REPORT OF
THE JOINT COMMISSION ON HEALTH CARE

LICENSURE ISSUES IN LONG-TERM CARE PURSUANT TO HJR 527, SB 1172 AND SB 1173

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 97

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

JOINT COMMISSION ON HEALTH CARE

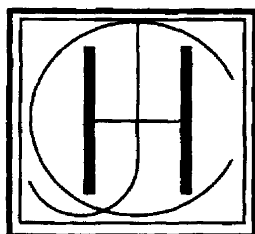
Chairman
The Honorable Kenneth R. Melvin

Vice Chairman
The Honorable Jane H. Woods

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Stanley C. Walker
The Honorable Thomas G. Baker, Jr.
The Honorable Robert H. Brink
The Honorable John J. Davies, III
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Claude A. Allen

Executive Director
Patrick W. Finnerty



Preface

Bills and resolutions approved during the 1999 General Assembly directed the Joint Commission Health Care to study a number of long-term care related issues. These included several long-term care licensure and certification issues, which are addressed in this report. Senate Bill 1172 directed the Joint Commission on Health Care to examine the Commonwealth's nursing home licensure regulations to determine: (i) means for making such regulations more outcome oriented and focused on continuous quality improvement, (ii) opportunities for gathering additional resident and family input as part of the licensure process for nursing homes, (iii) the advisability of accepting national accreditation as evidence of compliance with state licensure standards, and (iv) other states' laws regarding deemed status for state licensure of nursing homes. Senate Bill 1172 also directed the Joint Commission on Health Care, in cooperation with the Secretary of Health and Human Resources, to examine the concept of centers of excellence with regard to long-term care reimbursement, specialized care programs, best management practices, and other issues as appropriate.

Senate Bill 1173 directed the Joint Commission on Health Care, in cooperation with the Secretary of Health and Human Resources, to examine options for making adult care resident regulations more outcome oriented, (ii) means for making such regulations more focused on obtaining resident and family input, and (iii) the advisability of deemed status for nationally accredited adult care residences.

House Joint Resolution (HJR) 527 directed the Joint Commission on Health Care to examine staffing requirements for nursing home facilities and adult care residences to ensure adequate levels of care and adequate enforcement of these standards. HJR 527 also directed the Joint Commission to determine whether staffing requirements currently in effect in the Commonwealth adequately protect the health, safety and welfare of nursing home and adult care residents and the adequacy of the enforcement of such staffing guidelines.

Based on our research and analysis during this review, we concluded the following:

- Deemed status is the predominant regulatory approach for the hospital industry. Nursing facilities, however, are certified by state agencies (the Health Department in Virginia) on behalf of the U. S. Health Care Financing Administration (HCFA).

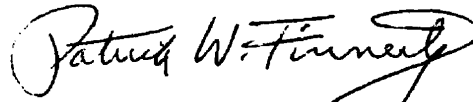
- HCFA opposes extending deemed status to nursing homes and requires nursing facilities which accept Medicaid or Medicare to be certified by the state. Since almost all of Virginia nursing facilities accept Medicaid or Medicare, very few facilities could benefit from deemed status endorsement.
- The current federal standard for staffing is to have sufficient staff to meet the needs of nursing facility residents. HCFA has commissioned a study regarding the need to institute additional staffing guidelines.
- JCHC's survey of 40 other states and the District of Columbia showed that the average number of hours of direct care staff per bed in Virginia (3.18 hours per day) exceeded the national average of 2.83 hours per day. Eighteen states reported having some type of direct-care staffing standard that was more precise than the federal requirement of "sufficient staff."
- A number of consumer advocates and family members reported feeling strongly about the need for nursing home staffing guidelines in Virginia.
- The licensing director for the Virginia Department of Health reported having adequate authority to cite staffing deficiencies and that having a specific staffing guideline to enforce would require more frequent state inspections.
- The shortage of certified nursing assistants in Virginia could make compliance with staffing guidelines difficult to comply with, particularly in areas of the state with very low unemployment.
- The Joint Legislative Audit and Review Commission identified deficiencies in DMAS' reimbursement of nursing homes and recommended various funding options for addressing those deficiencies.
- As part of the inspection process for licensing adult care residences (ACRs), licensing staff of the Department of Social Services (DSS) informally interview residents and may speak with family members who are visiting. However, there is no written protocol or requirement for DSS staff to do so.
- DSS staff suggested requiring new applicants for ACR licensure to receive training regarding Virginia's regulations for protecting the health and safety of ACR residents.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 27-29.

The Long-Term Care Subcommittee held three meetings at which testimony was received from interested parties. The staff briefing on these issues comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us

regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Health, the Department of Medical Assistance Services, the Department of Social Services, the Virginia Health Care Association, the Virginia Hospital and Healthcare Association, the Virginia Association of Nonprofit Homes for the Aging, and the Virginia Adult Home Association for their cooperation and assistance during this study.



Patrick W. Finnerty
Executive Director

December, 1999

TABLE OF CONTENTS

I. AUTHORITY FOR THE STUDY 1

II. INTRODUCTION 3

II. ADVANTAGES AND DISADVANTAGES OF DEEMED STATUS FOR LONG-TERM CARE FACILITIES 7

IV. NURSING HOME LICENSURE ISSUES 11

V. ACR LICENSURE ISSUES 21

VI. POLICY OPTIONS FOR PHASE I 27

VII. APPENDICES

Appendix A: Senate Bill 1172
Senate Bill 1173
House Joint Resolution 527

Appendix B: Summary of Public Comments

I.
Authority for the Study

Bills and resolutions approved during the 1999 General Assembly direct the Joint Commission Health Care to study a number of long-term care related issues. These include several long-term care licensure and certification issues, which are addressed in this report. Senate Bill 1172 directs the Joint Commission on Health Care to examine the Commonwealth's nursing home licensure regulations to determine: (i) means for making such regulations more outcome oriented and focused on continuous quality improvement, (ii) opportunities for gathering additional resident and family input as part of the licensure process for nursing homes, (iii) the advisability of accepting national accreditation as evidence of compliance with state licensure standards, and (iv) other states' laws regarding deemed status for state licensure of nursing homes. Senate Bill 1172 also directs the Joint Commission on Health Care, in cooperation with the Secretary of Health and Human Resources, to examine the concept of centers of excellence with regard to long-term care reimbursement, specialized care programs, best management practices, and other issues as appropriate. This report represents preliminary staff work on SB 1172; staff will consult with the Secretary's Office prior to the July 27, 1999 Commission meeting.

Senate Bill 1173 directs the Joint Commission on Health Care, in cooperation with the Secretary of Health and Human Resources, to examine options for making adult care resident regulations more outcome oriented, (ii) means for making such regulations more focused on obtaining resident and family input, and (iii) the advisability of deemed status for nationally accredited adult care residences.

House Joint Resolution (HJR) 527 directs the Joint Commission on Health Care to examine staffing requirements for nursing home facilities and adult care residences to ensure adequate levels of care and adequate enforcement of these standards. HJR 527 also directs the Joint Commission to determine whether staffing requirements currently in effect in the Commonwealth adequately protect the health, safety and welfare of nursing home and adult care residents and the adequacy of the enforcement of such staffing guidelines.

This report is the first of two reports to be prepared by Joint Commission on Health Care staff during 1999. A report to be presented at

the July 27, 1999 Joint Commission on Health Care meeting will address issues related to services for vulnerable adults (HJR 689), regulation and financing of adult care residences (HJR 751 and SJR 486), and adult foster care (SJR 485). Additional information related to issues addressed in this report may also be presented.

Report Outline

This report is divided into five sections. This section discussed the authority for the study. The second section provides a general overview of long-term care licensure in Virginia. The third section discusses the potential advantages and disadvantages of deemed status for long-term care facilities. The fourth section discusses nursing home licensure issues. The fifth section discusses adult care residence licensure issues. The sixth section discusses policy options.

II.
Introduction

Long-Term Care Licensure in Virginia Is Split Between Two Agencies

As noted in previous reports presented on long-term care, long-term care licensure in Virginia is a shared responsibility between two agencies. The Department of Social Services licenses adult care residences (ACRs), adult day care centers, and district homes for the aged. The Virginia Department of Health (VDH) licenses nursing homes, home health agencies, as well as hospitals, hospices, and ambulatory surgery centers. VDH also certifies nursing homes on behalf of the U.S. Health Care Financing Administration (HCFA) for participation in Medicare and Medicaid.

Regulation and licensure of adult care residences and adult day care centers is a responsibility of state government. Conversely, regulation of the vast majority (93 percent) of nursing homes in the Commonwealth which receive Medicaid and/or Medicare is driven by federal regulations. Excluding hospital-based long-term care units (all of which are federally certified) and mental health and mental retardation facilities, as of May 31, 1999 there are 265 nursing facilities in Virginia. Of these, 19 are not federally certified, 8 are certified for Medicare only, 191 are certified for both Medicaid and Medicare, and 47 are certified for Medicaid only (Figure 1).

