

**REPORT OF THE
JOINT COMMISSION ON HEALTH CARE**



**NURSE STAFFING RATIOS IN
NURSING FACILITIES STUDY**

(SB 1125/HB 2257)

**TO THE CHAIRMAN OF THE SENATE COMMITTEE ON
EDUCATION AND HEALTH**

Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
<http://legis.state.va.us/jchc/jchchome.htm>

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I.

Authority for Study/Organization of Report

Senate Bill 1125 Of The 2001 Session Of The General Assembly Was Referred To The Joint Commission On Health Care For Study

Senate Bill (SB) 1125 of the 2001 Session of the General Assembly would have required nursing homes in Virginia to meet minimum nurse staffing levels (expressed as a ratio of nurses and nurse aides to residents) in order to be licensed to operate in the Commonwealth. (A copy of SB 1125 is attached at Appendix A.)

While the bill was tabled in the Senate Committee on Education and Health, the motion to table the bill also included a motion to refer the bill to the Joint Commission on Health Care (JCHC) for study. In his letter requesting the JCHC to study the provisions of SB 1125, the Chairman of the Senate Committee on Education and Health (Senator Warren E. Barry) wrote: "there was much discussion concerning staffing standards and issues relating to quality of care, appropriate staffing ratios and required positions, patient acuity, and the costs of care as such costs could be affected by establishing strict staffing standards." The letter requested that the JCHC "...include an examination of the provisions of SB 1125 and the issues relating to staffing standards in its study plan for the 2001 interim and that the Commission provide the Senate Committee on Education and Health with any recommendations on these issues that it may deem appropriate." (A copy of Senator Barry's letter is attached at Appendix B.)

In addition to SB 1125, House Bill (HB) 2257 of the 2001 Session of the General Assembly also would have required nursing homes to meet certain nurse staffing standards in order to be licensed to operate in the Commonwealth. HB 2257 was tabled in the House Committee on Health, Welfare, and Institutions. This bill was not referred to the JCHC for further study. While the type of minimum nurse staffing required under HB 2257 (i.e., hours of direct care per resident per day) is different from SB 1125 (i.e., ratio of nurses and nurse aides to residents), the intent and purpose of both bills are very similar. Therefore, the provisions of HB 2257 and the type of minimum nurse staffing contemplated in this proposed legislation are reviewed in this report. (A copy of HB 2257 is attached at Appendix C.)

This Report Is Presented In Six Major Sections

This first section discusses the authority for the study and organization of the report. Section II reviews current federal and Virginia nurse staffing standards for nursing homes, and compares nurse staffing in Virginia nursing homes with that in other states. Section III reviews the findings of several studies that have analyzed nurse staffing in nursing homes, and discusses the concerns that have been raised by a number of advocacy groups and others regarding nurse staffing. Section IV reviews the nurse staffing requirements in other states. Section V analyzes the impact of mandating minimum nurse staffing levels in the Commonwealth, and discusses these requirements in the context of the current nursing workforce in the Commonwealth. Lastly, Section VI presents a series of policy options the Joint Commission may wish to consider in addressing the issue of minimum nurse staffing standards in nursing homes.

II. Nurse Staffing In Virginia Nursing Homes: Current Standards and Practices

The Centers For Medicare And Medicaid Services Require All Nursing Facilities Certified For Medicare Or Medicaid Reimbursement To Meet Certain Nurse Staffing Standards; Federal Requirements Do Not Include Direct Care Staffing Ratios Or A Minimum Number Of Hours Of Care Per Resident

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), require that in order to receive Medicaid or Medicare reimbursement, nursing facilities must meet certain nurse staffing standards. Specifically, Title 42, Section 483.30 of the *Code of Federal Regulations* requires that facilities “have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.” Facilities are required to have licensed nurses (i.e., licensed practical nurses [LPNs] and registered nurses [RNs]) and other nurses (i.e., certified nurse aides [CNAs]) on duty 24 hours each day. In addition to this general requirement, the federal requirements also include more specific directives regarding the services of licensed nurses. Section 483.30 of the federal regulations requires facilities to:

- (i) designate a licensed nurse to serve as a charge nurse on each tour of duty;
- (ii) use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week; and
- (iii) designate a registered nurse to serve as the director of nursing on a full-time basis.

These three specific requirements can be waived if the facility demonstrates to the State that certain circumstances exist which precludes it from hiring and retaining the required nurse staff.

Other than the three requirements noted above regarding licensed nurses, the federal staffing requirements do not require facilities to meet specific staffing ratios (e.g., 1 nurse aide for every 5 residents) as proposed in SB 1125 or a minimum number of direct care hours per resident per day (e.g., 5 hours of direct patient care per day) as proposed in HB 2257. Instead, the federal standards

require that the staffing be “sufficient” to meet the individual care needs of the residents.

States Conduct Certification/Recertification Surveys Of Nursing Facilities To Ensure Compliance With Federal Requirements; CMS Provides Guidance To State Surveyors In Determining Sufficiency Of Nurse Staff

CMS contracts with each of the 50 states to conduct nursing home certification/recertification surveys as a means of ensuring compliance with various federal requirements. States must survey each certified facility within 15 months of the facility’s last survey. The state survey agency must maintain a statewide average of 12 months for recertification, standard health surveys. In Virginia, the Virginia Department of Health (VDH) conducts the nursing facility surveys. CMS provides guidance to state surveyors for determining whether facilities are in compliance with the various federal requirements. If a facility does not comply with a federal requirement, state surveyors cite the facility with a deficiency in the survey report.

With respect to reviewing the sufficiency of a facility’s nurse staffing, CMS directs states to review staffing “whenever quality of care problems have been discovered.” The CMS guidance further states that “[E]xcept for licensed staff . . . the determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff.” The following are a sample of the probes included in the CMS guidance to surveyors regarding sufficiency of nurse staff.

- Is there adequate staff to meet direct care needs, assessments, planning, evaluation, and supervision?
- Do work loads for direct care staff appear reasonable?
- Do residents, family, and ombudsmen report insufficient staff to meet resident needs?
- Is staff responsive to residents’ needs for assistance, and are call bells answered promptly?
- Do residents call out repeatedly for assistance?
- Are residents, who are unable to call for help, checked frequently for safety, comfort, positioning, and to offer fluids and provision of care?
- Are identified care problems associated with a specific unit or tour of duty?

- How does the sufficiency of nursing staff contribute to identified quality of care, resident rights, quality of life, or facility practices problems?

In addition to the above probes, an investigative protocol is provided by CMS to guide the surveyors' review of staffing issues.

Concerns Have Been Raised Regarding The Ability Of State Surveyors To Determine If The Federal Nurse Staffing Requirements Are Being Met By Nursing Facilities

There are specific requirements for RN staffing (i.e., RN coverage of a minimum of 8 consecutive hours per day). However, the general requirement imposed by the federal government for nurse staffing is that it be sufficient to meet the needs of nursing home residents. There is no definition of the term "sufficient" in the federal regulations. In 2000, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services, conducted a study on the appropriateness of minimum nurse staffing ratios in nursing homes. In the study, HCFA reviewed the ability of state surveyors to enforce its general requirement that nursing homes provide "sufficient" nurse staffing.

In its report to Congress, HCFA noted that many professionals view this general requirement, when implemented in practice, as too vague to serve as an adequate federal standard. HCFA reviewed various data from state surveyors and assessed how the surveyors document whether a facility is providing "sufficient" nurse staffing. The HCFA report stated that the evidence it reviewed "raises serious doubts as to whether surveyors can in fact make what appears to be a very difficult judgment – a judgment with a high burden of documentation which must be generated under demanding time constraints." The HCFA report went on to say "[A]lthough staffing may appear to be easy for surveyors to cite when there are real staffing problems, a close reading of HCFA's regulations and guidelines to surveyors reveals that surveyors must meet a very demanding criteria. To cite appropriately, surveyors must demonstrate that nursing care has not been provided to residents or lack of sufficient staff has resulted in failure to identify, implement, and coordinate needed services."

The concern about the difficulty in enforcing the federal standard is shared by a number of consumer/resident advocacy groups, including the National Citizens' Coalition for Nursing Home Reform and TLC4Long Term Care. These organizations argue that the federal standard is difficult to interpret and enforce.

This ultimately leads to facilities being able to operate without an appropriate level of staff, and without being cited for insufficient staff.

Federal Staffing Requirements Apply To Almost All Nursing Homes In Virginia; However, 20 Are Subject Only To State Licensing Laws And Regulations; Virginia Statutes And Regulations Contain Minimal Nurse Staffing Requirements For Nursing Homes

As previously noted, the Virginia Department of Health (VDH) conducts nursing home surveys to ensure compliance with federal requirements. According to VDH, 278 of Virginia's 298 nursing homes are certified for Medicare and/or Medicaid. Accordingly, the vast majority of nursing homes must meet CMS requirements for nurse staffing. However, those 20 facilities which are not certified must comply only with the Commonwealth's nursing home licensing statutes and regulations.

The nursing home licensure provisions in the *Code of Virginia* contain only a reference to nurse staffing. Section 32.1-127 requires the Board of Health to promulgate regulations to ensure compliance with standards of health, hygiene, sanitation, construction and safety. Section 32.1-127(B) requires the regulations adopted by the Board to include minimum standards for the operation, staffing, and equipping of hospitals, nursing homes, and certified nursing facilities. There are no other *Code of Virginia* provisions that relate directly to nurse staffing in nursing homes.

The regulations adopted by the Board of Health which relate to nurse staffing in nursing homes are minimal, and provide very general direction as to the minimum level of acceptable staffing. With respect to licensed nurse staff (i.e., LPNs and RNs), some provisions of the state regulations are similar to federal regulations. For instance, 12VAC5-371-200(A) of the Virginia Administrative Code requires each facility to employ a full-time director of nursing (DON) to supervise the delivery of nursing services. The DON must be a registered nurse. Another state regulation that has a similar federal requirement is that each facility must have a nursing supervisor who is responsible for all nursing activities. However, state regulations do not require any minimum number of consecutive hours that a registered nurse must work in a given day/week as required by the federal regulations (8 consecutive hours per day/7days per week). As such, the 20 nursing facilities in Virginia that are not certified for Medicare or Medicaid do not have to meet this requirement.

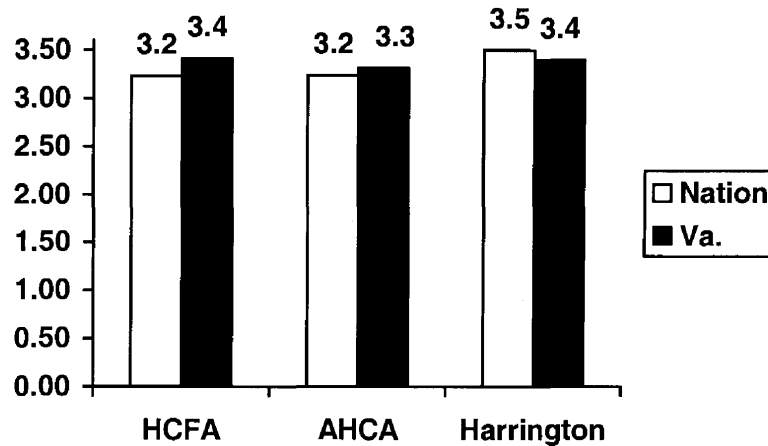
With respect to direct care nursing staff (i.e., certified nurse aides [CNAs]), the Virginia regulations contain a general requirement similar to the federal requirement. Virginia regulation 12VAC5-371-210(B) provides that “the nursing facility shall provide qualified nurses and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care needs of all residents.”

Overall, Nurse Staffing In Virginia Nursing Homes Is Comparable To The National Average

Various studies and reports published by government, nursing home industry, and advocacy organizations have included estimates of the number of nursing staff per resident and/or the number of nursing care hours per resident day. While each estimate is based on a slightly different methodology, each indicates that the nurse staffing in Virginia nursing homes is near the national average. Figure 1 presents the estimates reported in studies completed by the

Figure 1

**Estimates of Nurse Staffing In Virginia And The Nation:
Average Total Nursing Hours Per Resident Per Day (1999)**



Note: Harrington study estimate relates to total nursing in “certified” facilities; the CMS and AHCA estimates relate to all facilities

Source: U.S. Health Care Financing Administration’s Report to Congress, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes,” May, 2000; Health Services Research and Evaluation, American Health Care Association, “Staffing of Nursing Services in Long Term Care: Present Issues and Prospects for the Future,” February, 2001; and Charlene Harrington, Ph.D., et. al., Department of Social and Behavioral Sciences, University of California, San Francisco, “Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999,” October, 2000

Health Care Financing Administration (HCFA), the American Health Care Association (AHCA), and Charlene Harrington, Ph.D., et. al. from the University of California at San Francisco.

Within each of the three levels of nurse staffing (i.e., RNs, LPNs, and CNAs), Virginia also appears to be comparable to the national average. With respect to RNs, both the Harrington and AHCA studies indicate Virginia's average number of hours of care per resident day is slightly below the national average. For LPNs, both studies cite Virginia as just above the national average. For CNAs, the Harrington study estimates Virginia to be just under the national average, while the AHCA findings indicate Virginia is just above the national average. However, as seen in Figure 2, the differences between the two reports are minimal, and, in all cases, Virginia is essentially at the national average.

