



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



STATE-INITIATED NURSING HOME NURSE STAFFING RATIOS:

ANNOTATED REVIEW OF THE LITERATURE

May 2003

Office of the Assistant Secretary for Planning and Evaluation

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STATE-INITIATED NURSING HOME NURSE STAFF RATIOS: Annotated Review of the Literature

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INTRODUCTION

The purpose of this project is to inform federal and state policymakers about what can be learned about the implementation and enforcement of state minimum nursing staff ratios for nursing homes, and related issues, such as labor shortages and resident casemix. The experiences of states that have already grappled with the complexities of setting, monitoring, and enforcing minimum staffing ratios could be instructive. The project will describe the states' minimum ratios and their goals, the issues states confront as they implement the ratios, and the perceived impacts of these ratios on the quality and cost of nursing home care.

The study took a two-pronged approach to determining what is currently known about state minimum nursing staff ratios and their implementation. The first was an annotated review of the published and unpublished literature on state standards. The purpose of the literature review was to identify states with minimum nursing staff ratios and to learn how this type of standard is being implemented. This paper provides the annotated review of the literature.

The study also involved guided discussions with key national stakeholders about the issues around state nursing staff ratios. Our analysis of the literature and guided discussions identified major gaps in knowledge about the states' activities. We will attempt to fill these gaps via case studies that we will undertake in the second part of this study--a series of guided discussions with researchers and key stakeholders at the state level about various aspects of state minimum nursing staff ratios and their implementation.

REPORT OF THE JOINT COMMISSION ON HEALTH CARE TO THE CHAIRMAN OF THE SENATE COMMITTEE ON EDUCATION AND HEALTH: NURSE STAFFING RATIOS IN NURSING FACILITIES STUDY

Joint Commission on Health Care
Richmond, VA: Virginia Joint Commission on Health Care, 2002. 50 pages.

This report, authorized by the Chairman of the Virginia Senate Committee on Education and Health, studies the provisions of Senate Bill 1125 of the 2001 Session of the General Assembly. Senate Bill 1125 requires Virginia nursing homes to implement minimum nursing staff standards of 5.2 hours per resident day (hprd). For Certified Nursing Assistants (CNAs), the Bill requires minimum ratios of 1:5 residents (day), 1:5 (evening), and 1:10 (night) or a total of 4.0 hprd, and minimum licensed nurse-to-resident ratios of 1:15 (day), 1:20 (evening), and 1:30 (night) or a total of 1.2 hprd. These minimum standards exceed those of all other states as well as those recommended by advocacy and research organizations. The fiscal impact on the Medicaid program is estimated to be an additional \$91.2 million from the general fund annually. On January 1, 2001, the Bill was referred to the Committee on Education and Health where it failed.

Additionally, the Commission's report examines issues related to nursing staff standards and provides recommendations. Data from the National Ombudsman Reporting System for 1999 shows that shortage of staff is one of the most frequently cited complaints filed by Virginia's State Long-Term Care Ombudsman. However, since only a small number of facilities are actually cited for nursing staff deficiencies during the survey process, there is concern that surveyors face a high burden of proof in justifying this type of citation. The report cites studies that raise concerns about the adequacy of care in nursing homes including reports from the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS), the Hartford Institute Expert Panel, U.S. General Accounting Office, and the Centers for Medicare and Medicaid Services (CMS) Phase I and II studies. The report also describes nursing staff standards and activities regarding this issue in other states.

The report describes the Virginia nursing home industry's concerns about implementing a minimum nursing staff standard, some of which are:

- Need for appropriation of funds to increase Medicaid reimbursement rates to cover the cost of additional staffing,
- The current nursing shortage in Virginia that is likely to worsen in the future,

- The importance of the quality and supervision of staff, and
- Implementation of staffing levels that account for the acuity level of residents.