Nursing Home Regulation Is Driven by Federal Regulations

While nursing homes in Virginia are governed by state regulations, for most nursing facilities, federal regulations are the main driver. Section 32.1-125(A) of the *Code of Virginia* states:

> No person shall own, establish, conduct, maintain, manage or operate in this Commonwealth any hospital or nursing home unless such hospital or nursing home is licensed or certified as provided in this article.

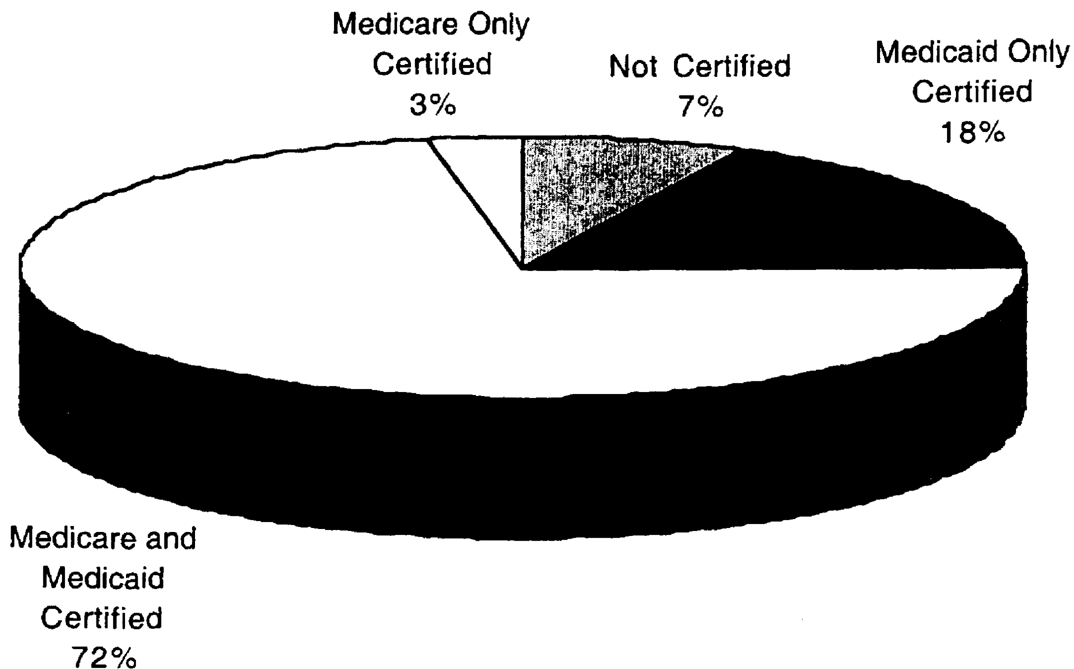
Section 32.1-126 of the *Code of Virginia* further states:

> B. The Commissioner shall cause each and every hospital, nursing home, and certified nursing facility to be inspected periodically, but not less often than biennially, in accordance

with the provisions of this article and regulations of the Board.

C. The Commissioner may, in accordance with regulations of the Board, provide for consultative advice and assistance, with such limitations and restrictions as he deems proper, to any person who intends to apply for a hospital or nursing home license or nursing facility certification.

Figure 1
Federal Certification Status of Virginia's Nursing Facilities (Excluding Hospital-Based LTC Units and MH/MR Facilities)



Source: Virginia Department of Health

While all nursing facilities in the Commonwealth must be licensed, state licensure regulations promulgated by the Board of Health are relatively modest when compared with federal regulations for

participation in Medicaid and Medicare. These regulations are promulgated by the HCFA, pursuant to its regulatory authority established in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87).

The Department of Social Services Regulates Adult Care Residences and Adult Day Care Centers

Unlike the case with nursing facilities, where the federal government is the primary regulator, adult care residences are exclusively regulated at the state level at this time. Section 63.1-174, of the *Code of Virginia* states, "The State Board [of Social Services] shall have the authority to promulgate and enforce regulations to carry out the provisions of this article and to protect the health, safety, welfare, and individual rights of residents of adult care residences and promote their highest level of functioning." Adult care residences in Virginia were previously referred to as "homes for adults."

In Virginia, the term "adult care residence" is defined by Section 63.1-172 of the *Code of Virginia* as "any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more persons who are aged, infirm, or disabled and who are cared for in a primarily residential setting." This definition potentially encompasses a number of care settings. These include: independent living wings of continuing care retirement communities (CCRC), assisted living components of CCRCs, residential care facilities (in some states termed "board and care facilities"), dedicated assisted living facilities, and independent living apartment complexes where the management entity brokers or arranges for services (for example a Section 8 housing project serving the low-income elderly that arranges for or provides housekeeping, personal care services, and home health services).

III.
Advantages and Disadvantages of Deemed Status for Long-Term Care Facilities

Definition of Deemed Status

As noted in House Document 50, prepared by the Joint Commission on Health Care for the 1999 General Assembly, deemed status is the acceptance of private accreditation by a governmental entity in lieu of licensure or certification by a government agency. An example of the use of deemed status is in the hospital industry, where hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) are deemed eligible to participate in Medicaid and Medicare. On behalf of the U.S. Health Care Financing Administration (HCFA), state regulatory agencies (typically health departments) validate a five percent sample of hospital surveys conducted by the JCAHO. In Virginia, this function is performed by the Virginia Department of Health (VDH). VDH also investigates complaints made against hospitals.

Unlike the case with hospitals, the federal government does not currently accept private accreditation of nursing homes as suitable for certification to participate in Medicaid or Medicare. In fact, in 1998, a HCFA contractor, Abt Associates, completed a report that was skeptical of deemed status for nursing facilities, at least if the accrediting agency was the JCAHO (other accrediting agencies were not reviewed in depth by the report).

Some Nursing Homes Are Voluntarily Accredited

At least three organizations currently offer voluntary accreditation for nursing homes. The JCAHO accredits nursing homes either as part of a hospital's accreditation process (in the case of hospital-based facilities) or separately. According to the JCAHO internet site, as of June 23, 1999 there were 90 JCAHO accredited long-term care organizations in Virginia. By comparison, in August 1998, there were 83 such organizations (the total for both years includes governmental facilities such as Veterans Affairs Medical Centers and state mental health facilities).

In addition to JCAHO, a more recently formed group, the Long-Term Care Evaluation and Accreditation Program (LEAP) also accredits nursing homes. Finally, the Continuing Care Accreditation Commission (CCAC) accredits continuing care retirement communities (CCRCs). This

accreditation includes reviews of the CCRC's nursing home and assisted living components.

As of August 1, 1998, there were seven CCAC accredited continuing care retirement communities in Virginia, according to the CCAC internet site. However, as of June 23, 1999 the number of accredited CCRCs in Virginia had increased to 12, nearly doubling in a ten-month period.

Nationwide Assisted Living Accreditation Standards are Being Developed

As already noted, CCAC reviews the assisted living component of CCRCs. However, it does not appear that any national organization has yet promulgated final accreditation standards for assisted living facilities outside of a continuing care setting. However, the JCAHO recently announced that it "Is convening an advisory group of key stakeholders including provider representatives, advocates, and representatives of national associations to provide input into the development of standards and survey process" for assisted living. JCAHO's announcement further stated that "upon field evaluation and approval by the Board of Commissioners, the accreditation manual will be available to the field in July 2000, with the first surveys anticipated by January 2001."

While it is difficult to predict whether JCAHO will ultimately become the dominant player in accreditation of assisted living facilities, it is worth noting that JCAHO accredits nearly all hospitals in the United States, a significant percentage of nationally accredited nursing homes, and is involved in accrediting more than 18,000 health care organizations in the United States in a variety of health delivery settings.

Some Consumer Advocates Express Concern About Deemed Status

In many cases, consumer advocates and/or senior advocates have expressed concern about deemed status for nursing facilities. For example, during the 1999 Session of the General Assembly, the Coalition for the Aging expressed concern about deemed status for either nursing homes or adult care residences. These concerns included:

- limited public disclosure of JCAHO and/or CCAC findings,
- infrequent site visits by accrediting agencies (varies for JCAHO depending on accreditation status, once every three years for CCAC),

- concern abut the lack of rigor in JCAHO's process for addressing non-compliance with standards,

- concern that state-level deemed status would be the first step in providing deemed status at the national level for nursing homes, thereby removing all government oversight from the industry.

In addition to concern expressed by the Coalition for the Aging, the AARP's *The Public Policy Agenda 1999* states: "The Association opposes efforts to deregulate the nursing home industry and supports strong federal nursing home quality standards." Conversations with AARP's Virginia representatives indicated that AARP supports private accreditation as a complement to, not a substitute for state and federal regulatory and enforcement efforts.

Current Legislative Options Related to Deemed Status

As noted in HD 50 from the 1999 Session of the General Assembly, impacted provider associations are strongly in favor of deemed status, viewing it as a more outcome oriented approach to regulation. As for crafting legislation for the 2000 Session of the General Assembly and addressing the concerns of consumer advocates, in the near term, deemed status for nursing homes may well be a more straightforward option. There are several reasons for this conclusion. These include:

- accreditation standards for nursing facilities are well-established; accreditation standards for adult care residences are not yet promulgated;

- JCAHO accreditation standards for long-term care facilities, in many respects, exceed the current state licensure standards for nursing homes;

- almost all nursing homes are also federally regulated; in this light state licensure can be viewed as a duplicative process for most nursing facilities that is not value added;

- the definitional problems that complicate ACR regulation do not exist to the same extent in the nursing home industry; put another way there is a greater degree of homogeneity among nursing homes than is the case among adult care residences in Virginia;

- JCAHO long-term care surveyors are all required to have a graduate degree and several years of professional experience; this exceeds the typical requirement for state long-term care inspectors (though many do meet this standard); and

- the impacted regulatory agency for nursing homes (VDH) would not oppose deemed status; the impacted agency for adult care residences (DSS) likely would.