Figure 2

**Estimates of Nurse Staffing In Virginia And The Nation:
Average Nursing Hours For RNs, LPNs, And CNAs Per Resident Per Day (1999)**

	RNs	LPNs	CNAs
AHCA Study			
▪ Virginia	.41	.87	2.03
▪ Nation	.51	.73	2.00
Harrington Study			
▪ Virginia	.6	.8	2.0
▪ Nation	.7	.7	2.1

Note: Harrington study estimates relate to total nursing in "certified" facilities; the AHCA estimates relate to all facilities

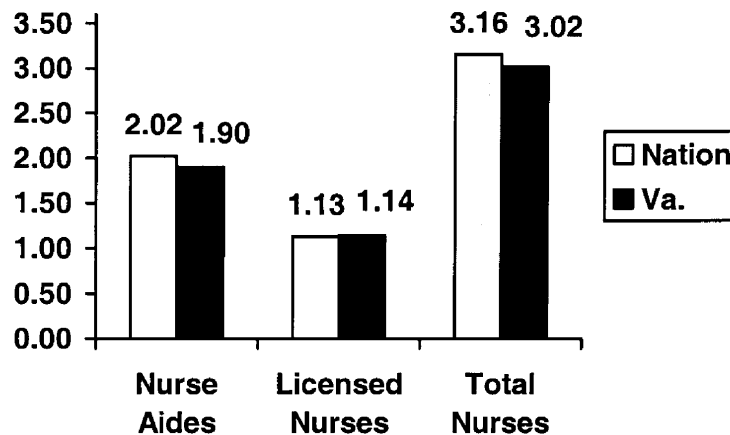
Source: Health Services Research and Evaluation, American Health Care Association, "Staffing of Nursing Services in Long Term Care: Present Issues and Prospects for the Future," February, 2001; Charlene Harrington, Ph.D., et. al., Department of Social and Behavioral Sciences, University of California, San Francisco, "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999," October, 2000

While Figures 1 and 2 present data regarding the "average" number of nursing hours per resident per day, a report published in 2001 by Harrington analyzed the "median" number of nursing hours per resident per day for each state. Harrington's analysis indicates that while Virginia is near the national median, it is below the median for nurse aides and "total" nurses (i.e., licensed and nurse aides), and just above the median for licensed nurses. Figure 3 illustrates Harrington's findings regarding actual median nursing hours per resident day in 1999.

Harrington also calculated a “state minimum staffing standard” of hours per resident per day based on each state’s regulations and statutes. Virginia’s standard for licensed nurses was .14 as compared to the national median of .41; Virginia’s standard for total nursing was 0.0 (due to no specific requirement for nurse aides), as compared to the national median of 2.32. However, while Virginia’s minimum staffing standard is significantly below the national median for both licensed nurses and total nurses, as seen in Figure 3, the actual median hours per resident per day is much closer to the actual median for the nation.

Figure 3

**Median Nursing Hours Per Resident Day in 1999:
Virginia and the Nation**



Source: Harrington, C., Ph.D., Department of Social and Behavioral Sciences, University of California, San Francisco, “State Minimum Nurse Staffing Standards for Nursing Facilities,” April, 2001

Nurse Staffing Levels That Are At Or Near The National Average Do Not Equate Necessarily To Appropriate Staffing

While the number of nursing hours per resident per day for Virginia approximates the national average, this finding does not mean necessarily that Virginia’s staffing levels, nor the nation’s, are appropriate. As will be discussed in the next section of this report, numerous studies and reports have charged that the level of nursing staff throughout the country is too low to ensure quality patient care. The fact that Virginia’s staffing levels are about the same as the rest of the country means just that . . . they are about the same. The appropriateness of the level of staffing is a separate issue.

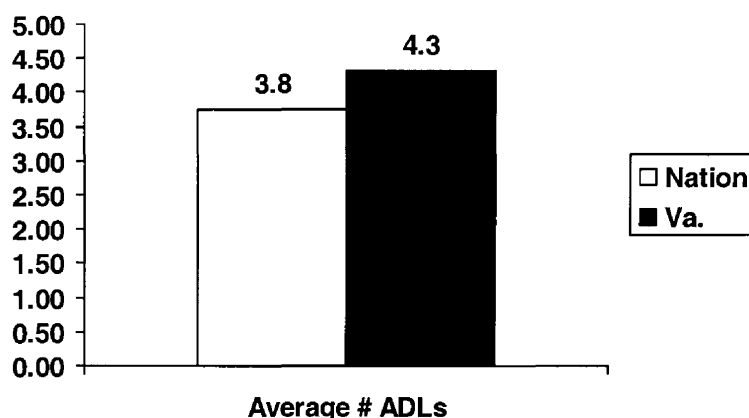
The Acuity Level Of The Patients In A Nursing Facility Is An Important Consideration In Determining The Appropriate Level Of Nurse Staffing; Virginia Nursing Facility Residents Have The Highest Level Of Acuity In The Nation

While the number of nursing hours per resident per day provides a useful measure of the level of nurse staffing in a facility, the acuity level of the residents is an important consideration when reviewing the appropriateness of a given level of staffing. While Virginia is at or near the national average for hours of nursing care per resident per day, the acuity level of the residents in Virginia nursing facilities is the highest in the nation. There is general agreement among industry representatives and resident advocates that the restrictive eligibility criteria for receiving Medicaid reimbursement for nursing home care is the principal reason for Virginia's high resident acuity level.

As seen in Figure 4, Virginia's acuity level, measured as the average number of activities of daily living (ADLs) with which residents need assistance,

Figure 4

Acuity Level Of Nursing Facility Residents As Measured By Activities of Daily Living: Virginia And The Nation (1999)



Note: ADLs refers to the average number of "activities of daily living" with which residents need assistance
Source: American Health Care Association, "Facts and Trends," 2001

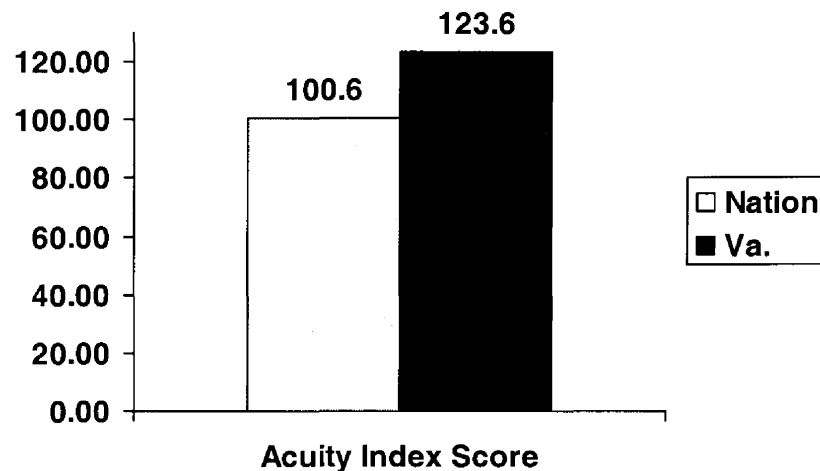
is 4.32 as compared with a national average of 3.75. Another measure of resident acuity is referred to as the "management minute index." This index is based on a compilation of resident characteristics including being bedfast, needing assistance with ambulation, needing full eating assistance, having an indwelling

catheter, and other similar limitations. The average index for the U.S. was 100.6 in 1999; the index for individual states ranged from a low of 69.8 in Iowa to a high of 123.6 in Virginia (see Figure 5).

The high acuity level of Virginia nursing facility residents means that the staff working within the facilities must meet a greater demand for service than is the case in any other state. Therefore, while the number of nursing hours per resident per day in a Virginia facility approximates the national average, a higher level of care must be provided within the same amount of nursing hours which places an extra burden on the staff. Nursing home resident advocates point to this finding as an indication of the need for greater staffing levels in the Commonwealth. Nursing home industry representatives also point to the high acuity level as justification for increased Medicaid reimbursement.

Figure 5

**Acuity Level Of Nursing Facility Residents In Virginia And The Nation (1999)
As Measured By "The Management Minute Index"**



Note: The "Management Minute Index" is based on a compilation of resident characteristics including being bedfast, needing assistance with ambulation, needing full eating assistance, needing some eating assistance, having an indwelling catheter, being incontinent, having a pressure ulcer, receiving bowel or bladder retraining, and receiving special skin care.

Source: Charlene Harrington, Ph.D., et. al., Department of Social and Behavioral Sciences, University of California, San Francisco, "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999," October, 2000

III.

Concerns Regarding Nurse Staffing In Nursing Homes

A Number Of Studies And Reports Have Raised Serious Concerns About The Adequacy Of Nurse Staffing In Nursing Homes Across The Nation

Over the past several years, numerous studies, reports, and articles published by government agencies, health care researchers, and advocacy groups have raised concerns about the level of nurse staffing in nursing homes. While each has reached varying conclusions about what the appropriate level of staffing should be, all have concluded that the current level of staffing is insufficient, and results in lower quality of care.

Office of Inspector General of the U.S. Department of Health and Human Services: In a report released in March, 1999, the Office of the Inspector General (OIG) concluded that serious quality of care problems persist in nursing homes, and that inadequate levels of nursing home staff contribute to quality of care problems. The OIG study examined several data sources from 10 sample states (New York, California, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, Florida, New Jersey, and Tennessee). Interviews also were held with survey and certification staff, state and local ombudsmen, and State Aging Unit Directors. The OIG reported that the representatives from all 10 states identified “inadequate staffing levels as one of the major problems in nursing homes. Most believe these staffing shortages lead to chronic quality of care problems, such as failure to adequately treat and prevent pressure sores.” Included in the OIG’s “broad outline of an effective strategy” to improve the quality of care in nursing homes is a recommendation to improve nursing home staffing levels.

Hartford Institute Expert Panel: A one-day conference of experts was convened at the Hartford Institute for Geriatric Nursing, Division of Nursing, New York University in 1998 to address the issue of staffing and quality of care in nursing facilities. Charlene Harrington, Ph.D. was the lead author of the expert panel’s findings and recommendations. National experts attending the conference included leading nurse researchers, educators and administrators in long-term care, consumer advocates, health economists, and health services researchers knowledgeable about nursing homes.

The expert panel’s article, which was published in the journal of the Gerontological Society of America, *The Gerontologist*, cited the results of numerous studies (Aaronson, et. al., 1994; Bliesmen, et. al., 1998; Cherry, 1991;

Cohen & Spector, 1995; Linn et. al., 1977; Munroe, 1990; Nyman, 1988; and Spector & Takada, 1991) which show the positive relationship between higher nurse staffing levels, especially RN staff, and the outcomes of nursing home care. Each of the aforementioned studies found that nurse hours per patient day were related positively to better outcomes and quality of care for nursing home residents. The Hartford Institute panel also cited the findings of a Health Care Financing Administration (HCFA) study regarding the amount of time necessary to provide needed nursing care to residents.

Based on the results of the prior studies and analysis of other information, the expert panel concluded “that current data show that the average nursing staffing levels for RNs, LPNs, and CNAs in nursing homes are too low in some facilities to provide high quality of care.” The panel proposed a comprehensive and detailed nurse staffing plan that it recommended be adopted by nursing homes. As will be discussed in Section V of this report, this panel’s recommendations formed the basis for much of the staffing levels proposed in SB 1125. Figure 6 summarizes the proposed nurse staffing standards developed by the Hartford Institute expert panel.

U.S. General Accounting Office: The U.S. General Accounting Office (GAO) has conducted a number of studies regarding the nursing home industry in recent years. Most of the GAO’s inquiry has focused on federal oversight of the nursing home industry, the state certification survey process, and complaint investigation procedures. The published GAO reports address staffing only indirectly as one contributing factor to overall quality of care in a nursing home. In addition, GAO has issued several reports on the nursing shortage across the U.S. and how the shortage of CNAs has a negative impact on quality of care in nursing homes.

Several National And State Nursing Home Resident Advocacy Groups Support Minimum Nurse Staffing Standards

The National Citizens’ Coalition for Nursing Home Reform (NCCNHR), an advocacy organization with 200 member groups and more than 1,000 individual members nationwide, was formed out of concern for what it considers to be substandard care in nursing homes. Inadequate staffing is among NCCNHR’s chief concerns about nursing homes. It adopted in 1998 a set of minimum nurse staffing standards that mirror the standards proposed by the Hartford Institute. (The Hartford Institute’s recommendations are summarized in Figure 6.)

Figure 6

**Minimum Staffing Standards for Nursing Homes Proposed by
Hartford Institute Expert Panel**

Administration Standard

- Full-time RN with a bachelor's degree as Director of Nursing
- Part-time RN Assistant Director of Nursing (full-time in facilities with 100 or more beds)
- Part-time RN Director of In-Service Education (full-time in facilities with 100 or more beds)
- Full-time RN Nursing Facility Supervisor on duty at all times, 24 hours/day; 7 days/week

Direct Care Staffing Standard

Minimum Direct Care (RN, LPN, or CNA)

- Day Shift: 1 FTE for each 5 residents (1.60 hours/resident/day)
- Evening Shift: 1 FTE for each 10 residents (.80 hours/resident/day)
- Night Shift: 1 FTE for each 15 residents (.53 hours/resident/day)

Minimum Licensed Nurse (RN or LPN)

- Day Shift: 1 FTE for each 15 residents (.53 hours/resident/day)
- Evening Shift: 1 FTE for each 20 residents (.40 hours/resident/day)
- Night Shift: 1 FTE for each 30 residents (.27 hours/resident/day)

TOTAL Direct Care Staffing: 4.13 hours/resident/day*

TOTAL Administrative and Direct Care Staffing: 4.55 hours/resident/day*

* Staffing must be adjusted upward for residents with higher nursing care needs

Note: Other recommendations included education and training standards as well as a recommendation that each nursing home have a part-time geriatric or adult nurse practitioner and or a geriatric clinical nurse specialist on staff (full-time for 100 beds or more)

Source: Harrington, et. al., "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities In the United States," *The Gerontologist*, Vol. 40, No. 1, 2000

TLC4Long Term Care (TLC4LTC) is an advocacy group based in Virginia which has been a very strong advocate of minimum nurse staffing ratios. TLC4LTC believes "[T]he enactment of minimum safe staffing standards is essential if Virginia's nursing home residents are to obtain the quality of care they need and deserve. . . The lack of safe standards, combined with actual staffing levels that fall behind the country's median is jeopardizing the health and welfare of the frailest nursing home residents in the country, as well as creating hazardous working conditions that lead to a lack of care, poor treatment and neglect. Surveyors need specific numerical standards to enable them to pinpoint and cite inadequate staffing so that the problem is identified and

corrected.” TLC4LTC helped to draft the provisions of SB 1125 and was a strong supporter of the legislation.

Other groups which have voiced support for minimum staffing standards in nursing homes include the Virginia Coalition for the Aging, the Virginia Poverty Law Center, the Virginia Long-Term Care Ombudsman Program, the Alzheimer’s Association of Northern Virginia, and the Northern Virginia Aging Network. Each has indicated that mandated nurse staffing ratios or standards are needed to improve the quality of care provided to nursing home residents. A number of other advocacy groups support increased staffing in nursing homes and improved quality of care, but have not endorsed specifically a mandated nurse ratio. In addition to advocacy groups, the Virginia Association of Professional Nursing Assistants also supports minimum nurse staffing standards.