Findings

- There are concerns that state surveyors do not have the ability to determine if nursing homes meet the federal nursing staff standards due to the vague definition of terms in the requirements such as "sufficient staff" and the subjective nature of the survey process.
- Nurse staffing in Virginia nursing homes is comparable to the national average. However, according to the report, the national average is not necessarily an appropriate staffing level.
- According to the authors, Virginia has the highest acuity level of nursing facility residents in the nation. In a 2001 study by the American Health Care Association,¹ Virginia's acuity level, measured as the average number of activities of daily living (ADLs) for which residents need assistance, is 4.32 compared to the national average of 3.75. In 1999, Virginia's score on the "management minute index," another measure of resident acuity based on resident characteristics such as needing assistance with ambulation, eating, and having an indwelling catheter, is highest among all states at 123.6 compared to the national average of 100.6. There is general consensus among industry representatives and resident advocates that the restrictive eligibility criteria for receiving Medicaid reimbursement for nursing home care in Virginia is the primary reason for Virginia's high acuity level. According to this report, acuity of residents is an important factor in determining the level of appropriate nursing care.

Recommendations

The report offers several recommendations to the committee including:

- Amending Senate Bill 1125 to phase in minimum nursing staff standards in line with the National Citizens' Coalition for Nursing Home Reform's (NCCNHR) recommendations.
- Increasing the hourly salary of CNAs.

¹ American Health Care Association (AHCA), "Facts and Trends," Washington, DC: AHCA, 2001.

- Developing an incentive system that would provide additional Medicaid reimbursement to facilities that increase staffing to meet certain criteria (e.g., minimum staff-to-resident ratios or hours of nursing care per resident day).
- Introducing legislation requiring nursing homes to post staffing levels by shift where it would be accessible to the public.

The current status of the above recommendations is unknown.

STATE LONG-TERM CARE: RECENT DEVELOPMENTS AND POLICY DIRECTIONS

Barbara Coleman, Wendy Fox-Grage, Donna Folkemer
Department of Health and Human Services, Assistant Secretary for
Planning and Evaluation.

Washington, DC: National Conference of State Legislators, July 2002. 134 pages.

The first of two reports funded by the Office of the Assistant Secretary for Planning and Evaluation, HHS, this report presents a state-by-state overview of recently proposed or enacted legislation, analysis of state fiscal activity, long-term care planning and outlook for the future for the 2001 fiscal year. Information for 2002 is included when available. Appendix A summarizes state activities for the 50 states plus the District of Columbia. The second report is scheduled to be released in the summer of 2003 and will provide updated information.

Fiscal data were gathered from the 26 states that responded to a National Conference of State Legislatures (NCSL) survey sent to legislative fiscal offices in 2001. Additional fiscal information was gathered from FY 2000 and FY 2001 Medicaid long-term care expenditures reports compiled by MEDSTAT, Inc., using HCFA 64 reports annually filed to the CMS by the states. Other fiscal data were collected from state websites and state legislative reports. Data for the report also came from "Medicaid 1915(c) Home and Community-Based Waivers: Program Data, 1992-1999" by Charlene Harrington, published by the Kaiser Commission on Medicaid and the Uninsured. Data on state legislative activity were gathered from the NCSL's Health Policy Tracking Service, while information on state's long-term care planning was derived from the report "The States' Response to the Olmstead Decision: A Work in Progress," published by the NCSL in December 2001.

In 2001, 19 states considered legislation on nursing home staffing and two states adopted minimum standards. Arkansas and Florida enacted legislation to increase nursing home staffing standards and plan to phase in increased staffing ratios for both licensed nurses (LNs) and nurse aides over the next few years.

Available online at: <http://aspe.hhs.gov/daltcp/reports/stateltc.htm>.

RESULTS OF THE 2002 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT CARE WORKFORCE

Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services, Office of Long Term Care
Raleigh, NC: NCDHHS, June 2002. 20 pages.