As for the specific concerns expressed by consumer advocates, one component of any deemed status legislation for nursing facilities could be that the accreditation reviews conducted by national accrediting organizations have the same degree of public disclosure as is the case with current VDH licensing inspections. In other words, as a condition of submitting private accreditation as evidence of compliance with state licensure, facilities could be required to agree to make all accreditation information available to both VDH and the public. Members of the public could then obtain the information either from the specific facility or from VDH.

Regarding the concern about whether private accreditation standards meet state licensure standards (which it must be emphasized are minimal in nature), the policy of JCAHO is to hold facilities it accredits to the more stringent of its own standards or the applicable state standard. In other words, if a state standard is more stringent, then the facility is held to the state standard. If a JCAHO standard is more stringent, then the facility is held to JCAHO standard.

As for the concern that state level deemed status is the first step in a national shift to deemed status for nursing facilities, this does not appear to be even remotely likely during the remainder of President Clinton's administration. In August 1998 the Secretary of Health and Human Services, Donna Shalala, stated in no uncertain terms that the U.S. Health Care Financing Administration would not approve deemed status for nursing facilities with regard to federal certification. JCHC staff have uncovered no evidence to suggest that this viewpoint has changed.

IV.
Nursing Home Licensure Issues

Virginia Currently Follows the Federal Guideline for Nursing Facility Staffing of Requiring "Sufficient Staff"

Neither federal law nor federal regulations require a specific number of direct care staff in a nursing home, with the exception of requirements for a nursing supervisor. Rather federal regulations state in general terms that facilities must have sufficient staff to meet patients' needs. Virginia's licensure regulations follow the lead of the federal regulations and require that "the nursing facility shall provide qualified nurses and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care needs of all residents" (12VAC5-371-210). Consumer advocates argue that the general nature of this regulatory requirement makes it unenforceable (VDH staff interviewed did not agree with this conclusion).

The U.S. Health Care Financing Administration has recently directed state agencies that certify nursing homes for participation in Medicaid and Medicare to more closely monitor staffing issues through the use of new protocols for long-term care surveyors that emphasize staffing. HCFA has also commissioned a study by Abt Associates to determine whether or not additional staffing guidelines in federal regulations, such as staffing ratios, are warranted. The HCFA administrator has stated publicly that HCFA will not hesitate to impose staffing ratios if these are deemed necessary.

At Least 18 Other States Have Staffing Requirements for Nursing Homes That Are More Specific than the Federal Requirement for "Sufficient Staff"

As part of the research for this report, JCHC staff conducted a telephone survey of state long-term care ombudsman to determine whether or not the given state had staffing requirements for nursing facilities that were more specific than the federal requirement for "sufficient staff." A total of 40 states and the District of Columbia responded to the survey. Results from this survey are shown in Figure 2. Of these states, 22 states and the District of Columbia currently follow the federal guidelines. Of these states, two indicated that they are actively studying adopting such guidelines.

Eighteen states indicated that they have adopted more specific guidelines than the federal standard. These guidelines sometimes take the form of a required direct care staff ratio, for example one staff member for every 20 residents. Guidelines also sometimes take the form of a required number of hours of direct care per resident, per day. An example of this would be a requirement for two hours of direct care per resident, per day. In some cases (for example Kansas and Michigan), a state has adopted both requirements for a minimum ratio of direct care staff to residents and requirements for a minimum number of hours of direct care per resident per day. It should be noted that in some instances state representatives interviewed indicated that an existing staffing guideline is in effect but not often enforced. Figure 3 summarizes these guidelines.

Figure 2
States With Nursing Home Staffing Guidelines More Specific than the Federal Requirements for "Sufficient Staff" (States Shaded in Black Indicated Having More Specific Guidelines)

Source: JCHC telephone survey of state long-term care ombudsman.

Figure 3
Specific Provisions for States Reporting Nursing Home Staffing Guidelines More Specific than the Federal Requirements

State	Staffing Guideline
Arkansas	staffing ratio for CNAs and licensed nurses (LPNs); ratios are phased in over time under recently passed legislation
California	requirement for 3-3.2 hours direct care per resident per 24 hour period
Colorado	2.0 hours of direct care per resident per 24 hour period (interview subject indicated this requirement is in effect but not often enforced)
Connecticut	specified number of licensed nursing hours and total nursing/nurse aide hours per patient (varies by day and evening)
Delaware	required ratios for direct care staff, licensed nurses, and nursing supervisors (varies by shift)
Florida	.6 hours direct care by a licensed nurse and 1.7 hours direct care by a CNA per resident per 24 hour period
Georgia	must average 2.0 nursing hours per resident per 24 hour period
Illinois	minimum number of nursing hours per resident per shift required (varies by shift)
Kansas	minimum staffing ratio of one nursing staff member per 30 residents; requirement for an average of 2.0 hours of direct care per resident per 24 hour period (calculated as an average per day on a weekly basis; no less than 1.85 hours of care per resident in a 24 hour period)
Maine	ratios for direct care staff to residents (1/8 for day shift, 1/12 for evening, and 1/20 for nights) and ratios for licensed nurses per resident (1/25 days, 1/35 evenings, 1/50 nights)
Maryland	minimum of two hours of "bed side care" per resident per day

Michigan	staffing ratio of nursing staff to residents of 1/8 day shift, 1/12 evening shift and 1/15 night shift); requirement of 2.25 hours of direct care per resident per day
Minnesota	requirements for amount of care required for each facility based on the case mix of the facility; overall minimum requirement of 2.0 hours of direct care per resident per 24 hour period
Mississippi	requirement of 2.33 hours direct care per resident per 24 hour period (considering revising this upward to 2.67 hours per resident per 24 hour period)
Oklahoma	nursing staff to resident ratios of 1/10 day shift, 1/15 evening shift, 1/20 night shift (interview subject indicated that these provisions are seldom enforced)
Pennsylvania	required ratio of one nursing staff member per 20 residents (applies for all shifts)
South Carolina	ratio of direct care staff to residents of 1/9 day shift, 1/13 evening shift, 1/22 night shift
Tennessee	2.0 hours direct care per resident per 24 hour period

Source: JCHC telephone survey of state long-term care ombudsmen.

VDH Report

In 1995, the Virginia Department of Health completed House Document 29, which examined nursing facility staffing guidelines. The report concluded: "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." The report further stated "none of the 44 states surveyed have collected objective data on the impact of additional staffing on resident care outcomes."

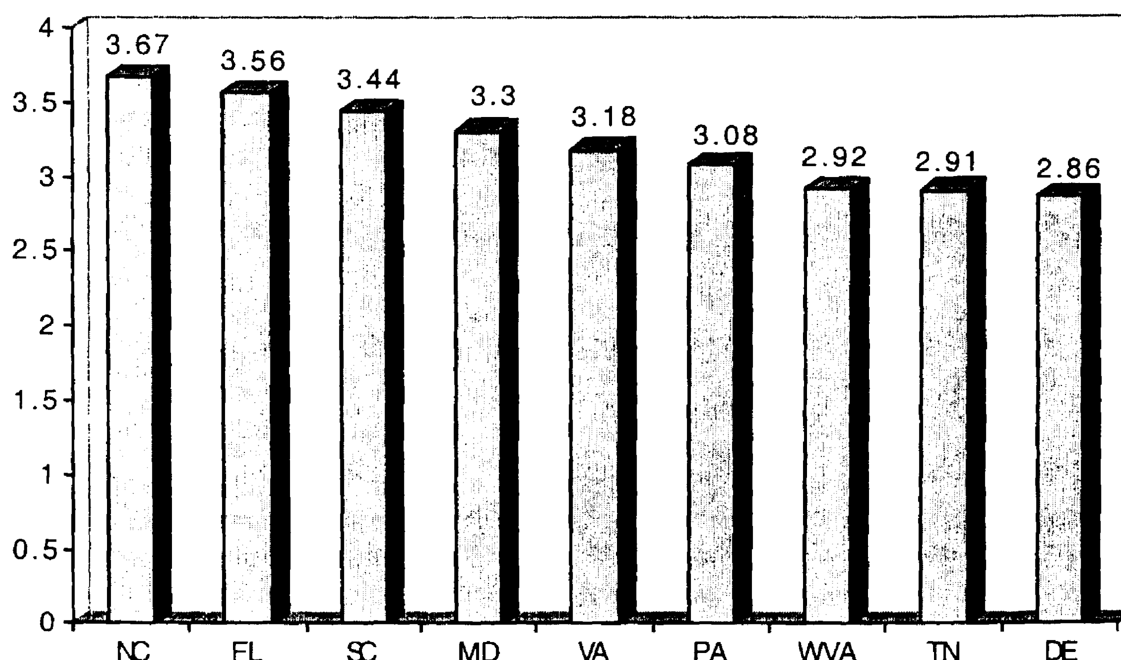
How Virginia Compares to National Average

Based on data from the American Health Care Association, it appears that staffing in Virginia nursing homes somewhat exceeds the national average. For 1997, the most recent year for which data was available, Virginia's nursing homes average 3.18 hours direct care staff to

beds (in other words an average of 318 staff hours per day per 100 beds). This compares favorably with the national average of 2.83. The fact that Virginia's staffing levels compare favorably with the national average is particularly striking given that Virginia's per diem reimbursement rate for nursing facilities was well below the national midpoint for 1997.