A Consensus Statement On The Nurse Staffing Crisis In Nursing Homes Was Issued By “The Campaign For Quality Care”

“The Campaign for Quality Care” is composed of advocacy groups (e.g., NCCNHR, Alzheimer’s Association, National Association for the Support of Long-Term Care), industry/provider representatives (e.g., American Health Care Association and American Association of Homes and Services for the Aging), nursing /employee groups (e.g., American Nurses Association, Food and Allied Service Trades, AFL/CIO, American Federation of State, County and Municipal Employees, and the Service Employees International Union), and other interested groups (e.g., National Association of Area Agencies on Aging, and Institute for Palliative & Hospice Care). These groups all endorsed a consensus statement regarding “the nurse staffing crisis in nursing homes.” Below are several excerpts from the consensus statement which express concern over the level of staffing in nursing homes:

Nursing homes across the country continue to experience a staffing crisis that can jeopardize quality of care and life for residents. This crisis includes insufficient numbers of staff, including certified nursing assistants (CNAs), licensed practical or vocational nurses (LPN/LVNs) and registered nurses.

In many nursing homes, CNAs, who provide most of the personal care, and licensed nurses, who also provide direct care, are assigned to more residents than

they can properly care for. In situations where unrealistic workloads exist, resident needs are often unmet, raising the risk of harmful and costly complications . . . reasonable workloads are a necessary condition for quality care.

Adequate staffing is an essential component to workplace safety. Insufficient numbers of staff or a shortage of appropriately trained staff can contribute to increased risk for staff injuries and illness.

While this consensus statement, which is endorsed by the AHCA, does not advocate for minimum nurse staffing standards or ratios, it does indicate clearly that there is a staffing problem in nursing homes across the country.

Data Collected Through The National Ombudsman Reporting System Indicate That Shortage Of Staff Is One Of The Most Frequent Complaints Received By The State Long-Term Care Ombudsman In Virginia

The National Ombudsman Reporting System (NORS) was established in 1995 as a centralized database into which all state long-term care ombudsman programs report complaint data. In 1999, there were a total of 172,662 complaints nationwide reported to NORS. Of this total, 1,086 were reported to NORS from Virginia. NORS reports regarding complaints for 1999 indicate that “call lights, requests for assistance” was the most frequent complaint nationwide. In Virginia, “shortage of staff,” “accidents, improper handling,” and “medications-administration, organization” were tied for the most frequent complaints. Figure 7 identifies the top ten categories of complaints received by long-term care ombudsman programs across the nation as compared to that for Virginia.

The information presented in Figure 7 is 1999 data. Virginia’s Long-Term Care Ombudsman Program reported that, in FY 2000, it received a total of 1,517 complaints regarding nursing homes, of which 64% (968) were related directly or indirectly to inadequate staffing.

The U.S. Department of Health and Human Services Office of the Inspector General (OIG) conducted a study in 1999 on the long-term care ombudsman program. As part of its review, the OIG interviewed ombudsmen in 10 states with the largest nursing home population, and found that “the problem ombudsmen say they see most frequently in nursing homes is insufficient nursing home staff.”

Figure 7

**Top Ten Long-Term Care Ombudsman Program Complaints In Nursing Homes:
Virginia and the Nation (1999)**

Nation			Virginia		
Complaint Category	Rank	% of Tot. Comp.	Complaint Category	Rank	% of Tot. Comp.
Call lights, requests for assistance	1	4.43%	Shortage of staff	1	4.60%
Personal hygiene	2	4.12%	Accidents, improper handling	1	4.60%
Accidents, improper handling	3	3.94%	Medications-admin/organization	1	4.60%
Dignity, respect-staff attitudes	4	3.74%	Other: financial, property	4	4.33%
Care plan/resident assessment	5	3.71%	Contracture	5	3.87%
Shortage of staff	6	3.32%	Physical abuse	6	3.59%
Discharge planning, notice, procedure	7	3.16%	Other: abuse, gross neglect, exploitation	7	3.41%
Menu quality, variation, choice	8	2.93%	Symptoms unattended to	8	2.95%
Physical abuse	9	2.66%	Pressure Sores	8	2.95%
Medications-admin/organization	10	2.55%	Call lights, requests for assistance	10	2.76%

Source: JCHC staff analysis of data reported to the National Ombudsman Reporting System administered by the U.S. Administration on Aging

Certification Surveys Of Nursing Facilities Help To Ensure Residents Receive Quality Care; Facilities Which Do Not Meet Federal Quality Standards Are Cited For Deficiencies

As discussed in Section II of this report, the Centers for Medicare and Medicaid Services (CMS) contract with the states to perform nursing home recertification surveys for purposes of receiving Medicare and Medicaid reimbursement. During the survey inspections, surveyors "cite" facilities for

failure to meet certain federal certification requirements. Surveyors review nursing facilities on approximately 185 criteria. Most of the 185 criteria are considered “process” indicators while others are “outcome” measures. The process measures include such things as whether proper procedures are followed in providing the major nursing home services. Outcome measures include ensuring that residents maintain good physical health, and that problems do not occur for residents such as accidents, bed sores, dehydration, weight loss, etc. When a facility fails to meet a given standard, a deficiency/citation is issued.

Data regarding nursing home survey deficiencies are reported by the states to a national database called the On-Line Survey Certification and Reporting (OSCAR) system. The OSCAR data allows cross-state comparisons regarding the number and type of deficiencies for which nursing facilities are cited in each state. Figure 8 summarizes the top ten deficiencies cited for nursing homes in Virginia as compared to the nation.

While none of the “top ten” deficiencies for the nation or Virginia is “insufficient staff,” several of the deficiencies that are included are “staff-related.” For instance, the development of pressure sores, inappropriate treatment of incontinence, failure to provide services to dependent residents, and failure to maintain acceptable body weight all can be impacted directly by the lack of appropriate staffing levels. Therefore, while “insufficient staff” is not among the top ten deficiencies, several are influenced to some degree by the amount of nurse staffing.

A Relatively Small Percentage Of Nursing Homes Are Cited For Insufficient Nurse Staffing During The Federal Nursing Home Survey Process; However, There Is Growing Concern That The Surveyors Must Meet A High Burden Of Proof To Justify Such A Citation

Insufficient nurse staffing is one of the deficiencies for which a facility can be cited. However, as discussed in Section II, there is growing concern among CMS officials that the “burden of proof” that surveyors must document in order to cite a facility for insufficient nurse staffing is too cumbersome and difficult. In its 2000 Report to Congress on the appropriateness of minimum nurse staffing ratios, HCFA stated that its analysis “has yielded no evidence surveyors typically meet the considerable burden of documentation required to determine compliance with the general requirement of nurse staffing based on the regulatory language at F353 (sufficient staff).” Advocacy groups also criticize this limitation of the current nursing home survey process, and argue that because of the difficulty in developing the necessary documentation to cite for

insufficient staff, nursing homes are able to operate with insufficient staff, and do not have to incur any penalties.

Figure 8

**Top Ten Certification Survey Deficiencies In Nursing Homes:
Virginia and the Nation (2000)**

Nation		Virginia	
Deficiency	Rank	Deficiency	Rank
Failure to develop plan of care	1	Provide necessary care and services	1
High number of pressure sores	2	Failure to develop a plan of care	2
Failure to conduct comprehensive assessments	3	Prepare resident assessment	3
Inappropriate treatment of urinary incontinence	4	Staff treatment of residents	4
Inappropriate use of restraints	5	Comprehensive assessment using the RAI	5
Failure to improve/maintain resident's well-being	6	Provide supervision and assistance devices to prevent resident accidents	6
Failure to improve/maintain resident's range of motion	7	Notification of rights and services	7
Inappropriate weight loss and poor nutrition	8	Treatment of pressure sores	8
Failure to provide services to dependent residents	9	Provide services to maintain good nutrition, grooming and personal/oral hygiene	9
Unnecessary drug use	10	Maintain acceptable body weight and protein levels	10

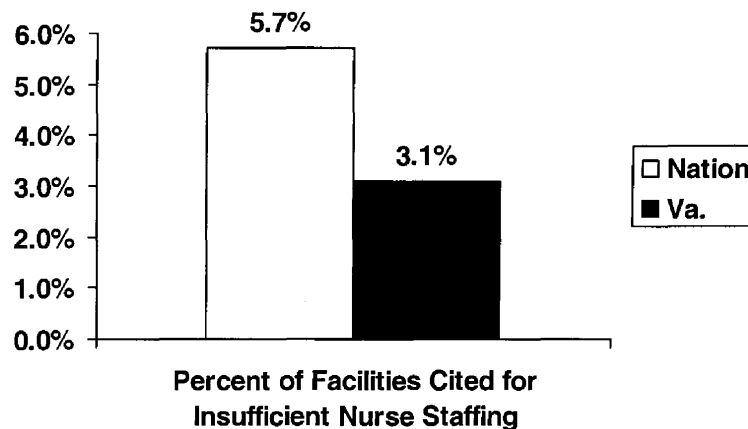
Source: Virginia Department of Health, "The LTC News," Summer, 2001

Despite the weaknesses of the current process for citing nursing homes for insufficient staff, comparative data on the number of nursing homes cited for this deficiency are compiled by the OSCAR system. As seen in Figure 9, the percentage of Virginia nursing homes cited for insufficient staff was small (3.1%),

and was appreciably below the national average (5.7%). It must be noted that these data inevitably are influenced to some degree on how the survey teams in the respective states complete their survey reviews. Another complicating factor is the fact that many states have established staffing ratios as part of their licensing requirements. (These states are discussed in Section IV.) While state licensing requirements do not apply directly to the federal requirement of “sufficient staff,” the existence of such a ratio likely has some impact on the surveyors’ assessment of a facility’s staffing during a survey inspection.

Figure 9

**Percent Of Nursing Facilities Cited For Insufficient Nurse Staffing (F353)
Virginia And The Nation (1999)**



Source: Charlene Harrington, Ph.D., et. al., Department of Social and Behavioral Sciences, University of California, San Francisco, “Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999,” October, 2000

The data presented in Figure 9 can be interpreted in different ways depending on one’s position regarding the need for minimum nurse staffing standards in Virginia. Those who argue that minimum nurse staffing standards are not necessary can point to the fact that because only 3.1% of facilities in Virginia have been cited for insufficient staffing, and because a lower percentage of Virginia facilities are cited for insufficient nurse staffing than the nation as a whole, there is no pressing need for imposing such standards. However, those who favor minimum staffing standards argue that the reason so few are cited is because the “burden of proof” to cite a facility is too high. In addition, advocates for nursing standards also would argue that with more quantifiable criteria, such as a ratio of staff to residents, it would be easier to determine if a facility has

appropriate staffing; and, thus, the number of facilities cited for staffing would increase.

The Health Care Financing Administration's 2000 Study Analyzed The Appropriateness Of Establishing Minimum Nurse Staffing Ratios In Nursing Homes In Response To Quality Of Care Concerns Raised In 1998

Public and congressional concern about nursing home staffing led to a 1998 study by the Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS). The 1998 study identified a range of serious problems including malnutrition, dehydration, pressure sores, abuse and neglect. In response to the findings of the 1998 study and the findings of other studies (e.g., General Accounting Office, and Office of the Inspector General), HCFA initiated a second study in 2000 with a specific focus on the appropriateness of minimum nurse staffing ratios in nursing homes. The 2000 study was mandated by Public Law 101-508 which required the Secretary of Health and Human Services to report to the Congress on the feasibility of establishing minimum staffing ratios for Medicare and Medicaid certified nursing homes. The 2000 HCFA study is being completed in two phases; the first phase examined if minimum staffing ratios are appropriate and whether there are nurse staffing ratios that strongly determine good or optimal resident outcomes. The first phase was completed in 2000; however, no recommendations have been made to Congress regarding nurse staffing ratios. Phase II of the HCFA study is still underway and is assessing the costs, benefits, and feasibility of implementing minimum ratio requirements. An official with CMS advised JCHC staff that the Phase II report is expected to be released by the beginning of 2002.

Phase I Of The HCFA Study Concluded There Are Nurse Staffing Thresholds Below Which Quality Of Care May Be Seriously Impaired

Based on a multivariate analysis of the relationship between staffing and quality of care, HCFA concluded that there are nurse staffing thresholds below which quality of care may be seriously impaired. The following is an excerpt from the HCFA report regarding the relationship between staffing and quality of care.

The evidence from these analyses for an association between low staffing levels and the likelihood of quality problems across an array of measures and for different types of staff was compelling. Staffing thresholds were identified for RN staff, RN and LPN staff combined

(licensed staff) and certified nurse's aide staff below which facilities were at higher risk for quality problems such as hospitalization for avoidable causes, incident events such as pressure sores and significant weight loss, and lack of improvement in function and resisting care.

Minimum & Preferred Minimum Staffing Levels: Based on the multivariate analyses completed in the study, HCFA identified a "minimum staffing level" and a "preferred minimum staffing level." HCFA differentiates between the two levels in the following way: the minimum staffing level may reduce the likelihood of quality problems in *several* areas of nursing care, while staffing which is at or above the "preferred minimum" level results in quality improvements *across the board*. In proposing these two levels of staffing, HCFA acknowledged that the current staffing levels at a significant percentage of nursing homes would fall below these standards. Figure 10 illustrates HCFA's "minimum staffing level" and "preferred minimum level" for nursing homes and the percentage of nursing homes whose current staffing falls below the two standards.

Figure 10

**HCFA "Minimum Staffing Level" And "Preferred Minimum Level"
For Nursing Homes**

Nurse Staff	Minimum Staffing Level	Percent of Nursing Homes Below Standard
Certified Nurse Aide	2.00 hrs/resident day	54%
RN and LPN	.75 hrs/resident day	23%
RN	.20 hrs/resident day	31%
TOTAL	2.95 hrs/resident day	N/A*
Preferred Minimum Level		
Certified Nurse Aide	2.00 hrs/resident day	54%
RN and LPN	1.00 hrs/resident day	56%
RN	.45 hrs/resident day	67%
TOTAL	3.45 hrs/resident day	N/A*

* HCFA did not report a percentage for this category

Source: Health Care Financing Administration, "Appropriateness of Nurse Staffing Ratios in Nursing Homes;" Report to Congress, 2000

Virginia's statewide average total nursing hours per resident, which is estimated to be 3.4, is above the minimum level and slightly below the "preferred minimum" level. However, there likely are individual facilities which fall below one or both of HCFA's minimum staffing levels.