This report examines data from a national survey conducted by the Paraprofessional Healthcare Institute (PHI) and the North Carolina Department of Health and Human Services' Office of Long-Term Care (NCDHHS). The report attempts to address whether or not direct care workforce shortages and state activities to address shortages have been affected by the slowing economy. Survey results along with additional state information from previous PHI and NCDHHS sources are compiled in the report (Appendix A). The survey collects data on state activities in response to direct care worker shortages. Surveys were sent to the state Medicaid agencies and State Units on Aging for 50 states; data were collected between February and April 2002.

Of the 43 states responding to the survey, 86% indicate that the shortage in direct care workers is a serious workforce issue. Eleven states report changes in programs, initiatives, and activities regarding the direct care workforce due to the slowing economy. Florida reports that the slowing economy has affected the state budget and may affect future funding increases for nursing home staffing ratios as enacted by SB 1202 in the 2001 Florida Legislature. Legislation passed in Delaware, SB 368, provides some nursing homes, which may have difficulty meeting the minimum staffing ratios of Eagle's Law (SB 115), flexibility with meeting the minimum standards. Nursing facilities that cannot meet the required staff-to-resident ratios may apply for a waiver through the Division of Long Term Care Residents Protection, waivers are subject to approval by the Delaware Nursing Home Residents Quality Assurance Commission. At the same time, the legislation weakens the staff-to-resident ratios for direct care staff by requiring less stringent shift ratios for licensed and unlicensed staff than those specified under previous law (Reference #4 details the changes in Delaware's staff-to-resident ratios).

Twenty-five states report coordinated efforts among state agencies to improve staffing conditions for direct care workers. Nine states report they were collecting and analyzing evaluative data on direct care initiatives. Eight states indicate they use a uniform methodology for collecting turnover data for direct care workers working in one or more settings such as home care, nursing homes, etc. However, given that these data efforts are recent initiatives, trend data are not available.

One-third of states responding indicate they had pending legislation related to direct care workers. Arizona, Florida, Michigan, New Jersey, and Ohio have pending

legislation regarding nursing staff ratios in long-term care settings, the status of which is unknown at this time. Tables and appendices with state data on nursing staff include:

- Table 2: Summary of 2002 Survey of State Initiatives on the Long-Term Care Direct Care Workforce;
- Table 3: Detailed State Comments from the 2002 Survey of State Initiatives on the Long-Term Care Direct Care Workforce;
- Table 4: Summary of State's Actions Taken to Address Recruitment and Retention of Nurse Aides and Other Direct Care Workers;
- Table 5: Detailed Summary of Prior State Actions on Recruitment and Retention; and
- Appendix A: Summary Chart for Each State.

ISSUE BRIEF:

NURSING HOME STAFFING STANDARDS

Elizabeth Devore

Washington, DC: Health Policy Tracking Service, June 28, 2002. 9 pages.

This issue brief highlights major legislative initiatives concerning nurse staffing in nursing homes in the Congress, the Federal Government, and among states from 2000 to 2002. Table 1 lists state minimum staffing requirements and regulatory state code information.