Virginia's staffing ratios are approximately at the mid-point of nearby states and other Southeastern states. Figure 4 compares Virginia's staffing per day to other Southeastern states and to selected nearby states.

Figure 4
Average Facility Direct Care Nursing Staff Hours to Bed Ratio: 1997



Source: American Health Care Association, Facts and Trends: The Nursing Facility Source Book

CNA Shortage

One concern that was expressed repeatedly by provider representatives during this study was that the shortage of CNAs nation-wide and in Virginia would make a staffing guideline for nursing homes difficult to comply with, particularly in parts of the state with very low unemployment such as Northern Virginia and the Shenandoah Valley. Consumer advocates, on the other hand, stated that implementing a staffing guideline would motivate nursing homes to take the necessary

steps to recruit and retain staff. Retention of staff is a traditional problem in the nursing home industry, due to the difficult and sometimes unpleasant nature of direct care work and relatively low pay compared with other entry level occupations. Other factors that are sometimes pointed to include the organizational climate within a facility and limited opportunities for career advancement for nursing facility staff.

A 1998 study by the Department of Medical Assistance Services (DMAS) found that turnover of nurse aides in Virginia nursing homes averages 80 percent per year (turnover averages 48 percent for registered nurses and 42 percent for licensed practical nurses). According to the DMAS report, the American Health Care Association reports a nationwide turnover rate higher than the turnover rate in Virginia. The nationwide turnover rate was reported as 50.5 percent for RNs, 51.3 percent for LPNs, and 93.3 percent for nurse aides. It should be emphasized that the figures for Virginia were collected using a different methodology from the methodology used in calculating the national figure and that they are therefore difficult to compare with certainty.

Fiscal Impact of Nursing Staff Guidelines

It is clear, however, that changes in nursing home staffing guidelines will have a fiscal impact, particularly given the difficulty in recruiting and retaining CNAs. The precise fiscal impact will depend on the approach taken. A small example is given in the 1995 VDH report, which concluded that "an increase of one Registered Nurse seven days/week/24 hours/day/facility would increase the 258 providers' cost a minimum of $32,659,704." State expenditures through Medicaid for nursing facility services were approximately $409 million in FY 1998. A one percent increase on this base would total $4.09 million.

On the other hand, consumer advocates argue that inadequate staffing itself has costs. These include the costs of incontinence supplies and staff time related to cleanup as a result of lacking adequate staff to take residents to the bathroom. Other potential costs include CNA turnover due to inadequate staffing (ironically, low staffing levels can cause additional turnover if staff are overworked, further exacerbating the problem), the cost of treating pressure ulcers, higher injury rates for staff, and preventable hospitalization of nursing home residents. One cost estimate was that in Maryland the cost of inadequate staffing in nursing homes was $86 million a year, though the methodology used in developing this cost estimate was not available for review and some assumptions made in the cost estimate appear at least debatable (for

example assuming half the cases of incontinence in Maryland nursing homes is related to staffing and could be prevented with additional staff).

Should the JCHC's Long-Term Care Subcommittee wish to pursue legislation regarding nursing facility staffing guidelines, staff will work with DMAS, consumer advocates, and affected provider groups to develop appropriate cost estimates.

State-Level Nursing Home Staffing Guidelines Would Represent a Major Policy Shift

In Virginia, nursing facilities have primarily been regulated by the federal government. Pursuant to an executive order issued during the last administration, Virginia's already modest nursing home licensure regulations were further modified to make them "minimally burdensome." At present the Virginia Department of Health is only required to make one licensure inspection every two years, compared with the requirement (to be modified July 1, 1999) that adult care residences be inspected at least twice annually (four-times as often). Virginia's nursing facility regulations, at present, are essentially dormant and the federal regulations are by far the driving regulatory factor for all but 19 of Virginia's nursing facilities.

Implementing nursing home staffing guidelines would require changing the frequency of nursing facility inspections to make such guidelines enforceable. Additional staff would also need to be given the Department of Health to conduct these inspections. Care would also need to be taken to ensure that conflicts did not develop between Virginia's staffing guidelines initiative and any federal initiatives (there are some indications that HCFA is considering mandating a more precise staffing guideline for federally certified facilities).

Centers of Excellence for Virginia's Nursing Homes

One non-regulatory approach to improving staffing in Virginia's nursing facilities would be to develop a staffing incentive through the Medicaid nursing home reimbursement system that rewarded good quality care, favorable patient outcomes, and appropriate staffing. At present, the efficiency incentive that is part of the Virginia Medicaid nursing home reimbursement methodology arguably acts as a financial disincentive to staff beyond a certain point.

The Joint Legislative Audit and Review Commission is currently studying the nursing facility reimbursement system which DMAS is in the process of revamping. A potentially valuable part of this reworking would be to develop a centers of excellence concept for Virginia's nursing homes. This concept would provide substantial incentive payments for nursing facilities that achieve benchmarks in patient care outcomes such as reduced incontinence among patients, reduction in pressure ulcer rates, and improved nutritional/hydration status. The newly implemented federal information system for nursing home residents (the Minimum Data Set or MDS System) provides a readily available resource for gathering this type of information.

Under this concept, staffing would be a means to the end of improving quality care rather than an end unto itself. While staffing could, in and of itself, be a quality benchmark, it may be more appropriate to focus the incentive benchmarks on resident care outcomes. The precise outcomes could be determined by DMAS (or the General Assembly if it chooses) after consultation with consumer advocates, provider groups, and other interested parties.

Other Options for Addressing CNA Shortage

Persons interviewed during this study in some cases identified non-regulatory options for addressing the shortage of CNAs and other nursing staff in long-term care facilities. These included:

- offering scholarships for nursing students who agree to work in a long-term care facility for a period of time after graduation from LPN or RN training;
- revising the state's policy regarding the ability of nursing facilities facing enforcement action to offer a CNA training program onsite;
- encouraging the Virginia Community College System to examine options for helping develop a long-term care workforce (including funding to help supplement such efforts),
- encouraging Virginia nursing schools to assist LPN and RN students in obtaining a CNA credential early in their training, allowing them to work as CNAs while completing more advanced nursing studies, and

- offering human relations and management training to nursing home administrators and directors of nursing to help them identify non-financial incentives to retain quality staff members,

Adequate Medicaid Funding Is an Important Part of Ensuring Adequate Nursing Facility Staffing

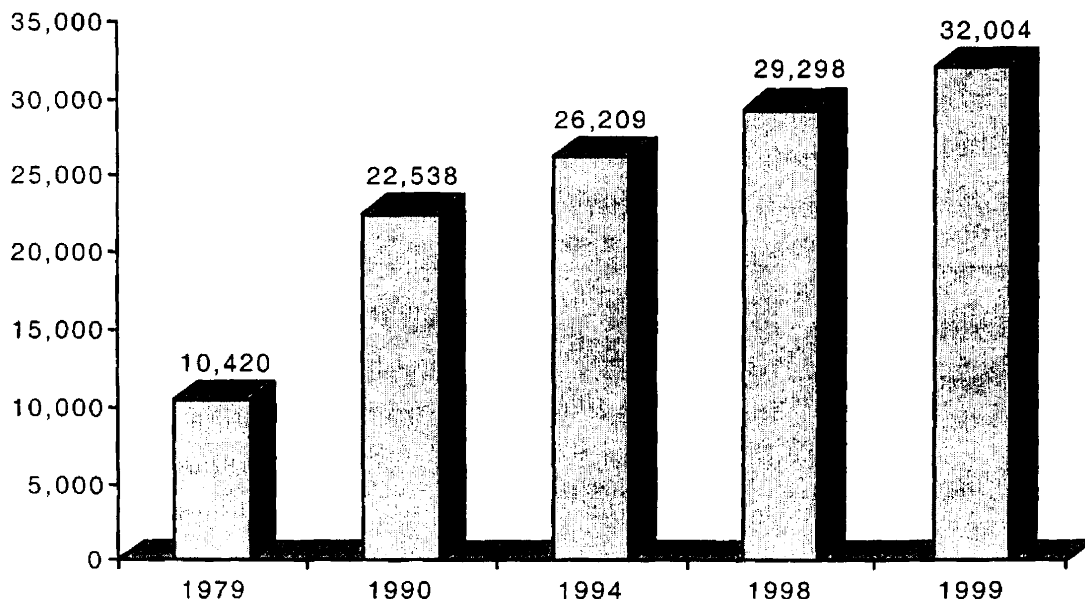
Several persons interviewed during this study also discussed the importance of raising Virginia's Medicaid reimbursement for nursing facilities to a level approximating the National median. The issue of nursing facility reimbursement was discussed in depth by the Long-Term Care Subcommittee last year. Data provided to the Long-Term Care Subcommittee found that Virginia ranked 42 among the states in per diem reimbursement for nursing facilities, despite having more stringent pre-admission screening standards than virtually any other state. The 1999 General Assembly approved an increase in nursing facility reimbursement of $3 per day, with a portion of the increase targeted towards CNA salaries.