The HCFA report also concluded that, based on time motion studies, the minimal nurse aide staff time to provide optimal care in delivering the five specific daily care services (i.e., repositioning and changing wet clothes, repositioning and toileting, exercise encouragement/assistance, feeding assistance, and activity of daily living independence enhancement) is 2.9 hours per resident day. HCFA stated that this standard should be viewed as a condition for optimal care by nurse aides, and that currently 92% of nursing homes in the U.S. fall below the 2.9 hours per resident day standard. (Virginia's statewide average is estimated to be 2.0 hours/resident day.)

Legislation Has Been Introduced In Congress That Would Implement Several New Requirements For Nursing Homes, Including Minimum Nurse Staffing Ratios

H.R. 2677: Representative Henry A. Waxman introduced H.R. 2677 in July, 2001 to address the incidence of abuse in nursing homes that was identified in a report prepared by the Minority Staff, Special Investigations Division, Committee on Government Reform. The legislation, which is referred to as the "Nursing Home Quality Protection Act of 2001," includes a number of actions intended to improve the quality of care in nursing homes. The key provisions of H.R. 2677 are summarized below:

- increases funding to nursing homes to hire more staff and comply with federal standards, and reinstates the "Boren Amendment," which, until its repeal by Congress in 1997, guaranteed "reasonable and adequate" reimbursement for providing quality care;
- requires nursing homes to comply with minimum staffing levels that provide each resident at least 4.13 hours of individual nursing care per day (based on the Hartford Institute recommendations). If the Secretary of Health and Human Resources finds that quality of care will not be compromised or that compliance is not feasible immediately, the standard can be modified or delayed. However, staffing levels cannot fall below a minimum level of 3.45 hours of care as identified in the HCFA 2000 report to Congress;

- establishes a new system of financial penalties for nursing homes with certain violations. The penalty monies would be used to make grants to recruit and retain nursing staff, improve education and training of staff, and improve workplace safety;
- requires greater Internet disclosure about conditions in nursing homes;
- institutes mandatory background checks for potential nursing home employees; and
- requires nursing home inspectors to monitor the well-being of all residents, whether or not their care is paid for by Medicare or Medicaid.

H.R. 118: Representative Holt introduced H.R. 118, called the “Nursing Home Staffing and Quality Improvement Act of 2001” in January, 2001 to establish a program to provide grants to the states to test innovative ways to increase nursing home staff levels, reduce turnover, and improve quality of care for residents in nursing homes. Under the proposed legislation, states would make application to the Secretary of Health and Human Services to receive funding that, in turn, could be provided to nursing homes, labor management partnerships, and educational institutions to enable nursing homes to recruit additional nursing staff, increase training of staff, or make other quality improvements. To receive grant funding, states would have to assure that nursing home residents receive at least 2.0 hours of direct CNA care per day.

As of this writing, Congress has not acted on H.R. 2677 or H.R. 118.

The Nursing Home Industry Agrees That Additional Nursing Staff Is Needed In Nursing Homes; The Key Issue Is How To Accomplish This Goal

As evidenced by the consensus statement issued by “The Campaign For Quality Care,” of which the American Health Care Association is a member, the nursing home industry agrees that additional nursing staff is needed. The critical issue is how to achieve the goal of increased staffing. As has been discussed in this section, there are several recommended levels of minimum nurse staffing. The industry’s chief concerns about all of these proposed minimum staffing standards are that: (i) appropriate Medicaid funding must be provided if their facilities are going to be required to hire additional staff, and (ii) even if funding is approved, there simply are not enough nurses and nurse aides in the workforce to hire. These issues regarding the impact of nurse staffing standards are discussed in greater detail in Section V.

IV. Nurse Staffing Standards In Other States

Thirty-Seven States Have Established Minimum Nurse Staffing Standards For Nursing Homes

All nursing homes that are certified to receive payment under Medicare or Medicaid must meet minimum federal nurse staffing requirements, as described in Section II of this report. However, this federal requirement does not preclude individual states from imposing more specific requirements under their licensing authority. A total of 37 states have established their own nurse staffing standards for nursing homes that are more specific than the federal requirement of "sufficient nursing staff." These requirements are extremely varied and are based upon one or more of the following: (i) number of residents, (ii) number of nursing care hours per resident per day, (iii) care and service needs, and (iv) shifts. The HCFA 2000 Report to Congress regarding minimum nurse staffing standards reported that 28 of the 37 states had established standards based on "hours of care per resident per day" (similar to HB 2257), while 11 states had expressed their requirements as a ratio of staff members to residents (similar to SB 1125). (HCFA counted two states as having both types of requirements in their staffing standards.)

State Standards Involving Hours Of Care Per Resident Per Day Are Extremely Varied And Often Include Other Additional Requirements; The Most Common Standard For Direct Care Staff Appears To Be 2.0 - 2.5 Hours Of Care Per Resident Per Day

There is wide variation among those states which have established nurse staffing standards based on a minimum number of hours of care per resident per day. Many of the states' minimum standards vary by the size of the facility and/or the acuity level of the residents in each of the facility's units. Moreover, many of the states' standards also include additional requirements regarding licensed nurses (RNs or LPNs) who must be in the facility, on each floor, or in each unit during various times of the day. Sometimes, the Director of Nursing (DON) is included in the total licensed nursing requirements, while other states specifically require the DON position to be in addition to other licensed staff. Some states have requirements only for licensed staff and no requirements for total nursing staff or direct care staff. In sum, the variations in the states' requirements make it very difficult to provide a range of the total hours per resident per day that exists across the country. While many complicating

variables exist, it appears that the most common standard for direct care staff is between 2.0 and 2.5 hours of care per resident per day.

States With Standards That Require A Minimum Staff-To-Resident Ratio Also Vary Substantially

Similar to those states which express their requirement as minimum hours of care per resident per day, the standards set by the 11 states which include staff-to-resident ratios also vary substantially. Overall, Maine's staff-to-resident ratios appear to be the most stringent (1:5 on the day shift; 1:10 on the evening shift; and 1:15 on the night shift). Texas appears to have the least stringent (1:20 on each shift). Oregon, Oklahoma, and South Carolina all appear to have comparable standards of roughly 1:10 on the day shift; 1:15 on the evening shift; and 1:20 on the night shift. However, it must be noted that each state also has other staffing guidelines which affect the total amount of nursing care available in the nursing facility. In sum, it is very difficult to make "apples-to-apples" comparisons among the various state standards.

HCFA Categorized All 50 States Into Three Groupings Based On Their Respective State Staffing Standards, And Compared The Groupings On Various Measures

In its 2000 report to Congress on the appropriateness of minimum nurse staffing standards, HCFA categorized all 50 states into three groupings based on their respective state staffing standards. The three HCFA groups were: (i) no specific state regulation or law beyond federal requirements; (ii) less-demanding state standards; and (iii) "more demanding" state standards. HCFA further defined the third grouping to be those states with more than 2.25 hours per resident day or more than one staff member to nine residents in the day shift, 13 residents in the evening shift, and 22 residents in the night shift.

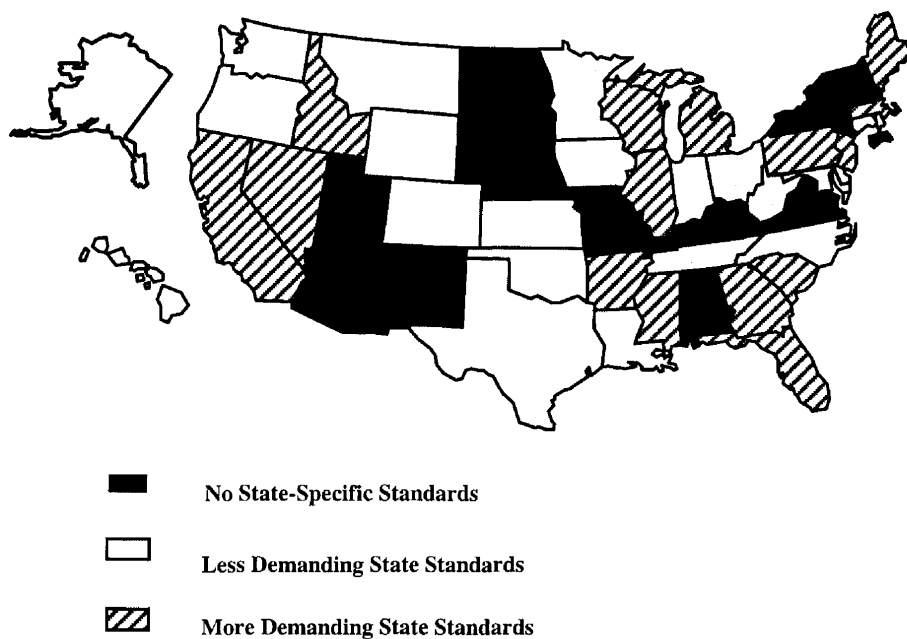
Because Virginia has not adopted any specific staffing requirements in statute or regulation beyond the federal standard, the Commonwealth is included in the first grouping of 13 states with "no specific state standards." Figure 11 illustrates which states were assigned to each grouping

HCFA noted in its report that "even for states that require only the federal minimum, this does not preclude facilities from exceeding that minimum, sometimes going beyond the minimum. Hence, states that require only the federal minimum may possibly have an actual average staffing ratio that exceeds that of other states that impose additional state minimum requirements." In fact,

when HCFA compared the state groupings according to the mean total number of nursing hours per resident day (weighted based on number of facilities in each state), the grouping which has no state-specific standard had a slightly greater mean number of hours than those states with a state-specific standard. The grouping with the “more demanding” state-specific standard had the highest mean number of hours. (See Figure 12.)

Figure 11

HCFA Categorization Of State-Specific Nurse Staffing Standards

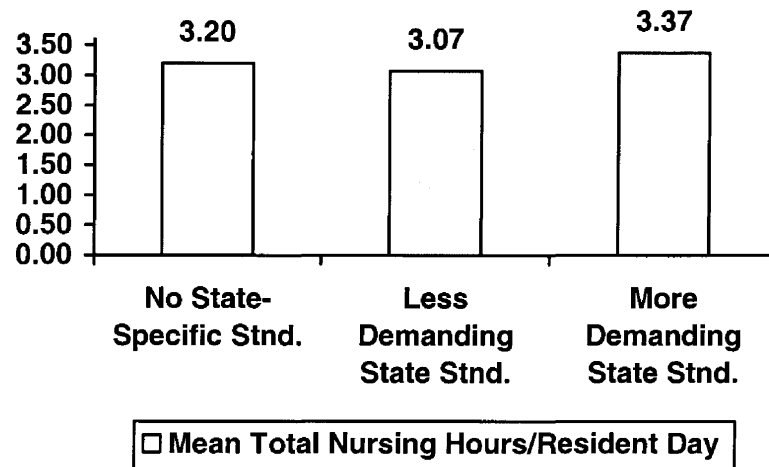


Source: JCHC staff analysis of Health Care Financing Administration’s “Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes,” 2000

Based on the HCFA analysis, while 37 states have enacted state-specific nursing standards, the standards of those 22 states which HCFA categorized as “less demanding” do not appear to have raised the average staffing any appreciable amount. On the other hand, the HCFA analysis shows that those 15 states categorized as “more demanding” have had an appreciable impact on the nurse staffing in their respective nursing homes.

Figure 12

Mean Total Nursing Hours Per Resident Day in 1999 By HCFA State Groupings

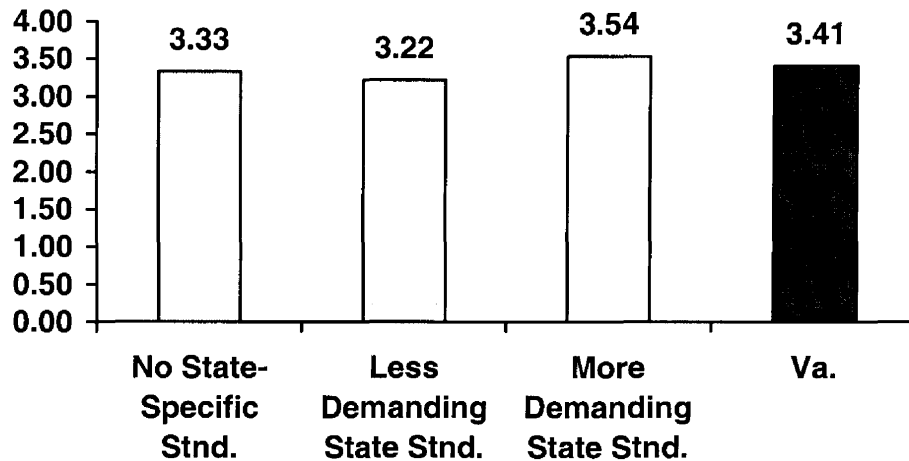


Note: Mean scores are weighted based on the number of nursing facilities in each state
Source: Health Care Financing Administration's "Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes," 2000

The specific weights assigned to each state were not published in the HCFA report; as such, it is not possible to compare Virginia's "weighted" mean total nursing hours to the HCFA groupings. However, using unweighted averages to compare the three state groupings shows that the "no state-specific standard" grouping's average for total hours per resident day is 3.33; the "less demanding state standard" grouping's average is 3.22; the "more demanding state standard" grouping's average is 3.54; and Virginia's average is 3.41. (See Figure 13.)

Figure 13

**Mean Total Nursing Hours Per Resident Day in 1999:
Virginia Compared To The HCFA State Groupings Using Unweighted Averages**



Source: Health Care Financing Administration's "Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes," 2000

While Virginia's Mean Total Number Of Nursing Hours Per Resident Day Is Greater Than The "Less Demanding State Standard" Grouping, A Virginia-Specific Standard Would Ensure That All Facilities Meet A Minimum Level Of Staffing

The above analysis indicates that, even without a state-specific minimum nursing staff standard, Virginia's mean total number of nursing hours per resident day is greater than the average for the HCFA grouping of those states that have adopted a "less demanding" state-specific standard. However, an average number of nursing hours may include some facilities which staff substantially lower than the statewide average. Adopting a state-specific standard in Virginia would ensure that all facilities provide at least a minimum level of care. HCFA's analysis of other states with state-specific standards supports this notion in that it found the "variance in staffing was lower for facilities in states with state standards."