Federal Activity

The 107th Congress (2001-2002) introduced several pieces of legislation addressing nursing home staffing issues. House Bill 118 creates a state grant program. Funds received by states are provided to nursing homes, labor management partnerships, and educational institutions to assist in the recruitment, retention, education and training of nursing staff, as well as other nursing home quality improvement initiatives. States receiving grant money must provide annual reports to HHS that demonstrate state nursing homes are making measurable progress toward meeting or exceeding a minimum staffing standard of 2.0 hours of direct care per resident per day within two years. The Bill also requires that staff data reported to HHS be made publicly available. A second Bill, House Bill 3331, requires minimum nurse staff-to-resident ratios for LNs and direct care workers in line with NCCNHR's Consumer Minimum Staffing Standard. Additionally, the resolution calls for posting of staffing level information by nursing facilities and minimum standards for administrative nursing staff. A third initiative, the Nursing Home Quality Protection Act of 2001, requires the Secretary of Health and Human Services to implement nursing staff ratios no lower than the NCCNHR requirements. The Act also creates a grant project from funds set aside either from moneys withheld from nursing facilities for deficiencies or moneys paid by facilities for substandard care. States could use the grants for the recruitment, retention, education, and training of nursing staff as well as improving workplace safety for nursing staff. In 2000, CMS submitted the first phase of the report to Congress on the appropriateness of nursing staff ratios in nursing homes. In December 2001, CMS completed Phase II of the study. In a letter to Congress accompanying the Phase II report, HHS Secretary Tommy Thompson notes the complex relationship between nursing staff levels and quality of care in nursing homes, as well as the limitations of the first phase of the study. Secretary Thompson concludes that the CMS Phase I and II studies are insufficient to determine the appropriateness of staffing ratios.

Legislation introduced in 2000 but not passed called for grant programs to increase nursing staff levels, civil monetary penalties for nursing homes that are endangering resident safety, staffing level information provided to consumers, and development and

implementation of staffing ratios following the release of the second phase of the CMS study. The Senate Special Aging Committee held a hearing in November 1999 to address the issue of staffing shortages in nursing homes. Senator Grassley stated that nursing home reform advocates would like to strengthen the 1987 federal guidelines, while the industry lobbied against minimum standards citing tight budgets and inability to afford more staff. Dr. Charlene Harrington, professor at the University of California, who moderated the hearing stated that inadequate staffing levels and inadequately trained staff are factors that contribute to poor quality in nursing homes.

State Activity

As of this report's release, 36 states have implemented staffing standards that either require nursing homes to provide a certain number of hprd or a specific staff-to-resident ratio. These standards go beyond the federal standards. In 2002, legislative activity took a different direction with state's staffing Bills focused on allowing nursing home's flexibility in determining staffing patterns. In May 2002, Delaware passed legislation allowing more flexible shift ratios for licensed direct care staff than those specified under previous law. Facilities may use the revised ratios through July 1, 2003, as long as they provide 3.28 hprd. The new day and evening staff-to-resident ratios for licensed staff will be 1:20 (day), 1:25 (evening) instead of 1:15 (day) and 1:23 (evening) with no changes to the nightly ratio. New staff-to-resident ratios for CNAs will be 1:9 (day), 1:20 (night) with no changes to the evening ratio. The Oklahoma legislature delayed implementation of a scheduled increase in nursing home staff requirements by one year. Nursing homes in compliance by January 1, 2004, are allowed to set more "flexible staff scheduling" if they maintain sufficient staff to provide 2.86 hprd, a direct care staff-to-resident ratio of 1:16, and two direct care staff on duty at all times. Higher staffing standards will take effect if the Medicaid rate is increased to adequately cover staff costs. In 2001, 20 states introduced a total of more than 50 Bills on nursing staff standards in nursing homes. These states include Arkansas, California, Connecticut, Delaware, Florida, Illinois, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Virginia, and West Virginia. Among these states Arkansas, Florida, and California passed legislation that strengthened their requirements. In 2000, six states (California, Delaware, Kentucky, Maryland, Minnesota, and Oklahoma) enacted laws regarding nursing home staffing ratios. Table 1 of the report shows current state laws and regulations on minimum staffing requirements; Table 2 identifies other state legislative activity in 2002.

CARING FOR OUR ELDERS: IMPROVING NURSING HOME CARE

Elizabeth M. Ready

Office of the Vermont State Auditor, Department of Aging and Disabilities.
Montpelier, VT: Office of the Vermont State Auditor, June 26, 2002. 92 pages.

The purpose of this report on the state's nursing homes, issued at the request of the Vermont State Legislature, is to make observations and provide recommendations to the Department of Aging and Disabilities (DAD) so that the agency might achieve the goals and objectives set forth in its mission and more fully comply with state laws and regulations.