One option for the Joint Commission on Health Care to pursue would be to introduce a budget amendment setting a goal of raising Virginia's nursing facility reimbursement over a period of time to the national average. Staff will develop specific cost estimates depending on the time frame the Long-Term Care Subcommittee may chose to target.

V.
ACR Licensure Issues

In addition to reviewing deemed status for ACRs, Senate Bill 1173 asks the JCHC to review the concept of making ACR regulations more outcome-oriented and more focused on obtaining resident and consumer feedback. Improving quality of care in ACRs, particularly for public pay clients, has been the subject of a number of legislative reports since 1979. As can be seen from Figure 5, the number of ACR beds has increased dramatically between 1979 and 1999.

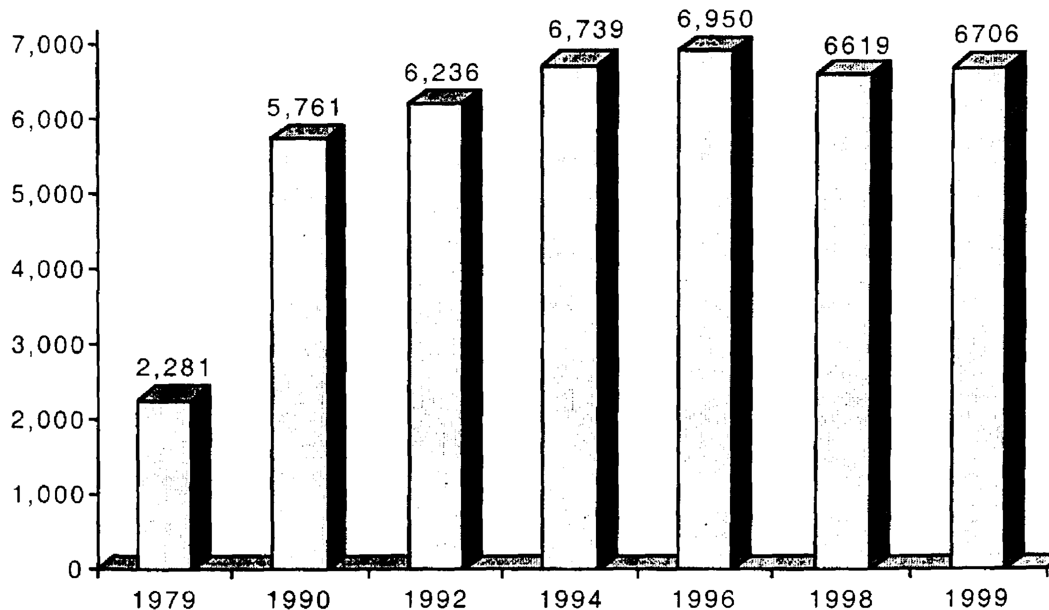
Figure 5
Number of ACR Licensed Beds, 1979-1999 (includes pending and new applications for 1999)



Source: Virginia Department of Social Services

While the number of ACR beds has been steadily increasing, the number of public pay clients has remained flat during the 1990s. Figure 6 shows the number of public pay clients in adult care residences from 1979 to 1999. As Figure 6 reflects, the number of public pay clients in ACRs (auxiliary grant recipients) has actually decreased since the mid-1990's.

Figure 6
Number of Auxiliary Grant Recipients, 1979-1999



Source: Virginia Department of Social Services

As the number of ACR beds has increased while the number of public pay clients has remained flat or actually decreased, auxiliary grant recipients are a decreasing percentage of the overall population of ACR residents. As Figure 7 reflects, auxiliary grant recipients currently occupy only 21 percent of the total number of licensed ACR beds in Virginia.

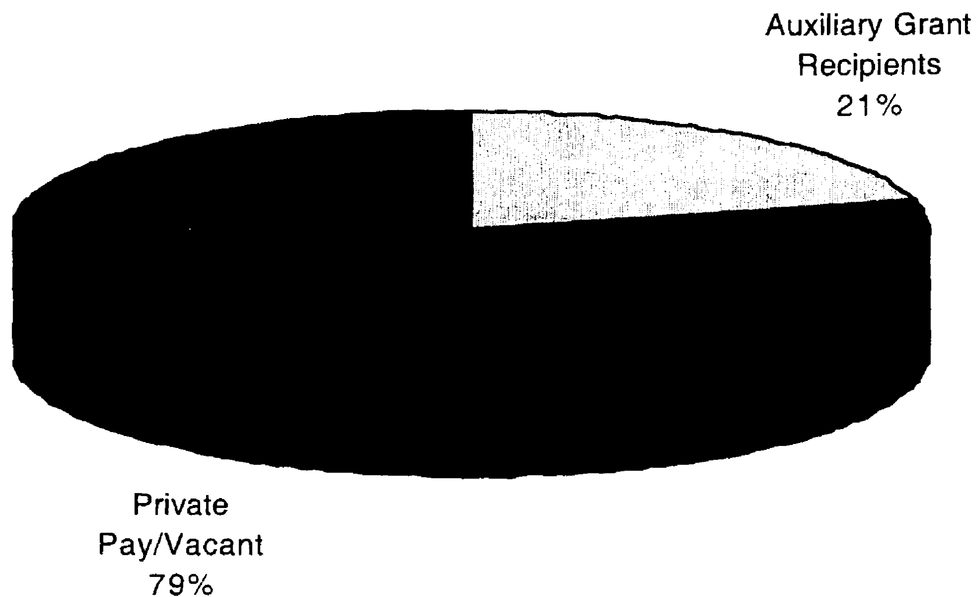
Mental Health Issues Are a Gap in Virginia's Regulatory System for ACRs

As has been noted in past JLARC and JCHC studies, there is a gap in Virginia's regulatory structure for adult care residences in terms of addressing the needs of the mentally ill population in ACRs. JLARC's 1997 study of adult care residences found that nearly half (47 percent) of the public pay population in adult care residences had a behavioral health diagnosis. A substantial number of these individuals had been discharged into adult care residences from a state mental health facility. For example, between 1992 and 1996, there were 3,023 persons discharged from state mental health and mental retardation facilities who were

placed in ACRs. This accounts for the clustering of public pay residents in ACRs in localities near large state mental health facilities. JLARC's 1997 study found that 35 percent of ACR public pay clients are housed in five localities: Richmond, Washington County, Roanoke, Roanoke County, and Petersburg.

An important part of making adult care residence regulation more outcome oriented would be to tailor Virginia's regulatory and enforcement system for ACRs to address the needs of the behaviorally ill population within ACRs. The July 27, 1999 report will examine in detail options for doing this.

Figure 7
Public Pay Residents in ACRs



Source: Virginia Department of Social Services, JCHC staff analysis.

Meaningful Cross-State Comparisons Are Difficult to Draw for Adult Care Residences

The term "adult care residence" is a Virginia term of art that is used in few if any other states. Other states have developed regulations for what are variously termed assisted living facilities, board and care homes, and other terms. Some states regulate these types of settings only for fire or building code compliance. Others attempt to regulate them more comprehensively. The degree of variation among states makes drawing meaningful cross-state comparisons difficult.

The Wide Variety of Care Settings Regulated as ACRs Complicates Developing Minimum Staffing Guidelines

As noted earlier, the term adult care residence as defined in Virginia encompasses a wide variety of care settings including but not limited to Section 8 housing, CCRCs, board and care facilities, assisted living facilities, facilities serving primarily behaviorally ill clients, and facilities serving primarily the elderly. This is not to say that it would be impossible to mandate staffing levels or some other staffing guidelines for adult care residences, only that such guidelines would be less than optimally effective because they would have to be applied to so many disparate settings.

Another important caveat is that state licensure regulations for ACRs do not adequately define care standards for special populations such as patients with Alzheimer's Disease, though some facilities do advertise themselves as providing specialized care for these populations. It is important that any staffing guidelines developed be sensitive not only to the differences in the care setting but also special populations that may be cared for within the facility.

SJR 486 and HJR 751 both require the JCHC to examine the ACR licensure and reimbursement process very broadly. The staffing guidelines issue for ACRs will therefore be considered in more detail in the July 27, 1999 report. As part of this review, JCHC staff will survey other states' regulatory agencies for assisted living/board and care/residential living. Additionally, JCHC staff tentatively plan to administer a mail survey instrument to a sample of ACR administrators. The results of these data collection efforts will be used to help pinpoint more precise options for staffing ratios (general options are shown in Section VI of this report).

However, at this point it must be noted that if the General Assembly should choose to implement a staffing guideline for ACRs, it should strongly consider doing so in tandem with appropriate increase in reimbursement and changes to the statutory definitions of ACRs to better distinguish among the disparate care settings currently defined as adult care residences.