Some Nursing Home Industry Representatives Have Expressed Concern That Establishing A Minimum Standard Actually Would Result In A “Staff Ceiling” That Facilities Would Not Staff Above; HCFA’s Analysis Found Mixed Evidence Of This Concern

One of the concerns expressed by some nursing home industry representatives is that higher-staffing facilities would “staff down” to a minimum staffing standard causing the minimum standard or “floor,” to become, in practice, a maximum standard or “ceiling.” In its review of other states’ nurse staffing standards, HCFA analyzed this concern. HCFA compared states’ nurse staffing on a variety of measures and concluded that “among very high staffed facilities, there was little evidence in support of the floors-ceilings hypothesis.” The HCFA report also noted: “[H]owever, it is possible that some facilities with high staffing levels reduce staffing in response to a minimum requirement. The evidence was mixed and inconclusive as to whether minimum staffing requirements reduce the variance in staffing for higher staffed facilities. Further research is needed to test the extent to which staffing floors become ceilings.”

Many States Have Enacted Changes To Their State-Specific Nurse Staffing Standards In Recent Years

A number of states adopted their state-specific nurse staffing standards in the 1970s and 1980s. The April, 2001 article written by Harrington (“State Minimum Nurse Staffing Standards for Nursing Homes”) included an analysis of recent changes in those states with state-specific standards. According to Harrington, four state staffing standards have not been changed since the 1970s-1980s (Hawaii, Minnesota, Montana, and Wyoming). However, 13 states have enacted changes in recent years that have increased their staffing requirements. Examples of these states are provided below.

- *California increased its minimum number of hours of care per resident from 3.0 (which allowed double counting of licensed staff) to 3.2 hours (without double-counting);*
- *Delaware increased its minimum number of nursing hours per resident day from 2.5 to 3.0; when administrative nurses are included, the total is 3.48; the total is set to increase to 3.67 in 2003 which would make it the highest standard in the nation;*
- *Maine increased its standard from 2.1 to 2.9 hours per resident day; and*

- *Mississippi increased its standard from 2.2 to 2.8 hours per resident day.*

Other states identified by Harrington as having increased their staffing standards include Iowa, Nevada, New Mexico, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, and the District of Columbia.

V. Impact Of Implementing Minimum Nurse Staffing Standards In Virginia Nursing Homes

Senate Bill 1125 And House Bill 2257 Would Require Minimum Nurse Staffing Requirements For Virginia Nursing Homes That Appear To Exceed All Other States' Standards And The Standards Recommended By Other Advocacy/Research Organizations

Senate Bill (SB) 1125 of the 2001 Session of the General Assembly would require Virginia nursing homes to meet extensive minimum nurse staffing levels in order to be licensed to operate in the Commonwealth. The provisions of SB 1125 are fashioned, in large part, to be consistent with the recommendations of the Hartford Institute's expert panel. However, several provisions of SB 1125 are more demanding than that proposed by the Hartford Institute. Moreover, the provisions of SB 1125 are more extensive than the ratios currently in place in any state. The ratio of CNAs to residents is more demanding than the levels recommended by other advocacy or research organizations. Figure 14 summarizes the key provisions of SB 1125.

House Bill (HB) 2257 would require that all nursing homes provide an average of 5 hours of direct care nursing services per resident per 24 hour period. This, too, exceeds the levels seen in other states and those recommended in various studies and reports. Figure 15 compares the provisions of SB 1125 and HB 2257 to the recommendations of the Hartford Institute expert panel, the provisions of H.R. 2677, the HCFA findings, and Virginia's current statewide average nursing hours per resident day.

Figure 14

Key Provisions Of SB 1125

Administration Standard

- Full-time RN as Director of Nursing
- Part-time RN Assistant Director of Nursing (full-time in facilities with 100 or more beds)
- Part-time RN Director of In-Service Education (full-time in facilities with 100 or more beds)
- Full-time RN Nursing Facility Supervisor on duty at all times, 24 hours/day; 7 days/week

Direct Care Staffing Standard

Minimum CNA

- Day Shift: 1 FTE for each 5 residents (1.60 hours/resident/day)
- Evening Shift: 1 FTE for each 5 residents (1.60 hours/resident/day)
- Night Shift: 1 FTE for each 10 residents (.80 hours/resident/day)

Minimum Licensed Nurse (RN or LPN)

- Day Shift: 1 FTE for each 15 residents (.53 hours/resident/day)
- Evening Shift: 1 FTE for each 20 residents (.40 hours/resident/day)
- Night Shift: 1 FTE for each 30 residents (.27 hours/resident/day)

TOTAL Direct Care Staffing: 5.20 hours/resident/day*

TOTAL Administrative and Direct Care Staffing: 5.62 hours/resident/day**

* Staffing must be adjusted upward for residents with higher nursing care needs

** Administrative hour requirement is based on NCCNHR's estimate for the same level of administrative nurses

Other Provisions

- Each nursing home must post, in a manner easily visible and readily accessible to residents, families, caregivers, and others, the actual staffing ratios according to the most recently completed cost reporting period.
- The Commissioner of Health shall enforce the staffing requirements
- Violations of the staffing requirements may evoke the penalties and remedies provided in §32.1-27 of the *Code of Virginia*

Source: SB 1125, 2001 Session of the Virginia General Assembly

Figure 15

**Comparison of Proposed Minimum Nurse Staffing Standards
(Hours of Care Per Resident Day)**

Nurse Type	Hartford Inst/H.R. 2677	HCFA Min. Stnd.	HCFA "Preferred Minimum"	SB 1125	HB 2257	Current Va. Avg.⁴
CNA	2.93	2.00	2.00	4.00	N/A ³	2.00
LPN	.60 ¹	.75 ²	1.00	.60 ¹	N/A ³	.80
RN	.60 ¹	.20	.45	.60 ¹	N/A ³	.60
TOTAL	4.13	2.95	3.45	5.20	5.00	3.40

¹ The total licensed nurse requirement of 1.20 hours was equally divided between RNs and LPNs

² HCFA figure represents a combination of RNs and LPNs

³ HB 2257 did not include hours per care for each type of nurse

⁴ Based on estimates included in Harrington analysis, October, 2000

Source: JCHC staff analysis of minimum nurse staffing standards included in: Hartford Institute recommendations; U.S. Health Care Financing Administration study; U.S. House Resolution 2677; Senate Bill 1125, 2001 Session of the Virginia General Assembly; and House Bill 2257, 2001 Session of the Virginia General Assembly

Charlene Harrington, Ph.D., et. al., Department of Social and Behavioral Sciences, University of California, San Francisco, "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999," October, 2000

The Fiscal Impact Of SB 1125 Is Estimated To Be Approximately \$91.2 Million (General Funds) Annually; The Actual Cost Could Range Between \$76.3 And \$106.1 Million

Because Medicaid pays for approximately 66% of all nursing home care in the Commonwealth, any increased staffing requirements would have a fiscal impact on the Medicaid budget. To estimate the fiscal impact of SB 1125 on the Medicaid program, JCHC staff worked with staff from the Department of Medical Assistance Services (DMAS). During the 2001 Session of the General Assembly, DMAS prepared a fiscal impact statement on SB 1125. JCHC and DMAS staff refined the methodology for calculating the estimated costs, and updated some of the data used in the calculations. The primary source of information used in developing the fiscal impact was data reported by nursing homes to DMAS during FY 2000. The key elements of the cost estimate methodology and the assumptions involved in the calculations are summarized below.

Estimate of Direct Care Costs

- The licensed nurse and CNA staff-to-resident ratios were converted to a required number of hours of care per resident day
- The required hours of licensed nurse and CNA nursing care were multiplied by the average number of occupied nursing home beds (i.e., residents); this total was then multiplied by 365 days to produce a total number of nursing hours needed to meet the minimum standards
- The total number of nursing care hours reported for FY 2000 was subtracted from the total number of nursing hours calculated in the step above to estimate the number of additional hours needed to meet the standards
- The amount of additional hours of nursing care needed to meet the standard was multiplied by the average “employee” salaries reported to DMAS for CNAs (\$10.70/hour) and RNs/LPNs (\$18.23/hour)
- Because many nursing homes rely on “agency nurses” to help fill nursing positions, the number of additional hours of nursing care also was multiplied by average “agency personnel costs” for both CNAs (\$15.55/hour) and RN/LPNs (\$27.59/hour) to estimate the cost of meeting the standards through the use of agency nurses

Estimate of Administrative Costs

- It was assumed that all facilities already would have a RN employed as a Director of Nursing and Assistant Director of Nursing
- It was assumed that one-half of the facilities with 100 or more beds would have to hire a full-time Director of Education, and that one-half of the facilities with fewer than 100 beds also would have to hire a part-time Director of Education
- It was assumed that each facility would have to hire 2 additional nursing supervisors to meet the requirement for nursing supervisors 24 hours/day/7days/week

Total Medicaid Costs

- The cost of each nursing standard was totaled and increased 3% to account for inflation
- The total cost of meeting all of the nursing standards was multiplied by .66 to estimate the percentage of the total costs that would be borne by Medicaid; the Medicaid total then was multiplied by .4855 to estimate the General Fund (GF) portion of the Medicaid cost

Figure 16 illustrates the total estimated cost of complying with the provisions of SB 1125. Three scenarios are provided in developing the cost estimate: (i) all required positions are filled with employee nurses; (ii) all required positions are filled by agency nurses; and (iii) one-half of the required positions are filled with employee nurses and one-half are filled with agency nurses. JCHC staff believe the most likely scenario would be that facilities would use both employee and agency nurses.

Figure 16

Estimated Fiscal Impact Of SB 1125

Cost Element	Employee Nurses		Agency Nurses		Employee/Agency Nurses*	
	Total \$**	GF \$	Total \$**	GF \$	Total \$**	GF \$
Direct Care Nurses	\$135,185,279	\$65,497,268	\$196,598,728	\$95,252,084	\$165,892,004	\$80,374,676
Nurse Supervisors	\$19,033,753	\$9,221,853	\$19,033,753	\$9,221,853	\$19,033,753	\$9,221,853
Full Time Education Director	\$2,361,081	\$1,143,944	\$2,361,081	\$1,143,944	\$2,361,081	\$1,143,944
Pt. Time Education Director	\$908,706	\$440,268	\$908,706	\$440,268	\$908,706	\$440,268
TOTAL	\$157,488,819	\$76,303,333	\$218,902,268	\$106,058,149	\$188,195,543	\$91,180,741

* Costs assume one-half of nursing positions to be filled by employee nurses, and one-half by agency nurses

** Total \$ represent total Medicaid costs that have been inflated 3% over FY 2000 figures

Source: JCHC and DMAS staff analysis of SB 1125

The Fiscal Impact Of HB 2257 Is Estimated To Be \$81.5 Million (General Funds) Annually; The Actual Cost Could Range From \$65.9 Million To \$97.1 Million

While HB 2257 was not referred to the JCHC for study, estimates of the fiscal impact of this type of minimum nurse staffing standard were calculated for comparative purposes. The requirements of HB 2257 are not as prescriptive as those contained in SB 1125. Essentially, HB 2257 requires that nursing facilities provide an average of 5 hours of direct nursing care services per resident per 24 hour period.

Many of the assumptions, data sources, and methods used in estimating the impact of SB 1125 were used in developing an estimate for HB 2257 as well. Based on the total number of nursing care hours reported to DMAS, the number of hours needed to meet the minimum standard in HB 2257, and a weighted average hourly salary of RNs/LPNs, and CNAs (\$12.43/hour), the fiscal impact of HB 2257 is estimated to be \$65.9 million, if employee nurses only are used; \$97.1 million, if agency nurses only are hired; and \$81.5 million, if one-half of the nurses hired are employees and the other half are agency nurses. Almost the entire difference in costs between SB 1125 and HB 2257 can be attributed to the costs associated with the administrative nurse and nurse supervisor requirements of SB 1125 that are not required in HB 2257. As with SB 1125, JCHC staff believes the most likely scenario would be that nursing facilities would use both employee nurses and agency nurses. Accordingly, the \$81.5 million figure is likely the most accurate estimate.

While The Fiscal Impact Of Minimum Nurse Staffing Standards Is Significant, Some Argue There Are Even Greater Costs Of Not Instituting Such Standards

As noted above, the estimated cost of enacting either SB 1125 or HB 2257 is significant. However, many nursing home resident advocates argue that the cost of not instituting such standards likely is much higher. These costs represent the added expense of unnecessary hospitalizations, an increased number of incontinent residents, and the development of pressure sores, all of which can result from insufficient staffing. Clearly, an insufficient number of nursing staff can result in poor quality outcomes. However, the difficulty is in identifying the level of staffing at which poor outcomes or unsatisfactory quality of care result.

The Service Employees International Union (SEIU) conducted an analysis of the cost of short staffing in nursing homes in several states, such as Maryland and California. The SEIU analysis estimates that “avoidable incontinence, pressure sores, and hospitalizations for residents, in addition to injuries and high

turnover rates for nursing assistants, cost Maryland more than \$86 million per year and potentially more than twice that amount.” A similar SEIU analysis of nursing homes in California estimated the cost to be more than \$229 million per year. However, in calculating these estimates, SEIU makes critical assumptions such as one half of all cases of incontinence and pressure sores are related to short staffing. Little additional information was available to JCHC staff to determine the basis for these assumptions.

As HCFA concluded in its study of minimum nurse staffing ratios, there are staffing thresholds below which quality of care may be seriously impaired. When quality of care is seriously impaired, unnecessary hospitalizations, pressure sores, and incontinence not only incur substantial costs of additional care, but also cause pain and suffering for residents. However, estimating the financial impact of not instituting minimum nurse staffing standards is very difficult.

The Nursing Home Industry In Virginia Has Raised Several Concerns Regarding The Imposition Of Minimum Nurse Staffing Standards

In JCHC staff interviews with representatives of the Virginia Health Care Association (VHCA), the Virginia Hospital & Healthcare Association (VHHA), and the Virginia Association of Non-Profit Homes for the Aging (VANHA), a number of concerns regarding the possible enactment of minimum nurse staffing standards in Virginia were raised. These concerns are outlined below.