This study reviews the laws, regulations, policies, contracts, internal memoranda, and correspondence pertaining to the licensing requirements, regulations, funding, and oversight of Vermont's nursing homes. Data were collected from interviews with key state government officials, reviews of the complaints log and files, reviews of inspection reports from various nursing homes, as well as quality initiatives and other supporting data. This study discusses findings and recommendations on several different topics regarding nursing staff and improving the quality of nursing home care. Among the findings and recommendations related to nursing staff ratios, the study finds nursing homes are meeting the new requirements for minimum staffing. The standards mandate a minimum of 3.0 hprd of direct care for nursing staff and went into effect on December 15, 2001. The study recommends that consideration be given to new awards that address staffing and turnover ratios, with reporting requirements detailing how nursing homes use award amounts.

ELDER ABUSE IN RESIDENTIAL LONG-TERM CARE FACILITIES: WHAT IS KNOWN ABOUT PREVALENCE, CAUSES AND PREVENTION

Catherine Hawes

Testimony before the U.S. Senate Committee on Finance, ed.
Washington, DC: U.S. Senate Committee on Finance, June 18, 2002. 12 pages.

In testimony before the U.S. Senate Committee on Finance, Catherine Hawes, Professor and Director of the Southwest Rural Health Research Center at the School of Rural Public Health, Texas A&M University System Health Science Center, highlights the escalating rates of abuse and neglect in nursing homes. Hawes emphasizes the need to prevent such mistreatment stating that it is often difficult to distinguish between outright neglect and inadequate care that may stem from staffing shortages, staff burn-out, and poor staff training. Hawes also notes that if she could do one thing to reduce abuse and neglect in nursing homes it would be to increase the number of staff in nursing homes.

From previous research on nursing home quality, Hawes found that 85% of nurse aide registry directors maintain that staffing shortages, too few staff, and poor staff-to-resident ratios are the main cause of abuse and neglect in nursing homes. In focus group interviews, CNAs explain that short-staffing affects their ability to meet residents' needs. As a result, activities such as range of motion exercises, keeping residents hydrated, and assistance with eating are often neglected. According to Hawes, CNAs find the guilt associated with the inability to meet residents needs a major cause of staff turnover as well as job stress, which may make abuse more likely to occur. Hawes finds that many facilities have adopted policies or programs to prevent abuse and neglect. Those policies or programs related to nurse staffing include facilities, particularly non-profits and some Alzheimer's Special Care Units, that have staffing ratios of 1:6 or 1:8 for their direct care staff and have more staffing and supervision by registered nurses (RNs) than the average facility.

THE NEED FOR INCREASED STAFFING LEVELS IN CALIFORNIA'S NURSING FACILITIES

Eric Carlson, Esq.

Los Angeles, CA: National Senior Citizens Law Center, 2001. 34 pages.

This paper examines what staffing levels would result in acceptable quality of care in California nursing homes and what is a feasible timetable for implementation of these staffing levels. The paper cites federal studies that reveal substandard quality of care in California nursing homes including a 1998 GAO report, "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight," a 1999 Congressional report concerning Los Angeles County nursing facilities, and a 2000 Congressional report concerning nursing facilities in the San Francisco Bay Area. The report also cites studies that support a relationship between inadequate staffing and substandard nursing home care such as the Institute of Medicine Reports, an expert panel convened at New York University, and the CMS Report to Congress regarding the appropriateness of minimum staffing levels. Additionally, a Congressional report concerning California's Thirteenth District found a significant percentage of nursing homes failed to meet the CMS Occurrence of Harm Threshold and Occurrence of Harm Threshold -- Improved.²

Based on the cited studies, the paper concludes that nursing homes in California are providing inadequate quality of care, leading to frequent violations of the law which endanger residents health and well-being. The author's recommendations include adopting a CNA staffing level of 2.9 hours per resident day, as specified in the CMS time-motion study and the expert panel. For LNs, recommendations include 1.2 hours per resident day, specified by the expert panel. Meeting these standards would provide nursing home residents a total of 4.1 hours of direct care per resident day.