Protocols Could Be Developed for DSS Staff to Interact With Family Members as Part of their Licensing Visits; This Would Require Some Increase in DSS Licensing Staff

DSS staff informally interview residents as part of their inspection process, however there is no written protocol or guidance per se requiring them to do so. DSS staff also periodically will speak to family members who are in the ACR at the time of an inspection, though there is no systematic attempt to gather comments of family members. One means of getting such input is through the complaint process. Complaints about conditions within ACRs are often generated by family members, though there is no formal tracking of the category of complainant.

One option for DSS to consider would be developing internal protocols to encourage staff, to the extent feasible, to gather input from residents and family members. This information could be a valuable part of the inspection process for adult care residences. This information could also be taken into account by DSS in considering applications for renewal of licensure. A variant on this option would be to post a notice in the facility upon receipt of application for re-licensure requesting comments from residents or family members to be submitted in writing to DSS or orally by telephone.

Initial Training for ACR Operators and Administrators

One option proposed by DSS staff interviewed during this study was for the General Assembly to consider requiring that new applicants for an ACR license undergo an initial training period with DSS staff to cover Virginia's regulations for protecting the health and safety of ACR residents. This initial training could be directed at either ACR owners, ACR administrators, or both. It would be appropriate to waive this training for experienced operators and administrators who have previously maintained a good compliance history under Virginia's regulations (out of state persons would benefit from the training, given the significant variation among states in regulation of ACRs).

This option would require additional training staff and funds for DSS. Assuming a position graded between grade 10 and grade 12 on the state scale, the cost per position would be approximately $45,000 (including benefits). Five additional positions (total cost $220,000 (GF)) would allow statewide coverage, with one position to be based in the Northern Region, one in Tidewater, one in the Central Region, one in Roanoke, and one in Abingdon. In addition to training new providers, these additional staff members could also assume an inspections caseload, allowing for additional compliance assistance to be offered to struggling facilities.

VI.
Policy Options for Phase I

Policy Options

The following policy options are offered for the Joint Commission on Health Care regarding the long-term care topics discussed in this report. It is noted that, for the most part, these policy options are not mutually exclusive for the most part. The Joint Commission on Health Care may choose to pursue two or more of these options.

Policy Options

Option I: **Take no action.**

Option II: **Introduce legislation allowing national accreditation by JCAHO or CCAC to serve as evidence of compliance with state licensure regulations for nursing facilities provided that: (i) the facility agree to share the complete accreditation report and associated documents with VDH and interested members of the public, and (ii) VDH would retain the authority to inspect the facility whenever deemed appropriate by the VDH commissioner or designee.**

Option III: **Introduce a budget amendment (language and associated funding) directing DMAS to modify its reimbursement system for nursing facilities to provide a substantial financial incentive for nursing facilities to reach and maintain a targeted staffing level for direct care staff on all shifts.**

Option IV: **Introduce a budget amendment (language and associated funding) directing DMAS to develop a financial incentive system for nursing facilities that meet certain patient care benchmarks such as reduced incontinence among patients, improvement in the incidences and treatment of pressure ulcers, and improved nutritional and hydration status of patients.**

Option V: **Introduce legislation requiring nursing homes licensed in the Commonwealth of Virginia to maintain a specified staffing level for direct care staff. It would be appropriate to consider (i) modifying this ratio for special populations and**

skilled nursing units, (ii) phasing the mandated level in over a period of three years, and (iii) making allowances for facilities making a good faith effort to hire staff in areas with low unemployment. *Note: this option would require a companion budget amendment to fund the fiscal impact on the Medicaid budget and a budget amendment to fund additional enforcement positions at the Virginia Department of Health.*

Option VI: Introduce legislation amending Section 32.1-126 of the *Code of Virginia* to increase the frequency of required inspections for licensed nursing homes from biennially to twice annually. *Note: This would require a companion budget amendment for additional enforcement positions at the Virginia Department of Health. This option would be appropriate if Option V is selected, as Option V would be difficult to enforce with the current frequency of inspections.*

Option VII: Introduce a budget amendment (language) requesting that the Virginia Community College System develop a funding request and action plan for assisting in developing a trained long-term care nursing workforce statewide, including CNAs, LPNs, and RNs.

Option VIII: Introduce a budget amendment (language) directing the Virginia Department of Health to offer nursing facilities maximum allowable flexibility in providing onsite CNA training, irrespective of the enforcement status of the facility.

Option IX: Introduce a budget amendment requesting that the Board of Nursing Home Administrators consider requiring additional human resources management and human relations training for licensed nursing home administrators, focused on staff retention (alternatively, this could be offered by the Board, though funding and perhaps staff would be required).

Option X: Introduce legislation and a budget amendment establishing a scholarship program for CNAs, LPNs, and RNs interested in pursuing a career in long-term care. As a condition of the scholarships, students would agree to work a period of time in a Virginia long-term care facility.

Option XI: Introduce a joint resolution requesting the State Council of Higher Education for Virginia to work with Virginia's nursing schools to ensure that students receive a CNA credential early in their training to become LPNs or RNs.

Option XII: Introduce a budget amendment appropriating sufficient funds to DMAS to raise average nursing facility reimbursement in Virginia to the national median over a period of time to be determined by the Long-Term Care Subcommittee.

Option XIII:Introduce a budget amendment (language) requiring the Virginia Department of Social Services to develop staff protocols for obtaining resident and family member feedback as part of its process for renewing ACR licenses.

Option XIV:Introduce legislation requiring the Virginia Department of Social Services to provide training to ACR operators and administrators prior to granting an initial license for a facility, provided the operator and/or administrator do not already own or operate an ACR in Virginia. This training should focus on health and safety issues addressed in regulations for adult care residences promulgated by the Virginia Board of Social Services. *Note: this would require a companion budget amendment providing an additional five FTE and $220,000 (GF) for additional training staff in DSS. The additional training staff could also assume an inspections caseload.*

APPENDIX A

CHAPTER 813

An Act requiring the Joint Commission on Health Care to study nursing home licensure regulations and centers of excellence in nursing homes.
[S 1172]
Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. § 1. Study of nursing home licensure regulations and centers of excellence in nursing homes.

A. The Joint Commission on Health Care shall (i) study the adequacy of current Virginia regulations for licensure of nursing homes and the advisability of utilizing "deemed status" for nationally accredited nursing homes with the assistance of the Department of Health and (ii) examine the concept of centers of excellence in long-term care in cooperation with the Secretary of Health and Human Resources.

B. The Joint Commission shall examine the Commonwealth's nursing home licensure regulations to determine: (i) means for making such regulations more outcome oriented and focused on continuous quality improvement, (ii) opportunities for gathering additional resident and family input as part of the licensure process for nursing homes, (iii) the advisability of accepting national accreditation as evidence of compliance with state licensure standards, and (iv) other states' laws regarding deemed status for state licensure of nursing homes.

C. The Joint Commission shall examine the concept of centers of excellence with regard to long-term care reimbursement, specialized care programs, best management practices, and other issues as appropriate in cooperation with the Secretary of Health and Human Resources.

D. The Joint Commission shall submit its report to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions prior to October 1, 1999.

CHAPTER 964

An Act to amend and reenact §§ 63.1-175 and 63.1-177 of the Code of Virginia, relating to adult care residences.

[S 1173]

Approved April 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§63.1-175 and 63.1-177 of the Code of Virginia are amended and reenacted as follows:

§63.1-175. Licenses required; expiration and renewal; maximum number of residents; restrictions on nomenclature.

A. Every person who constitutes, or who operates or maintains, an adult care residence shall obtain the appropriate license from the Commissioner, which may be renewed. The Commissioner or his designated agents, upon request, shall consult with, advise, and assist any person interested in securing and maintaining any such license.

B. The licenses shall be issued on forms prescribed by the Commissioner. Any two or more licenses may be issued for concurrentoperation of more than one adult care residence. Each license and renewals thereof may be issued for periods of up to three successive years, unless sooner revoked or surrendered. The length of each license or renewal thereof shall be based on the judgment of the Commissioner regarding the compliance history of the facility and the extent to which the adult care residence meets or exceeds state licensing standards. Based on this judgment, the Commissioner may issue licenses or renewals thereof for periods of six months, one year, two years, or three years.

C. Each license shall indicate whether the residence is licensed to provide residential living or residential living and assisted living and shall stipulate the maximum number of persons who may be cared for in the adult care residence for which it is issued.

D. Any facility licensed exclusively as an adult care residence shall not use in its title the words "convalescent," "health," "hospital," "nursing," "sanatorium," or "sanitarium," nor shall such words be used to describe the facility in brochures, advertising, or other marketing material. No facility shall advertise or market a level of care which it is not licensed to provide. Nothing in this subsection shall prohibit the facility from describing services available in the facility.

§63.1-177. Inspections and interviews.

A. Applicants and licensees shall at all times afford the representatives of the Commissioner reasonable opportunity to inspect all of their facilities, books and records, and to interview their agents and employees and any person living in such facilities.