- **Current Medicaid Reimbursement:** Because the current Medicaid reimbursement level for nursing homes would not cover the cost of additional nurses required by SB 1125 or HB 2257, additional dollars would have to be appropriated. (The estimated fiscal impact of SB 1125 and HB 2257 is provided earlier in this section.)
- **Nursing Shortage:** Even if Medicaid reimbursement is increased, nursing home industry representatives expressed grave concern over whether facilities would be able to hire nurses, given the current nursing shortage. (The current nursing workforce in Virginia is discussed later in this section.) Representatives of all three organizations (VHCA, VHHA, and VANHA) indicated that their member facilities would hire additional nurses now, without a mandate, if they could find them. JCHC staff interviewed administrators of several nursing homes during this study, all of whom indicated they have a very difficult time filling CNA, LPN, and RN positions. As evidence of their difficulty in hiring nurses, the facility

administrators point to the fact that they pay nurse staffing agencies substantially higher amounts to get nurses in their facilities than they would pay if they hired them as employees. They argue that they would not be paying these higher fees if they could find nurses to hire on as employees.

It should be noted that representatives of TLC4Long-Term Care indicated to JCHC staff that they do not believe there is a nursing shortage. They believe that nursing homes could hire enough nurses, but choose not to for financial reasons.

- **Quality and Supervision Of Staff Are Equally Important:** Industry representatives argue that while the number of staff is important, the quality and supervision of staff are equally important factors. They further argue that simply having more staff does not necessarily equate to better outcomes or a higher quality of care. Equally important issues are: how well the individual is trained, how motivated he/she is to perform, and what the individual actually does during a shift. A related concern is that if they are mandated to hire a minimum number of nurse staff, administrators will feel pressured to hire individuals that they would not have hired in the past, resulting in a lowered standard of nursing employees.
- **Staffing Needs To Account For Acuity Level of Residents:** Another concern is that ratios or a minimum number of nursing hours per resident day do not take into account the acuity level of the resident. Industry representatives argue that administrators need to be able to adjust their staffing according to the acuity level of the residents which can change on a daily basis. (It should be noted that SB 1125 does contain a provision that requires nursing facilities to increase staffing, if necessary, to meet the needs individual residents. Also, such a requirement could be included in the regulations that would be drafted pursuant to HB 2257.)

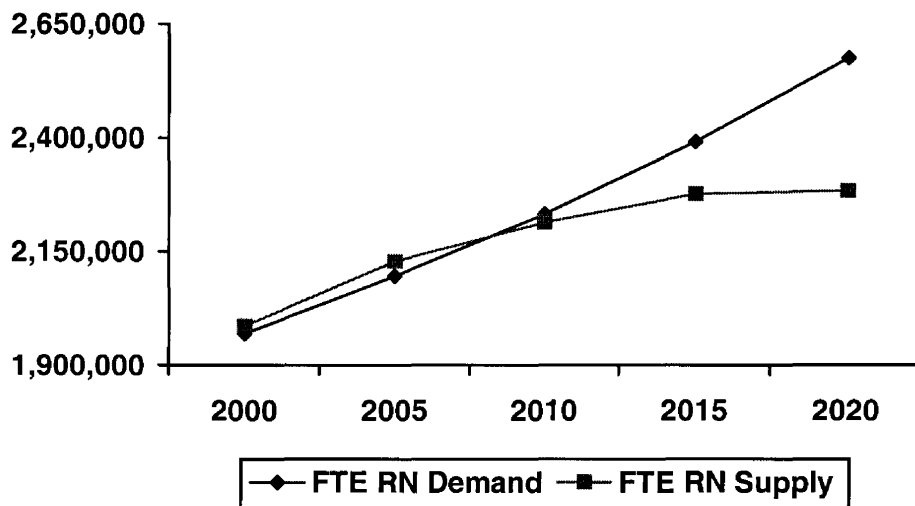
There Are Strong Indications That A Nursing Shortage Exists And That It Will Worsen In Future Years

There are numerous studies, reports and articles throughout the literature that indicate a nursing shortage exists today, and that it likely will worsen in the next several years unless some dramatic changes occur. The Bureau of Labor Statistics (BOL) predicts that employment opportunities for RNs will grow faster than average in all sectors through 2008. The "Occupational Outlook

Handbook," which is published by the BOLL ranked RNs among the top seven occupations in expected growth over the next decade. Virginia employment data also indicate a growing demand for all types of nurses. The most recent projections from the Division of Nursing within the U.S. Health Resources and Services Administration indicate a shortage beginning in 2008 that will continue to worsen in future years. Figure 17 illustrates the projected shortage of RNs.

Figure 17

Projections of Supply and Demand For Full-Time Equivalent RNs: U.S. 2000-2020



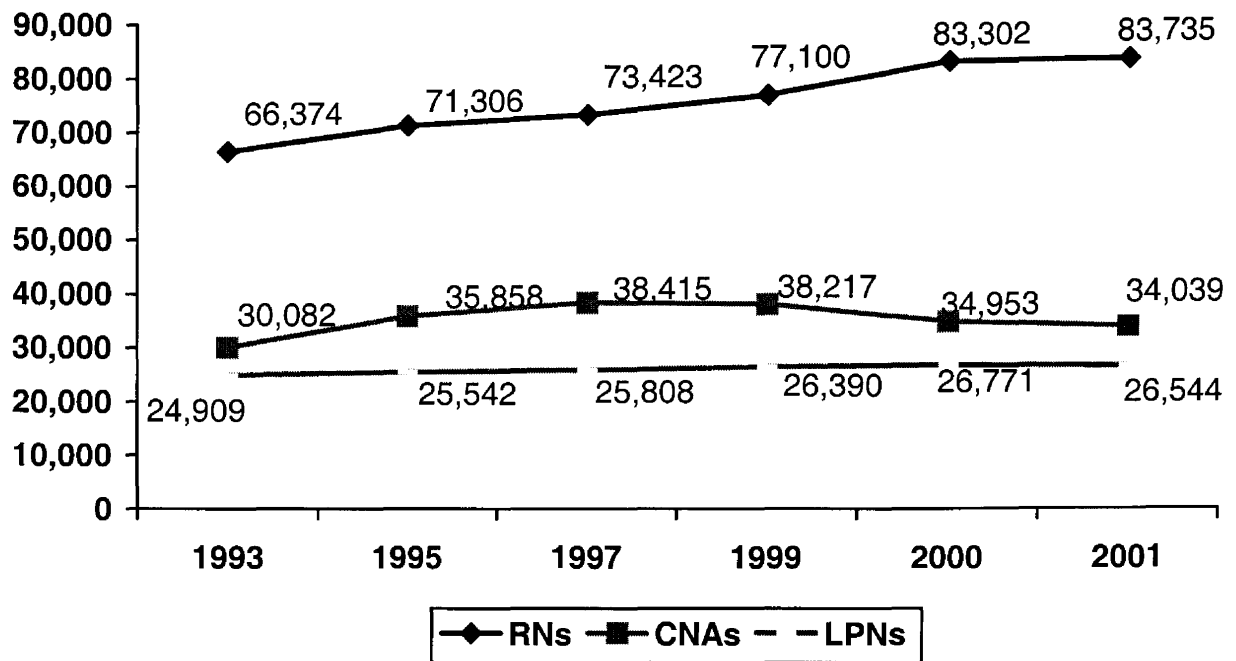
Source: Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, December 1997

There are a number of factors that are contributing to the nursing workforce shortage that many experts believe exists today and project will worsen in the next several years. These contributing factors are interrelated and cannot be viewed in isolation of each other. These factors include: (i) expanded employment opportunities for nurses; (ii) increasing work pressures/dissatisfaction; (iii) an aging workforce; and (iv) decreasing admissions and graduations from nursing education programs.

In Virginia, The Number Of RNs Has Continued To Increase; However, The Increase In 2001 Is Far Less Than Increases In Previous Years; The Number Of LPNs Declined In 2001, And The Number Of CNAs Declined For The Second Consecutive Year

Data obtained from the Virginia Board of Nursing indicate that the number of RNs licensed in the Commonwealth has continued to increase in recent years. However, the increase from 2000 to 2001 (.52%) is far less than the increases that have occurred in previous years (average annual increase of 5.87%). More importantly, the number of LPNs declined in 2001 for the first time, and the number of CNAs has decreased for the second consecutive year. Figure 18 illustrates the trend in nurse licensure and certification from 1993 through 2001.

Figure 18
Number of Licenses, Registrations, And Certifications
Issued In Virginia By Nurse Category:
1993 - 2001



Source: Virginia Board of Nursing

While It Is Too Early To Tell If The Decrease In The Number Of LPNs And CNAs Will Continue, To The Degree The Trend Continues, It Will Become More Difficult For Nursing Homes To Meet Minimum Nurse Staffing Standards; The Virginia Partnership For Nursing Is Studying Ways To Address The Projected Shortage Of LPNs And RNs

At this time, it is not clear whether the decline in the number of LPNs and CNAs will continue into the future. However, given the current difficulty reported by the nursing home industry in finding nurses, should this trend continue, the industry will find it increasingly difficult to meet minimum nurse staffing standards. In an effort to respond to the concern about the difficulty in hiring nurses, the JCHC introduced a study resolution (HJR 664) during the 2001 Session of the General Assembly requesting the Virginia Partnership for Nursing to examine various issues regarding the nursing shortage, including ways to increase the number of admissions and graduations from Virginia's RN and LPN education programs. The HJR 664 report is scheduled to be presented to the JCHC at its October 10, 2001 meeting.

The Decline In The Number Of CNAs Likely Has Been Caused By Several Factors, Including A Lower Passing Rate Of CNAs Taking The Certification Exam, The Low Salary Of CNAs, And Difficult Working Conditions

As reported in a JCHC study of the nursing workforce last year (2001 House Document #45), one of the reasons for the decline in the number of CNAs is a significant decrease in the percentage of applicants who pass the certification exam. Due to changes in the criteria for passing the certification exam implemented in 1999, the percentage of applicants who pass the "skills" portion of the exam declined from 95% to 55%. The Board of Nursing reports that the percentage of applicants who pass the exam has increased to 63%; however, this is still significantly below the previous level of 95%.

Other likely reasons for the decline in the number of CNAs are the low hourly wage (DMAS reports the average to be \$10.70), limited benefits, and the difficult working conditions. Nursing home administrators have reported that, due to the low wage, many CNAs work two jobs, sometimes seven days per week, in order to meet their financial obligations. Additionally, because of the shortage of CNAs, they often have very high workloads in terms of the residents for whom they must provide care. The job itself is physically demanding and often involves having to care for difficult residents. In the end, the low pay and difficult working conditions often lead to "job burnout"

which leads to more CNAs leaving their position for other work, which leads to greater workloads, which leads to more difficult conditions, and the cycle continues to worsen. With or without nurse staffing ratios, in order to increase the number of persons working as CNAs in Virginia nursing homes, improvements in the salaries and working conditions of CNAs are needed.

At The Recommendation Of The JCHC, Additional Funds Were Appropriated For CNA Salaries In FY 2000; Additional Salary Increases May Improve The Ability Of Facilities To Recruit And Retain CNAs

Due to the low hourly wage of CNAs, the JCHC recommended to the General Assembly that additional Medicaid reimbursement be provided to nursing facilities to raise the salary by \$1.00 per hour. This request was approved by the General Assembly, and funding became effective in FY 2000. Further increases in CNA salaries would improve the ability of facilities to recruit and retain CNAs. According to DMAS, for each \$1.00 increase in CNA salaries, an estimated \$7 million (GF) would need to be appropriated. To make a substantial difference in the current salary and enhance the attractiveness of the CNA position, the hourly salary likely would have to be increased by several dollars.

One Possible Alternative To Mandating Minimum Nurse Staffing Standards Would Be To Provide A Financial Incentive To Facilities To Hire Additional Nurses

While many states have imposed mandatory nurse staffing standards on nursing facilities, another possible alternative to mandates is to provide a financial incentive to facilities to increase their nurse staffing. Under this scenario, facilities would receive additional reimbursement through Medicaid if they met certain staffing criteria (e.g., minimum staff-to-resident ratios or hours of nursing care per resident). The incentive may need to provide a level of reimbursement somewhat above the actual cost to hire additional staff in order to encourage facilities to increase staffing.

While Medicaid pays for about 66% of long-term care provided in nursing homes, a Medicaid-based incentive would not be applicable to the reimbursement that facilities receive from their private pay or Medicare residents. However, it would increase the overall reimbursement of the facility which would enable them to hire additional staff. One drawback of this approach is that it would not apply to the 20 facilities in Virginia which are not certified for Medicare or Medicaid residents. These facilities would

not be eligible for a staffing incentive. However, inasmuch as these facilities are entirely private pay, it is likely that staffing is less of an issue.

Establishing a financial incentive for nursing facilities to increase their nurse staffing will require that a number of issues be resolved. Among these issues are: (i) the staffing levels facilities would have to achieve to receive the additional reimbursement; (ii) the amount of the additional reimbursement; (iii) the process by which facilities would receive the additional reimbursement; and (iv) reporting requirements to ensure the staffing criteria are being met. Working through these issues will require the involvement of the nursing home industry and DMAS staff. If it is decided to pursue this course of action, a task force comprised of industry and DMAS staff could be formed to address these implementation issues. JCHC staff also could be involved, if desired.

VI. Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue. The Joint Commission may wish to pursue one or more of the listed options.

- Option I** **Recommend to the Senate Committee on Education and Health that SB 1125 not be reported**
- Option II** **Recommend to the Senate Committee on Education and Health that SB 1125 be reported as introduced and that appropriate budget amendments be approved to fund the nurse staffing requirements**
- **Assuming that nursing facilities would have to use both facility employees and agency nurses to meet the staffing standards, the estimated GF amount would be \$91.2 million**
- Option III** **Recommend to the Senate Committee on Education and Health that SB 1125 be amended in the nature of a substitute to conform to the minimum number of hours per resident per day standard contained in HB 2257, and that appropriate budget amendments be approved to fund the staffing requirements**
- **Assuming that nursing facilities would have to use both facility employees and agency nurses to meet the staffing standards, the estimated GF amount would be \$81.5 Million**
- Option IV** **Recommend to the Senate Committee on Education and Health that SB 1125 be reported with one or more of the following amendments:**
- A. The mandated nurse staffing standards would be phased in over a period of 2 biennia**
 - B. The CNA nurse staffing mandates be reduced to be consistent with the recommendations of the National Citizens Coalition for Nursing Home Reform (1:5 on days; 1:10 on evenings; and 1:15 on nights)**

C. The nurse staffing standard be converted to hours of nursing care per resident per day and set at the “preferred minimum level” (i.e., 3.45 hours) identified in the Health Care Financing Administration’s (HCFA) 2000 Report to Congress

Option V Introduce a budget amendment (language and funding) to increase the hourly salary of CNAs

- **For each \$1.00 increase, \$7 million (GF) would need to be appropriated**

Option VI Direct JCHC staff to convene a task force of DMAS staff and nursing home industry representatives to develop an “incentive” provision in the Medicaid nursing facility reimbursement system that would provide additional reimbursement to those facilities which increase their nurse staffing to meet established staffing criteria (as part of JCHC’s 2002 workplan)

Option VII Introduce legislation to require nursing facilities to post their nurse staffing levels by shift in a manner that is easily accessible to residents and their families

APPENDIX A

2001 SESSION

014153406

SENATE BILL NO. 1125

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact § 32.1-127 of the Code of Virginia, relating to the establishment of staffing levels in nursing homes.