The report estimates that adoption of the expert panel's staffing levels would cost the state an additional \$150-199 million in Medi-Cal costs annually, while a three-year phase-in of this plan would cost between \$40 and \$50 million annually. According to the author, these increases would be in line with similar Medi-Cal increases to nursing facilities in recent years. For example, in fiscal year 2000-2001 nursing facilities received a total of \$164 million in Medi-Cal increases granted by the state, over \$131 million from an across-the-board increase and over \$33 million from a wage pass-through. However, a calculation of the costs associated with increasing staffing should also consider reductions in certain expenses due to higher staffing levels. According to earlier studies cited in this paper, low staffing can be correlated to harm suffered by residents. The author states that a reduction in harm suffered by residents could lead to

² The CMS Occurrence of Harm Threshold is 2.75 total direct care hprd and Occurrence of Harm Threshold -- Improved is 3.00 total direct care hours per resident per day.

decreased hospitalization costs, and ultimately lower spending by Medicare and Medi-Cal. Additionally, increases in staffing could reduce the costs associated with staff turnover.

The report highlights several concerns about the current conditions of the labor market for nursing staff in California. A tight labor market for CNAs and nurses suggests a need for phased-in implementation of higher staffing levels. The report also recognizes the importance of facility management styles and staffing patterns that are significant factors in the retention of staff. A report published by Harvard Professor Susan Eaton concerning management styles in a sample of California nursing homes finds short-sighted management practices that leave employees overworked, under-supervised, and with minimal training. Moreover, Eaton finds that both management and staff view their jobs as transitory.

The report concludes that academic and government research has shown that understaffing is related to substandard nursing home care and recommends that California adopt the direct care minimum standards of 4.13 hprd recommended by the expert panel held at the John A. Hartford Institute for Geriatric Nursing, Division of Nursing, at New York University.

APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES: PHASE II FINAL REPORT

Abt Associates, Inc.
Baltimore, MD: CMS, December 24, 2001.

Secretary of HHS Transmittal Letter to Congress

Responding to concerns about the adequacy of nursing home staffing, Congress authorized CMS to study the "appropriateness" of establishing minimum nursing staff ratios in nursing homes. In a letter to Congress, Secretary Thompson presents the work and conclusions of Abt Associates, Inc., in the Phase II Final Report. Secretary Thompson states that the relationship between the number of staff and quality of care is complex, listing several important staffing issues related to nursing home quality of care that the Phase I and Phase II studies do not address. These factors include management, tenure, staff training, nursing shortages, experience of nursing staff, staff mix, retention and turnover rates, and staff organization. Due to these limitations and concerns about the reliability of staffing data at the facility level, HHS concludes that the Phase I and Phase II studies are insufficient for determining the appropriateness of minimum staffing ratios and cannot support the implementation of recommended thresholds in the Phase II study.

Phase II Report

The Phase II study replicates analyses from Phase I using a larger, more nationally representative sample of nursing homes along with more recent and improved quality of data with over 5,000 facilities in ten states. With findings similar to those from the previous Phase I report, the Phase II report identifies nursing staff ratios that maximize quality outcomes in nursing homes. Unlike the Phase I thresholds, the Phase II thresholds vary by nurse category and care requirements of the nursing home population.

Conclusions

- Thresholds at which the quality of care is maximized range between 2.4 and 2.8 hprd for CNAs, 1.15 to 1.40 hprd for RNs and Licensed Practical Nurses (LPNs) combined, and 0.55 to 0.75 for RNs, depending on the resident population. Significant quality improvement is seen with incremental staffing increases up to these ratios, while no improvement is seen with levels above them.