B. The Commissioner and his authorized agents shall have the right to inspect and investigate all adult care residences, interview their residents and have access to their records.

C. The Commissioner or his authorized agents shall make at least two inspections of each licensed adult care residence each year, one of which shall be unannounced. The Commissioner may authorize such other announced or unannounced inspections as he considers appropriate. For any adult care residence issued a license or renewal thereof for a period of six months, the Commissioner or his authorized agents shall make at least two inspections during the six-month period, one of which shall be unannounced. For any adult care residence issued a license or renewal thereof for a period of one year, the Commissioner or his authorized agents shall make at least three inspections each year, at least two of which shall be unannounced. For any adult care residence issued a license or a renewal thereof for a period of two years, the Commissioner or his authorized agents shall make at least two inspections each year, at least one of which shall be unannounced. For any adult care residence issued a three-year license, the Commissioner or his authorized agents shall make at least one inspection each year, which shall be unannounced.

D. For any licensed adult care residence, the Commissioner may authorize such other announced or unannounced inspections as the Commissioner considers appropriate.

2. That the Joint Commission on Health Care and the Secretary of Health and Human Resources shall report by October 1, 1999, to the chairpersons of the House Committee on Health, Welfare and Institutions, and the Senate Committee on Rehabilitation and Social Services regarding (i) options for making adult care resident regulations more outcome oriented, (ii) means for making such regulations more focused on obtaining resident and family input, and (iii) the advisability of deemed status for nationally accredited adult care residences.

HOUSE JOINT RESOLUTION NO. 527

Directing the Joint Commission on Health Care to review staffing requirements for nursing home facilities and adult care residences to ensure adequate levels of care and adequate enforcement of these standards.

Agreed to by the House of Delegates, February 5, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, elderly and disabled citizens are very important to the Commonwealth and every effort should be made to ensure that they receive quality care in nursing home facilities and adult care residences; and

WHEREAS, Article I (§32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia requires nursing home facilities to be licensed and the State Board of Health promulgates regulations for these nursing home facilities, and Article I (§63.1-172 et seq.) of Chapter 9 of Title 63.1 of the Code of Virginia requires adult care residences to be licensed and the State Board of Social Services promulgates regulations for these adult care residences; however, guidelines do not exist that dictate staffing requirements beyond meeting the medical and physical needs of residents in nursing home facilities and adult care residences; and

WHEREAS, staffing is the key for providing satisfactory care to a vulnerable group of the Commonwealth's population; and

WHEREAS, the Secretary of Health and Human Resources in House Document 29 (1995) reviewed staffing guidelines for nursing facilities and recommended that the State Department of Health should continue to collect and study, in cooperation with industry providers and advocates, available data on nursing facility staffing; and

WHEREAS, the Congress of the United States, following 1993 hearings on the 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 there is a need for an increase in staff in nursing homes to promote the quality of patient care and, in 1996 the Institute of Medicine recommended by the year 2000 a 24-hour presence of registered nurse coverage in nursing home facilities and that research on staffing levels of licensed practical nurses and nurse assistants to quality of care be continued; and

WHEREAS, the Commonwealth's Joint Legislative Audit and Review Commission in 1998 recommended the development of an appropriate staffing

standard to ensure the adequate supervision and care of residents of adult care residences; and

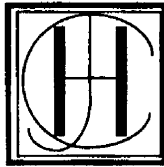
WHEREAS, the establishment of higher standards for staffing in nursing home facilities and adult care residences would lead to higher quality of care and would enable increased supervision for residents; now, therefore, be it

RESOLVED by the House of Delegates, the Senate Concurring, That the Joint Commission on Health Care be directed to review staffing requirements for nursing home facilities and adult care residences to ensure adequate levels of care and adequate enforcement of these standards. The Joint Commission shall determine whether staffing requirements currently in effect in the Commonwealth adequately protect the health, safety and welfare of nursing home and adult care residents. Such review shall also include the adequacy of the enforcement of such staffing guidelines, and a recommendation for enhanced staffing guidelines based on objective data resulting from the study.

All agencies of the Commonwealth shall provide assistance to the Joint Commission, upon request.

The Joint Commission shall complete the study in time to submit all findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: LICENSURE ISSUES IN LONG-TERM CARE (SB 1172, SB 1173, HJR 527)

Organizations Submitting Comments

A total of 12 organizations and individuals submitted comments in response to the SB 1172/SB 1173/HJR 527 report on licensure issues in long-term care.

- Northern Virginia Long-Term Care Ombudsman Program
- Virginia Adult Home Association
- Virginia Long-Term Care Ombudsman Program
- Cheryl Cooper, Coordinator – Nursing Assistant Institute
- Virginia Health Care Association
- Virginia Association of Nonprofit Homes for the Aging
- Appalachian Agency for Senior Citizens
- Gayle L. Dovel
- AARP
- Virginia Hospital & Healthcare Association
- Two John, Inc. Residential Care & Assisted Living Facilities
- Johnson Senior Center, Inc.

Policy Options Included in the SB 1172/SB 1173/ HJR 527 Issue Brief

Option I: **Take no action.**

Option II: **Introduce legislation allowing national accreditation by JCAHO or CCAC to serve as evidence of compliance with state licensure regulations for nursing facilities provided that: (i) the facility agree to share the complete**

accreditation report and associated documents with VDH and interested members of the public, and (ii) VDH would retain the authority to inspect the facility whenever deemed appropriate by the VDH commissioner or designee.

Option III: Introduce a budget amendment (language and associated funding) directing DMAS to modify its reimbursement system for nursing facilities to provide a substantial financial incentive for nursing facilities to reach and maintain a targeted staffing level for direct care staff on all shifts.

Option IV: Introduce a budget amendment (language and associated funding) directing DMAS to develop a financial incentive system for nursing facilities that meet certain patient care benchmarks such as reduced incontinence among patients, improvement in the incidences and treatment of pressure ulcers, and improved nutritional and hydration status of patients.

Option V: Introduce legislation requiring nursing homes licensed in the Commonwealth of Virginia to maintain a specified staffing level for direct care staff. It would be appropriate to consider (i) modifying this ratio for special populations and skilled nursing units, (ii) phasing the mandated level in over a period of three years, and (iii) making allowances for facilities making a good faith effort to hire staff in areas with low unemployment. *Note: this option would require a companion budget amendment to fund the fiscal impact on the Medicaid budget and a budget amendment to fund additional enforcement positions at the Virginia Department of Health.*

Option VI: Introduce legislation amending Section 32.1-126 of the *Code of Virginia* to increase the frequency of required inspections for licensed nursing homes from biennially to twice annually. *Note: This would require a companion budget amendment for additional enforcement positions at the Virginia Department of Health. This option would be appropriate if Option V is selected, as Option V would be difficult to enforce with the current frequency of inspections.*

Option VII: Introduce a budget amendment (language) requesting that the Virginia Community College System develop a funding request and action plan for assisting in developing a trained long-term care nursing workforce statewide, including CNAs, LPNs, and RNs.

Option VIII: Introduce a budget amendment (language) directing the Virginia Department of Health to offer nursing facilities maximum allowable flexibility in providing onsite CNA training, irrespective of the enforcement status of the facility.

Option IX: Introduce a budget amendment requesting that the Board of Nursing Home Administrators consider requiring additional human resources management and human relations training for licensed nursing home administrators, focused on staff retention (alternatively, this could be offered by the Board, though funding and perhaps staff would be required).

Option X: Introduce legislation and a budget amendment establishing a scholarship program for CNAs, LPNs, and RNs interested in pursuing a career in long-term care. As a condition of the scholarships, students would agree to work a

period of time in a Virginia long-term care facility.

Option XI: Introduce a joint resolution requesting the State Council of Higher Education for Virginia to work with Virginia's nursing schools to ensure that students receive a CNA credential early in their training to become LPNs or RNs.

Option XII: Introduce a budget amendment appropriating sufficient funds to DMAS to raise average nursing facility reimbursement in Virginia to the national median over a period of time to be determined by the Long-Term Care Subcommittee.

Option XIII: Introduce a budget amendment (language) requiring the Virginia Department of Social Services to develop staff protocols for obtaining resident and family member feedback as part of its process for renewing ACR licenses.

Option XIV: Introduce legislation requiring the Virginia Department of Social Services to provide training to ACR operators and administrators prior to granting an initial license for a facility, provided the operator and/or administrator do not already own or operate an ACR in Virginia. This training should focus on health and safety issues addressed in regulations for adult care residences promulgated by the Virginia Board of Social Services. *Note: this would require a companion budget amendment providing an additional five FTE and $220,000 (GF) for additional training staff in DSS. The additional training staff could also assume an inspections caseload.*

Overall Summary of Comments

The comments from each of the 12 respondents were generally favorable. Options VII, X, XI, XIII, and XIV received the greatest level of support. Most of the respondents expressed clear support for these options, and none expressed clear opposition. Options II, III, IV, V, VI, VIII, IX, and XII received varying levels of support and opposition from the numerous commenters. None of the respondents expressed support for Option I.