Patrons—Byrne, Edwards and Miller, Y.B.; Delegate: Hull

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.) of this chapter.

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to assure the environmental protection and the life safety of its patients and employees and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a routine contact protocol which ensures that the families of suitable organ and tissue donors are offered the opportunity by the chief administrative officer of the hospital or his designee to consider organ, tissue and eye donation;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of

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54 such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be
55 given to patients on admission, shall be based on Joint Commission on Accreditation of Healthcare
56 Organizations' standards; and

57 9. Shall establish standards and maintain a process for designation of levels or categories of care
58 in neonatal services according to an applicable national or state-developed evaluation system. Such
59 standards may be differentiated for various levels or categories of care and may include, but need not
60 be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical
61 protocols.

62 10. *Shall establish the following staffing standards for all nursing homes licensed pursuant to this*
63 *article: (i) each nursing home shall employ a full-time director of nursing who shall be a professional*
64 *registered nurse; (ii) each nursing home shall have designated nursing supervisors on duty at all*
65 *times who shall be professional registered nurses; (iii) each nursing home with 100 beds or more*
66 *shall employ a full-time assistant director of nursing who shall be a professional registered nurse;*
67 *(iv) each nursing home with fewer than 100 beds shall employ a part-time professional registered*
68 *nurse as assistant director of nursing; (v) each nursing home with 100 beds or more shall employ a*
69 *full-time director of in-service education; and (vi) each nursing home with fewer than 100 beds shall*
70 *employ a part-time director of in-service education. In addition, each nursing home shall maintain a*
71 *minimum staffing ratio of registered nurses or licensed practical nurses to residents of at least one to*
72 *fifteen during the day shift, at least one to twenty during the evening shift, and at least one to thirty*
73 *during the night shift. A nursing home shall maintain a minimum staffing ratio of certified nurse aides*
74 *to residents of at least one to five during the day shift, at least one to five during the evening shift,*
75 *and at least one to ten during the night shift. Further, in order to meet the individual needs of*
76 *residents with extensive nursing care requirements or higher acuity levels, each nursing home shall*
77 *decrease the caregiver to resident ratios provided in this subdivision. On a form provided by the*
78 *Board, each nursing home shall post, in a manner easily visible and readily accessible to residents,*
79 *families, caregivers, and others on each wing and floor of its facility, the actual staffing ratios,*
80 *according to the most recently completed cost reporting period, grouped by categories of employees*
81 *and shifts, in accordance with this subdivision, and a list, in at least forty-eight-point type, of the*
82 *names of the nursing staff on duty at the beginning of each shift on each such wing or floor. This*
83 *information shall be expressed in actual numbers and as staffing ratios, and shall include the actual*
84 *numbers of additional staff employed to meet the additional needs of residents with extensive nursing*
85 *care requirements or higher acuity levels. The Commissioner of Health shall ensure that the nursing*
86 *home staffing requirements provided in this subdivision are enforced and, in the case of any*
87 *violations of this subdivision, may evoke the penalties and remedies provided in § 32.1-27.*

88 C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and
89 certified nursing facilities may operate adult day care centers.

90 D. All facilities licensed by the Board pursuant to this article which provide treatment or care for
91 hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all
92 lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is
93 found to be contaminated with an infectious agent, those hemophiliacs who have received units of this
94 contaminated clotting factor may be apprised of this contamination. Facilities which have identified a
95 lot which is known to be contaminated shall notify the recipient's attending physician and request that
96 he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by
97 mail, return receipt requested, each recipient who received treatment from a known contaminated lot
98 at the individual's last known address.

Official Use By Clerks			
Passed By The Senate		Passed By The House of Delegates	
with amendment	<input type="checkbox"/>	with amendment	<input type="checkbox"/>
substitute	<input type="checkbox"/>	substitute	<input type="checkbox"/>
substitute w/amdt	<input type="checkbox"/>	substitute w/amdt	<input type="checkbox"/>
Date: _____		Date: _____	
_____ Clerk of the Senate		_____ Clerk of the House of Delegates	

APPENDIX B

SENATE OF VIRGINIA



WARREN E. BARRY
37TH SENATORIAL DISTRICT
PART OF FAIRFAX AND
PRINCE WILLIAM COUNTIES, AND
PART OF THE CITY OF FAIRFAX
POST OFFICE BOX 1146
FAIRFAX, VIRGINIA 22030-1146

COMMITTEE ASSIGNMENTS:
EDUCATION AND HEALTH, CHAIR
COMMERCE AND LABOR
FINANCE
TRANSPORTATION
RULES

April 4, 2001

The Honorable William T. Bolling, Chairman
Joint Commission on Health Care
1001 East Broad Street
Richmond, Virginia 23219

Dear Senator Bolling:

Senate Bill 1125 (Byrne), a bill establishing staffing standards for all nursing homes as a condition of licensure, was considered by the Senate Committee on Education and Health during the 2001 Session. Although the Committee tabled this bill, there was much discussion concerning staffing standards and issues relating to quality of care, appropriate staffing ratios and required positions, patient acuity, and the costs of care as such costs could be affected by establishing strict staffing standards. The motion to table SB 1125 included a motion to refer this bill and the many issues it conjures to the Long-Term Care Subcommittee of the Joint Commission on Health Care.

Therefore, I respectfully request, on behalf of the members of the Senate Committee on Education and Health, that the Joint Commission on Health Care include an examination of the provisions of SB 1125 and the issues relating to staffing standards in its study plan for the 2001 interim and that the Commission provide the Senate Committee on Education and Health with any recommendations on these issues that it may determine appropriate. Thank you in advance for your consideration of this request.

Sincerely,

A handwritten signature in black ink, appearing to read "W. E. Barry".

Senator Warren E. Barry, Chairman
Senate Committee on Education and Health

cc: Members, Senate Committee on Education and Health
The Honorable Leslie L. Byrne

Enclosures

APPENDIX C

HOUSE BILL NO. 2257

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact § 32.1-127 of the Code of Virginia, relating to the Board of Health.

Patrons-- Watts, Moran, Plum and Van Landingham; Senators: Byrne and Ticer

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.) of this chapter.

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to assure the environmental protection and the life safety of its patients and employees and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Health Care Financing

Administration (HCFA), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in HCFA regulations for routine contact, whereby the provider's designated organ procurement organization certified by HCFA (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (i) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (ii) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing,

postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be based on Joint Commission on Accreditation of Healthcare Organizations' standards;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols; and

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.1-55.3 on such reporting procedures and the consequences for failing to make a required report.; and

11. Shall establish staffing standards in nursing homes that will provide an average of five hours of direct care services per resident per twenty-four-hour period. The Board shall promulgate regulations defining direct care services and procedures for quarterly reporting.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

APPENDIX D



JOINT COMMISSION ON HEALTH CARE

**SUMMARY OF PUBLIC COMMENTS:
Nurse Staffing Ratios in Nursing Homes
SB 1125/HB 2257**

Individuals/Organizations Submitting Comments

A total of 67 individuals and organizations submitted written comments to the JCHC in response to the staff report on Nurse Staffing Ratios in Nursing Homes. In addition to the 67 individual letters and e-mails received by JCHC staff, a petition supporting passage of SB 1125, signed by 111 persons, also was received.

Policy Options Included in the Nurse Staffing Ratios in Nursing Homes Study

- Option I Recommend to the Senate Committee on Education and Health that SB 1125 not be reported
- Option II Recommend to the Senate Committee on Education and Health that SB 1125 be reported as introduced and that appropriate budget amendments be approved to fund the nurse staffing requirements
- Assuming that nursing facilities would have to use both facility employees and agency nurses to meet the staffing standards, the estimated GF amount would be \$91.2 million
- Option III Recommend to the Senate Committee on Education and Health that SB 1125 be amended in the nature of a substitute to conform to the minimum number of hours per resident per day standard contained in HB 2257, and that appropriate budget amendments be approved to fund the staffing requirements

- Assuming that nursing facilities would have to use both facility employees and agency nurses to meet the staffing standards, the estimated GF amount would be \$81.5 million

- Option IV Recommend to the Senate Committee on Education and Health that SB 1125 be reported with one or more of the following amendments:
- A. The mandated nurse staffing standards would be phased in over a period of 2 biennia
 - B. The CNA nurse staffing mandates be reduced to be consistent with the recommendations of the National Citizens Coalition for Nursing Home Reform (1:5 on days; 1:10 on evenings; and 1:15 on nights)
 - C. The nurse staffing standard be converted to hours of nursing care per resident per day and set at the “preferred minimum level” (i.e., 3.45 hours) identified in the Health Care Financing Administration’s (HCFA) 2000 Report to Congress
- Option V Introduce a budget amendment (language and funding) to increase the hourly salary of CNAs
- For each \$1.00 increase, \$7 million (GF) would need to be appropriated
- Option VI Direct JCHC staff to convene a task force of DMAS staff and nursing home industry representatives to develop an “incentive” provision in the Medicaid nursing facility reimbursement system that would provide additional reimbursement to those facilities which increase their nurse staffing to meet established staffing criteria (as part of JCHC’s 2002 workplan)
- Option VII Introduce legislation to require nursing facilities to post their nurse staffing levels by shift in a manner that is easily accessible to residents and their families

Overall Summary of Comments

A total of 67 comments were received. The vast majority of comments (61) were received from individuals and organizations commenting in support of SB 1125 (i.e., mandated minimum staff ratios in nursing homes). Of the 61 comments in support of SB 1125, 52 individuals submitted general comments that did not mention specifically any of the Policy Options. The remaining nine individuals and organizations in support of SB 1125 commented on specific Policy Options. Several of the 61 commenters disagreed that agency staff

nurses would be needed to meet mandated staffing ratios, and argued that the cost estimate of implementing SB 1125 must reflect cost savings associated with better care outcomes. As previously noted, in addition to the 61 individuals and organizations who commented in support of SB 1125, 111 individuals signed a petition supporting SB 1125. Six commenters (one individual and five providers/provider groups) commented in opposition to SB 1125 and mandated nurse staffing ratios in nursing homes.

Summary of Individual Comments

The Following 52 Individuals/Organizations Submitted General Comments In Support of SB 1125 (Mandated Nurse Staffing Ratios in Nursing Homes)

Gail Macinnes (NCNHR)	Elisabeth Wittenberg	Donna Burechson	Monika Wood
Wanda Bowdel	Barbara Mitchell	Valerie Joseph (TLC4LTC)	June Harvie (Cent. Va. AAA)
Elizabeth Hall	Janet G. Bixler	Nancy B. Jarvis	K.J. Austin
Daniel R. Black	Dale Belrose	Mrs. Robert W. Buster, Jr.	Kay Chidlaw
Janet E. Curtis	Patsy & Clyde Collie	Janet Crooks	Henry Cullerton
Maxine C. Dellinger (Dist. 3 Sen. Services)	Mary Ann Wollerton	Rosemary Furcher	Kelly Wilkinson
Eleanor S. Gray	Mike Guy (Dist. 3 Gov. Coop.)	Margie Hartman	Jean Holbrook
Andrea Novotny	Tony Ingrassia (NVa. LTC Program)	Edward L. Jaffe	Sharon Lynn
Michael J. Korin	Kathy Keoughan	Diana Lavery	Dottie L. Wingo
Wanda Nolan	Laura Nichols	Jack N. Wilson	Rebecca M. Ridpath
Sandra L. Reid	Yolanda Thompson	Joan Simons	Debra Harvey (Bristol APS)
Ronald Snodgrass (APS)	Diane Wheeler (APS)	Rita Schumacher	Charles E. Sell
Juanita Smith & Myron Chubb-Hale	John. Doris, & Patricia Tugwell	Ron Tugwell	William W. Wingo, Jr

(Note: Some of the comments received from these individuals were hand-written letters. JCHC staff apologizes if some of the above names are misspelled.)

While the comments submitted by these individuals/organizations did not state specific support for any of the Policy Options, they expressed strong

support for SB 1125 and mandated nurse staffing ratios in nursing homes. Many of these individuals have had first-hand experience in caring for a loved one in a nursing home, and indicated that the lack of staffing had a very negative impact on care. Several of these individuals are volunteer ombudsmen who commented that they see the need for staffing ratios every day in their work. A few are current nursing home residents who also expressed strong support for additional staffing.

A number of the comments indicated that while there is a substantial cost to hiring additional nurses, much of the added cost would be offset by reducing unnecessary hospitalizations, bed sores, and other health problems that could be avoided if more staff were present to care for the residents.

The following are excerpts from a number of the comments received from these individuals/organizations.

- *I do not exaggerate when I say that nursing home residents in the state of Virginia are suffering every day that inadequate staffing levels are allowed to continue.*
- *The staffing ratio in Virginia nursing homes is dangerously low resulting in inadequate care and neglect of patients. When frail and compromised patients do not get required attention the result is dehydration, inadequate nutrition, bedsores, bodily wounds, infection, broken bones from falls, and other infirmities which require hospitalization often through the emergency room. I know these things from experience, they have happened to my father as a result of inadequate care in nursing facilities. The reason always given is “we’re understaffed.”*
- *There is a direct correlation between understaffing and neglect and abuse of nursing home residents. It is imperative that nursing homes be required to meet minimum staffing levels. They will not do that voluntarily. I wholeheartedly support SB 1125.*
- *Child care in Virginia requires one adult for every four children. Adult day care requires one caretaker for every six participants. Nursing home residents have a much higher acuity rate, and yet to date, there is no law mandating a ratio of direct-care givers. That must be corrected now!*
- *I am a registered nurse living in Burke, Virginia. I used to work in long term care and I have left the work force because of the unsafe conditions for residents and nurses created by the lack of quality staff in adequate numbers. I believe that a legislative approach to staffing in nursing homes is the only way we will ever see improvement.*
- *Frequently, there is only one aide for a shift with 17 patients. How can one person feed (more than ½ of patients need*

assistance), change their clothes and diapers, straighten their bedding and help with positioning in the bed for the night for 17 patients in an eight hour shift?

- I urge, implore, plead with you for those most vulnerable citizens to support this bill – it would prevent hospitalizations which result in huge costs to us taxpayers.
- This bill is long overdue! The staffing levels are totally below accepted standards for proper care of residents.
- My mother's care in a nursing home here in Northern Virginia was not good. She and the other residents were often left to sit in their own vomit or excrement for hours at a time. When we would question this, the answer was always that the person assigned to their care had not had the time to get to them.
- As the current President of the Sleepy Hollow Manor Nursing Home Family Council, I am authorized by our very active group to urge the enactment of a minimum staffing requirement for all nursing homes in Virginia. The need is acute, the need is now at a crisis point.
- We strongly support efforts to establish and enforce minimum standards for the staffing of nursing homes. Shortage of staff is probably the most common complaint we hear from residents and their families.
- I visit my father at least twice a week and have found that the care he is receiving has gone down tremendously in the last year. The reason for this poor care is understaffing in the nursing home. The CNAs are doing all they can do in most cases. They are so overworked and simply cannot get to everyone when needed.
- As you are aware there is a direct correlation between understaffing and patient abuse and neglect. As Adult Protective Service Investigators we see the results of understaffing. Let us start to provide better care for our elderly.
- I am a volunteer ombudsman for Fairfax County, serving in the INOVA Cameron Glen Nursing Home. I observe first hand the severe shortage of qualified nursing assistants and the negative impact this shortage has on the care of the patients, the morale of the staff, and the frustration of the home's administrators. I strongly support legislation that would require minimum staffing levels for certified nursing assistants.
- I strongly urge you to support the bill for minimum staffing. Our elder citizens are in desperate need of good care, and they cannot get it with the staffing regulations in place today.
- The need for staffing ratios in nursing facilities is evident by the number of bed sores, medication mistakes, dehydration, and other unnecessary health issues that affect many long-term

care residents. There is a direct correlation between staffing ratios and neglect/abuse in long-term care facilities too.

TLC 4 Long-Term Care (TLC4LTC)

Ilene R. Henshaw commented that minimum staffing ratios are a “win-win” . . . residents win because they receive better and more loving care . . . families win because they know their loved ones are receiving good care . . . nurses and nursing assistants win because they are able to do and be successful at what originally attracted them to nursing home work –providing good quality care for the elderly . . . nursing homes win because they attract and retain the very best workers . . . taxpayers win because their tax dollars are going to support quality care, not to paying for the negative outcomes of understaffing.

TLC4LTC commented in opposition to Option I and in support of Option II. However, they question the assumption made that agency nurses would be needed to meet the standards, and also believe that any calculation of cost must include cost savings from reducing hospitalizations, bed sores, and lower worker compensation costs. TLC4LTC would support Option III as an initial step toward SB 1125, but the standard must be set forth in numerical ratios. TLC4LTC would support: Option IV(A) if implemented in no more than 2 years; Option IV(B) with ratios increased to SB 1125 levels in no more than 2 years; Option IV(C) with standards increased to SB 1125 levels in no more than 2 years and standards expressed in ratio format; and Option V, but only in conjunction with the enactment of appropriate staffing guidelines and strict accountability measures. TLC4LTC expressed strong opposition to Option VI. Lastly, TLC4LTC would support Option VII only in accordance with the standards delineated in SB 1125, with the understanding that such posting will be required by federal law by 2003.

Virginia Long-Term Care Ombudsman Program

Joani Latimer, State Long-Term Care Ombudsman, commented in favor of mandated nurse staffing ratios. She stated that Virginia needs a specific measurable standard that does not rely on the evidence of harm as a catalyst for correction. Ms. Latimer also noted that a standard expressed in terms of a ratio of staff to residents is more meaningful and useful than one limited to a calculation of nursing hours per resident day. She commented that while there are genuine concerns about the unavailability of staff to meet more stringent staffing requirements, the problem has clearly more to do with the retention of staff due to the hard work, low pay and benefits. “Until we have a staffing standard that protects workers and residents from the results of this kind of overload, the staffing crisis cannot be ameliorated. Ironically, we must require a certain level of staff before we will begin to find them. If this suggests the adoption of staffing ratios, with a phase-in plan of implementation, then perhaps that is the answer.”

Ms. Latimer noted that the Long-Term Care Ombudsman Program supports Option II, and could support Option IV (A) allowing for a two-year phase-in of the mandated staffing levels. She commented that while there certainly are costs associated with mandating minimum staffing ratios, there are savings to be realized as well. These savings include lower staff turnover costs, and better outcomes which result in fewer instances of bed sores, contractures, pneumonia, hip fractures, etc. Ms. Latimer indicated opposition to Option VI as an alternative to a more specific staffing standard. Lastly, she fully endorsed the concept of posting staffing levels (Option VII), with the understanding that federal regulations will require this in 2003.

Northern Virginia Aging Network (NVAN)

Erica F. Wood, Legislative Chair, commented that NVAN supports the comments of the State Long-Term Care Ombudsman. She further noted that the current standards at the federal and state levels are difficult to enforce. Ms. Wood stated that any additional costs may be offset by cost savings inherent in better care. NVAN supports Option II.

Louisa County Commission on Aging (LCCA)

Mrs. Peg Franklin, Chair, commented that the LCCA supports the phasing in of mandated staffing levels over a two year period (Option IV). Mrs. Franklin recommended beginning with the National Citizen Coalition for Nursing Home Reform staffing levels and moving toward the levels outlined in SB 1125. She also noted that "skilled care" residents should have a 1:3 ratio for day and 1:6 for nights, and that RNs should be on duty 24 hours a day in all units. Lastly, she indicated opposition to converting staffing ratios to hours of nursing care per day because it is too easy for facilities to include staff who are not providing direct patient care.

Gregory J. Huber

Mr. Huber commented that data presented in the issue brief indicates more staff increases quality of care (or at least less staff hurts quality). Due to the nursing shortage, it would be difficult for facilities to comply with mandated numbers. Offering incentives to facilities would make the goal of increased staffing more attainable. For these reasons, Mr. Huber expressed support for Options I, V, and VI.

The Committee on Aging of the Episcopal Diocese of Virginia

Mrs. Betsy Power, Chair, commented that the Committee on Aging of the Episcopal Diocese of Virginia supports the phasing in of mandated staffing levels over a two year period (Option IV). Mrs. Power recommended beginning with the

National Citizen Coalition for Nursing Home Reform staffing levels and moving toward the levels outlined in SB 1125. She also noted that “skilled care” residents should have a 1:3 ratio for day and 1:6 for nights, and that RNs should be on duty 24 hours a day in skilled care units. Lastly, she indicated opposition to converting staffing ratios to hours of nursing care per day because it is too easy for facilities to include staff who are not providing direct patient care.

Friends and Families of the Residents (FFOR)

The Rev. Dr. Marian Windel, Chair, commented that while the acuity level at Louisa Healthcare Center is higher than national and state averages, staffing is below the national and state levels. She also noted that there should be different mandated staffing levels for skilled and unskilled units. She indicated support for the phasing in of mandated staffing levels over a two year period (Option IV). She recommended beginning with the National Citizen Coalition for Nursing Home Reform staffing levels and moving toward the levels outlined in SB 1125. She also noted that “skilled care” residents should have a 1:3 ratio for day and 1:6 for nights, and that RNs should be on duty 24 hours a day in skilled care units. Lastly, she indicated opposition to converting staffing ratios to hours of nursing care per day because it is too easy for facilities to include staff who are not providing direct patient care.

Virginia Health Care Association (VHCA)

Mary Lynne Bailey, Vice President, Legal and Government Affairs, indicated VHCA supports Options I and V, and does not support any of the other options contained in the report. Ms. Bailey noted that the perception that some people have that Virginia nursing facilities do not staff at a higher level in order to save money is inaccurate. She also noted that “staffing mandates will not solve the very real problem of a shortage of nurses at all levels –RNs, LPNs and CNAs. Virginia’s nursing facilities would hire more nursing staff if they could. Common sense tells us that providers would not spend money to advertise for nursing staff week after week and pay high rates for agency and traveling nurses if they could hire adequate numbers of qualified nursing staff.” Ms. Bailey also commented that VHCA does not believe it is necessary to develop a financial incentive to encourage nursing facility providers to increase their nurse staffing (Option VI). Instead, the Commonwealth should reimburse facilities more adequately to deliver the high quality care they want to provide. Ms. Bailey concluded by stating that “[E]ach year it becomes harder and harder for Virginia nursing facility providers to continue to provide the quality care they are striving to give. Mandating staffing ratios that providers are unable to meet will not solve any problems.”

Jefferson Area Board for Aging (JABA)

Gordon Walker, CEO, commented that JABA supports Virginia pursuing not the minimum level of care, but the highest level of care we can afford to deliver. In response to Option I, Mr. Walker commented that SB 1125 “should be reported out.” However, with regard to Option II, Mr. Walker stated that “without knowing what the impact of this would be on facilities unable to meet the regulation – the penalty system – and how resident acuity would be factored in, it is difficult to give complete support to this option.” He indicated that “phasing in the regulations may be the most feasible for nursing homes, as they develop programs/training to support staff. It is important, however, that there be hiring benchmarks facilities need to meet on the way to full implementation.” He also expressed concern for converting a ratio approach to hours of care per day. In response to Option V, Mr. Walker indicated that increasing the hourly salary of CNAs will have a limited effect on the problem of recruitment. Any salary increase needs to be coupled with changes in the work environment and additional training and career development opportunities. With respect to Option VI, Mr. Walker noted “it would be good to see the incentive tied to improvements in resident care, as well as additions in the number of staff.” Lastly, Mr. Walker commented that posting staffing levels (Option VII) is easy to accomplish, but it must take into account the varying acuity levels on each unit; and the posted numbers must be actual rather than scheduled staffing.

Virginia Hospital and Healthcare Association

Susan C. Ward, Vice President and General Counsel, commented in support of Option I. Ms. Ward stated “the existing state and federal regulatory systems are more than adequate to ensure quality of care, to the extent that regulations in and of themselves are able to achieve this objective. The quality concerns regarding nursing homes nationwide stem from workforce shortages and payment inadequacies, particularly from public payors.” Ms. Ward indicated that VHHA would be supportive of Option V. VHHA also has no objection to Option VI and would be supportive of this option if the fiscal circumstances of the state preclude proceeding with Option V. Lastly, Ms. Ward indicated that VHHA opposes Options II, III, IV and VII because “none of these options addresses the underlying concerns of workforce shortages and payment inadequacies facing Virginia’s long-term care facilities.”

Virginia Association of Nonprofit Homes for the Aging

Marcia Tetterton, Vice President of Public Policy, commented in support of Option I.

INOVA Health System

Donald L. Harris, Vice President, Government Relations, commented that INOVA “has increasingly found it difficult to locate and hire the needed health care professionals to serve the growing population of Northern Virginia.” Mr. Harris stated that “INOVA supports Policy Option I because we do not believe that mandatory staffing ratios accomplish the desired intent.” In support of INOVA’s position, Mr. Harris noted that staffing ratios have the danger of the “floor” becoming the “ceiling,” and that mandated staffing ratios puts an external control on staffing decisions without considering the needs of the patients. Lastly, Mr. Harris noted that rather than meeting minimum staffing standards, “language that requires facilities to meet minimum outcome measures would be more preferable.”

AARP

Jack R. Hundley, Chairman, Virginia State Legislative Commission, commented that there is growing evidence and consensus that good nursing staffing levels are directly related to good quality of care in nursing facilities. “Establishing minimum safe levels is the first of many steps needed to improve the quality of nursing care in the Commonwealth. Of course, minimum staffing levels alone will not guarantee quality care, but without them, quality care in nursing homes is a hit or miss proposition.” AARP opposes Option I, and would endorse Option II “although we do not agree that agency employees would be necessary to meet the proposed staffing standards.” Mr. Hundley also noted that “we understand the significant financial impact of SB 1125, but believe that providing good care, thus reducing unnecessary hospitalization, bedsores and infections and other negative outcomes, as well as reducing staff turnover, will result in containing costs ...” With respect to Options III and IV, AARP feels strongly that staffing standards should be expressed in the form of numerical ratios. Regarding Option V, AARP agrees that direct care workers should be appropriately compensated for a very difficult and demanding job and that additional funding will assist facilities attract staff. Mr. Hundley noted AARP would support Option VI only if Option IV and V are not implemented. Lastly, AARP indicated that it supports Option VII and urges posting of staffing levels in numerical ratios.

Alzheimer’s Association

Ian Kremer, Public Policy Director, commented that the Alzheimer’s Association supports Policy Option II, but disagrees with the cost assessment which is predicated upon high use of agency staff and which does not account for cost savings associated with improved care. Mr. Kremer also stated the Association supports Options IV(A), V, and VII. The Association opposes Options I and VI. He also stated that the Association specifically endorses the comments submitted by the State Long-Term Care Ombudsman and AARP.

Bon Secours Maryview Nursing Care Center

Steven L. Minter, Administrator, commented that Bon Secours strongly supports Option I. Of the remaining options, Bon Secours also would support any effort to increase funding for increased CNA salaries. Mr. Minter also commented in support of Option VI; he indicated that they would not oppose Option VII. Mr. Minter outlined specific reasons why Bon Secours believes mandated staffing ratios are a bad idea, including the following: (i) nursing homes currently cannot fill vacant budgeted positions; (ii) the use of temporary agency staff is generally bad. . .mandating staffing ratios will increase the use of temporary agency staff; (iii) mandating ratios will guarantee some providers will reduce current staffing to the mandated levels; (iv) mandating staffing ratios will increase administrative costs; and (v) mandated staffing ratios do not guarantee improved patient care.

JOINT COMMISSION ON HEALTH CARE

Executive Director

Patrick W. Finnerty

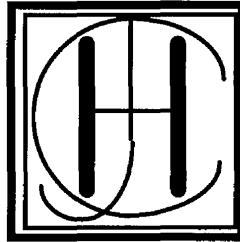
Senior Health Policy Analysts

Joseph J. Hilbert
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>