- If the maximum thresholds are implemented, 97% of all nursing home facilities would fail to meet one or more of the standards. A different methodology estimates that 91% of nursing homes have nursing assistant (NA) staffing levels below the minimal levels identified to provide necessary care.
- The study examines factors other than staffing, such as enhanced training or better management practices, that facilities below the minimum requirement may be able to use to address quality problems.
- Facilities in the "worst" deciles for five quality measures had the highest amount of NA turnover.
- Demand for nurses would increase as a result of implementation of staffing thresholds, requiring a wage increase of 2.5-7% for RNs, based on an average RN wage rate of \$20.00 per hour, and a wage increase between 10% and 22% for nurse aides.
- One policy alternative, intended to achieve the same objective of improved quality, is to require minimum expenditures for nursing staff. This alternative would allow facilities the flexibility to allocate nursing resources according to their staffing needs and the labor market demand for nurses in their community. For example, some facilities may increase staff numbers while others may increase the wages of existing staff. However, the effectiveness of this policy alternative, whether alone or in conjunction with minimum nursing staff standards, depends on whether increased nursing expenditures result in improved quality. According to analysis conducted in the Phase II report there is strong evidence linking total nursing wages in dollars to quality of care.
- There is a need for accurate staffing data on nursing homes that would provide useful information to consumers even if minimum staffing requirements are not implemented.
- According to the authors, an important element in the consideration of the appropriateness of nursing staff ratios is the cost to federal and state governments, providers, residents, consumers, and taxpayers. The report discusses the costs of implementing Phase II minimum nursing staff ratios under the current Medicare Prospective Payment System, but does not consider any potential reductions in Medicare skilled nursing facility (SNF) payments.

NURSING STAFF REQUIREMENTS AND THE QUALITY OF NURSING HOME CARE: A REPORT TO THE CALIFORNIA LEGISLATURE

Department of Health Services' Licensing and Certification Program
Sacramento, CA: California DHS, June 2001. 26 pages.

This report, authorized by California Health and Safety Code 1276.7, reviews the federal and national discussion of nursing home staffing and quality of care, the implementation of California's increase in minimum nursing staff standards effective January 2000, and the policy and financial implications of raising nursing staff standards above current levels. The report assesses the need for an increase in the minimum number of nursing hours per resident in California's nursing homes and provides recommendations for such an increase.

As of this report's release, California had the third highest nursing home staffing standard in the country (3.2 hprd). Only Arkansas and Delaware have more stringent requirements. As of September 2000, Arkansas requires staff-to-resident ratios equivalent to 3.5 hprd; as of May 2000, Delaware requires 3.25 hprd. Appendix E details other states' staffing requirements. Table 1 summarizes various minimum staffing proposals discussed in the report.

Enforcement of the 3.2 hprd standard by the Department of Health Services (DHS) occurs primarily during routine licensing and certification (L&C) surveys or through on-site reviews in response to complaints. When a facility is found out of compliance with the 3.2 hprd standard, DHS may issue a deficiency or a citation subject to the effect on resident care. As of April 2000, nursing homes are expected to be in full compliance with the minimum standard.

Findings

This study's findings and recommendations are based on data from several sources including submitted materials and information from stakeholders, publications in the past decade on nursing home staffing standards and quality of care, nursing home financial data from the Office of Statewide Health Planning and Development, data from the L&C Program Automated Certification and Licensing Administrative Information Management System and the On-line Survey Certification and Reporting System (OSCAR), and Medi-Cal Program cost data.

Information from survey data from a sample of 111 California nursing facilities representative of the proportion of non-profit and proprietary facilities completed between January and February 2001 are also used. Surveyors calculated the average nursing staff hprd for the week preceding the survey for all SNFs surveyed during this

timeframe. DHS was limited in the available time to conduct analysis therefore findings from survey data are not conclusive. Since the implementation of the 3.2 hprd, the available data suggest that:

- Nursing staff levels have increased, however, one-third of nursing facilities in the sample did not meet the requirement,
- Deficiency citations for federal "substandard quality of care" have decreased, and
- Facilities with a higher proportion of Medi-Cal residents are less likely to provide higher staffing levels.