Summary of Individual Comments

Northern Virginia Long-Term Care Ombudsman Program

The Northern Virginia Long-Term Care Ombudsman Program commented in support of Options II through XIV, and strongly endorsed Options III through VI. In support of Option III, it was stated that "Virginia nursing facilities have the highest acuity in the country as measured by the level of assistance needed for basic daily functions...." In reference to Option IV, "introducing patient care benchmarks will increase the quality of care and in the long run should reduce overall medical costs." In support of Option V, it was stated that "as a substate ombudsman I have [seen] the quality of care deteriorate over the last nine years." Concerning Option VI, "increasing required inspections from biennially to twice annually would increase the quality of care." In reference to Option VII, "the training program should include a significant amount of hours in working with the Alzheimer's resident and aggressive behaviors." Concerning Option XIV, "ACR operators and administrators should also receive training in Alzheimer's and aggressive behavior in older adults."

Virginia Adult Home Association

Michael Osorio, Executive Director, commented concerning the issue of deemed status: "In addition to being prohibitively expensive for adult care residences, deemed status has not met expectations in the hospital arena. JCAHO is in the process of

formulating an approach to monitoring assisted living systems. We ask you not to embrace this approach. No matter how anyone has characterized the regulatory performance of the Virginia Department of Social Services, no one can say that it has been cozy and predictive."

Mr. Osorio also commented concerning funding for adult care residences: "We feel that funding is **the** problem...Virginia has failed to fully utilize (fund) the Medicaid waiver program. They need to do so...We still do not have an AG reimbursement methodology. This has been repeatedly recommended by JLARC. The victims of this inattention are the residents. They have been denied the opportunity to shop for more accessible and comprehensive care."

Virginia Long-Term Care Ombudsman Program

Mark C. Miller, State Ombudsman, commented in support of Options II through XIV, and strongly endorsed Options III through VI. According to Mr. Miller, "phasing-in staffing ratios (Option V) while reworking the Medicaid reimbursement system (Options III and IV) presents a win-win situation for all parties, but most importantly the residents." Mr. Miller also stated that "The fact that eight of the thirteen action options presented are staffing related indicates the complexity of the staffing issue. There is no single answer. Therefore each of these options represents a critical piece of a comprehensive approach to reach the solution to this growing problem effecting quality care."

Cheryl Cooper, Coordinator, Nursing Assistant Institute

Ms. Cooper was generally supportive of Options II through XIV, but stated that she most strongly supported Option IV: "This is a reward for improving quality of care that may be related to increased staffing levels, though an equally important component of these improvements is training of the staff." In support of Option VII, Ms. Cooper stated that "it may be that the action plan will need to include steps on screening prospective students to ensure that those entering the

programs are sufficiently sure that this is a line of work they want to pursue." In terms of Option VIII, Ms. Cooper stated that "It would seem appropriate to consider the nature of the problem that resulted in a survey deficiency. If the problem were solely administrative, training could continue on-site. If the problem was clinical and related to the quality of care the residents receive, continuation of training may not be appropriate." Ms. Cooper commented that Option XI is "a positive step that may help to some degree," and called Option XII "an excellent consideration."

Virginia Health Care Association

Mary Lynne Bailey, Vice President, Legal and Government Affairs, commented in support of Options II, IV, and VII through XIV. According to Ms. Bailey, the VHCA enthusiastically supports Option XII, stating that "When Virginia's [reimbursement] rates were adjusted for resident acuity, Virginia's Medicaid payment rate fell to **50th lowest in the country**."

Ms. Bailey expressed opposition to Options I, III, V, and VI. Concerning Option III, Ms. Bailey stated that "VCHA is opposed to targeted staffing levels because professional nursing home administrators who understand the staffing and care needs of a changing patient population must have the flexibility to meet those needs in the most cost effective manner. The assumption that more 'bodies' on a given shift will be the single answer to quality care is not valid." In expressing opposition to Option V, Ms. Bailey commented that "Since HCFA is currently conducting a study of mandated staffing ratios, it is premature for the Commonwealth to legislate staffing ratios at this time." Ms. Bailey also stated that "The Health Department has sufficient tools in its current survey process to cite and penalize a facility for not having adequate staff. In fact, the Department of Health's 1995 study found no need to mandate staffing ratios in nursing facilities." Finally, in reference to Option VI, Ms. Bailey stated that "There is currently no need for more than biennial licensure inspections, since the federal survey inspections are conducted more frequently."

Virginia Association of Nonprofit Homes for the Aging

Marcia A. Melton, Vice President for Public Policy, expressed support for Options II, IV, VII, and X through XIII.

Appalachian Agency for Senior Citizens

Jennifer S. Marrs, Local Long-Term Care Ombudsman, stated that "policy options II through XIV all have potential for enhancing the lives of long-term care residents as well as provide working incentives for nursing/direct care staff." Ms. Marrs commented that "low staff-to-resident ratios serve to develop poor staff attitudes, difficult working conditions, and most of all, inadequate care and neglect of the residents." Finally, Ms. Marrs stated that "Although the proposed policies are directed to improving care in long-term care facilities, I believe it is equally important to consider the community-based long-term care system."

Gayle L. Dovel

Ms. Dovel stated that she and her husband each have one parent still living and being cared for in a nursing home facility. Commenting in support of Option V, Mrs. Dovel stated that "For the past year and a half, we have watched the quality of care disintegrate to the point of personal injury. The lack of supervision has led to the loss of personal property and, at times, the loss of the patient herself. We suffer with inadequate staffing, inedible food, and continual excuses for mistakes made. This needs to be stopped, for our parents and for the parents of others."

AARP

William L. Lukhard, Vice- Chairman, Virginia State Legislative Committee, commented in support of Options V, VI, VII, X, XI, XIII, and XIV. Concerning Options VII, X, and XI, Mr. Lukhard suggested that "educational assistance to students and staff be heavily targeted towards CNAs and LPNs." Concerning Option XIV, Mr. Lukhard suggested that "the training initially apply to

all operators and administrators in the first 2 years of the program and then to new operators and administrators prior to granting an initial licensure for a facility."

Mr. Lukhard expressed opposition to Options II, III, IV, VIII. Concerning Option II, Mr. Lukhard stated that deemed status "affords little protection for consumers due to potential conflict of interest concerns between the accrediting organization and its members who provide revenue to the accrediting organization...." Mr. Lukhard commented that Options III and IV "seem to provide for increased reimbursements with no assurance as to improved quality of care. A number of states have attempted financial incentives and none have been able to show that quality of care has improved." Mr. Lukhard expressed opposition to Option VIII by commenting that "on site CNA training at a facility that is not in compliance with state licensure laws and regulations could be a bad training ground for the most critical of direct caregivers."

Finally, Mr. Lukhard commented that Option XII as presented is "too loose," and raises the question of whether the national median reimbursement rate is "reflective of the quality of care." Mr. Lukhard stated that "it is difficult to compare rates across states as each state has different standards and may incorporate different cost components into its rates." He stated that "any funds appropriated under this concept should specify what the increases could be used for in order to ensure a move toward better quality of care at that facility."

Virginia Hospital & Healthcare Association

Susan C. Ward, Vice President, commented in support of Options II, VII through XI, and XII. Ms. Ward expressed opposition to Options V and VI, by stating that enforcement of staff ratios "do not consider resident outcomes and will not constructively address staffing needs." Concerning Options XIII and XIV, Ms. Ward stated that "we reserve comments on these options for the more detailed discussion of ACRs expected in a later brief."

In terms of Options III and IV, Ms. Ward commented that "These options addressing nursing facility staffing issues both recognize important principles that we support, i.e., that sufficient financial resources are needed to maintain optimum staffing levels and that 'optimum staffing levels' should be identified and measured based on resident outcomes." However, with respect to Option III, Ms. Ward stated that "it is unclear to us what 'targeted staffing levels' are." Ms. Ward also stated that "It appears that Virginia's nursing facilities are already giving staffing a high priority, but low reimbursement levels may be forcing us to neglect other important elements contributing to positive quality of life in order to emphasize staffing needs."

Two John, Inc. Residential Care & Assisted Living Facilities

JoElla John, owner, commented that staffing ratios should not be mandated "without first determining that regulating the number of care givers will, in fact, improve the quality of care. It has been my experience that too little staff stresses even the best employees, but too much staff is worse." Ms. John suggested the use of an outcome-based system to measure the adequacy of staffing levels.

Johnson Senior Center, Inc.

Robert L. Johnson expressed opposition to the concept of mandatory staffing ratios: "My experience with staffing has been that you can have too many employees as well as not enough." For example, "Too many people working get in each others way- whereby duties are not performed, mistakes happen, and one employee will put the blame on another." According to Mr. Johnson, instead of having a required staffing ratio, "the state should consider rewarding operators for the quality of services."

JOINT COMMISSION ON HEALTH CARE

Executive Director

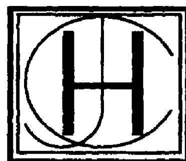
Patrick W. Finnerty

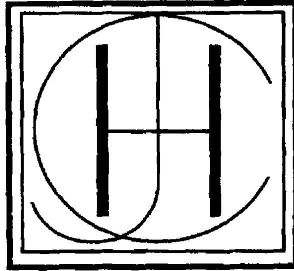
Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.
E. Kim Snead

Office Manager

Mamie V. White





Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm