1. Document results of 4A and 4B.	VHCA, VANPHA, Mary Chiles	Data Base	07/25/94	08/15/94
	4-C-2. Compare current staffing versus projected additional staffing by FTE and skill mix.	VHCA, VANPHA DMAS	Spreadsheet	07/25/94	08/15/94
	4-C-3. Analyze data from 4C1 and 4C2 and project costs/facility.	VHCA, VANPHA DMAS	Spreadsheet	07/27/94	08/15/94
4.D. Determine current funding for Nursing Facility reimbursement.	4-D-Review state funding for Medicaid Nursing Facility reimbursement.	Mary Chiles DMAS	Budget	07/27/94	08/15/94

Objective #4: Continued

Responsibility: Nancy Durette

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
4E. Determine additional funding required to cover additional staffing costs.	4-E-1. Review/analyze data from 4C3.	Mary Chiles	Spreadsheet	07/24/94	08/15/94
	4-E-2. Identify alternative funding sources if available.	Mary Chiles	Budget Sections State	07/27/94	08/15/94

Objective #5: To recommend staffing guidelines based on objective data resulting from the study.

Responsibility: Nancy R. Hofheimer

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
5A. Analyze the results of study.	5-A-Using data from previous objectives identify major issues impacting key actors/stakeholders.	Nancy Hofheimer Study Group	Spreadsheet Summary of other data analysis	08/01/94	08/05/94
5B. Propose an approach which is achievable, cost effective and ensures the health, welfare and safety of nursing facility residents.	5-B-1-Draft preliminary recommendations.	Nancy Hofheimer Study Group	Draft recommendations	08/03/94	08/05/94
	5-B-2-Finalize recommendations.	Nancy Hofheimer	Recommendations	08/05/94	08/09/94
	5-B-3-Finalize Report.	Nancy Hofheimer Study Group	Written Report	08/01/94	09/15/94
	5-B-4-Report to Deputy Commissioner.	Nancy Hofheimer	Report	08/09/94	08/15/94

Literature Review

Francese and Mohler, "LTC Nurse Staffing Requirements: Has OBRA Really Helped?," Geriatric Nursing Volume 15, No. 3,

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