Conclusions

The authors conclude that adequate staffing is a necessary factor but not the only factor to achieve quality care. Other policy considerations include:

- Developing an appropriate definition of quality;
- Accounting for acuity and casemix, however, technology to calculate and enforce this recommendation does not currently exist;
- Considering shift differences in the duties, workload, and number of staff;
- Developing strategies that address nurses' wages, work conditions, education, career advancement, and turnover due to nursing shortages in California;
- Researching management systems and staffing models common in other manufacturing and service industries.

The report states that hprd are not directly comparable to shift and skill mix ratios, and that both approaches should serve as useful guidelines to providers and stakeholders. Both hprd and ratios allow nursing homes flexibility to staff according to resident need and staff skills. Both types of requirements can be enforced by state regulatory agencies; however, they do not ensure staff actually provide appropriate care.

Additionally, the report describes several studies that suggest the skill mix of staff (RNs, Licensed Vocational Nurses (LVNs), CNAs) is as important as staffing levels in ensuring positive care outcomes. This research indicates higher RN and LN ratios lead to better resident outcomes and a proper LN-to-direct care worker ratio is important for supervision as well as for direct care needs.

Recommendations

DHS does not recommend raising the minimum staffing standard above 3.2 hprd unless empirical data are available to support the conclusion that raising the standard would improve quality of resident care. However, DHS would recommend future

consideration of converting the 3.2 hprd standard to a staff-to-resident ratio measure that provides nursing homes the flexibility to meet staffing needs.

DHS also recommends reforming nursing home payment to improve "accountability" and "quality of care" while controlling costs. As part of the DHS directed review of the Medi-Cal nursing home reimbursement methodology and analysis of alternative models for reimbursement, DHS would like to expand this study to include analysis of a facility-specific rate-setting system. Such a system should be designed to reflect the costs and staffing levels associated with quality of care.

The report states that "aggressive" enforcement is necessary for minimum nursing standards to be effective in maintaining and improving quality of care. DHS plans to add a component to the federal nursing home survey protocol that will calculate compliance with the 3.2 hprd. About 25% of facilities will be subject to this calculation each year with deficiencies or citations issued to facilities found in non-compliance. The report does not address why only 25% of facilities will be subject to this calculation each year nor how facilities will be selected.

The current status of the above recommendations is unknown at this time.

NURSING HOME STAFFING STANDARDS IN STATE STATUTES AND REGULATIONS

Charlene Harrington
Kaiser Commission on Medicaid and the Uninsured.
San Francisco, CA: University of California, May 2001. 37 pages.

This report documents information on state statutes and regulations of nursing home staffing standards. The study updates a previous survey conducted by NCCNHR (1999). While nursing facilities must meet all federal standards for Medicare and Medicaid certification, states establish staffing standards as part of their own licensure requirements. These state licensing requirements may be higher or lower than the federal standard. Facilities that are licensed but not certified are expected to meet the state requirement, while certified facilities must meet the federal standard unless the state requirement is more stringent.

The report includes state-by-state staffing standards established by state regulations, statutes, Medicaid or administrative requirements, dates when standards were established and how they have changed over time, and a comparison of state standards with federal staffing standards. Included in the report are website locations and citations for state information.

Data for state's staffing standards were collected during 2000 and 2001 from the Internet with phone calls to state L&C program officials when information was not available. Follow-up phone calls were made for clarification on any unclear standards or responses to the telephone survey.

The author finds that state regulations and licensing requirements are complex, vary in how they are described, and are difficult to interpret. As a result, she develops her own methods of standardizing information and characterizing states. Standards presented in ratios are converted to hprd in order to develop a uniform comparison across states. For purposes of comparing staffing, the author calculates staffing for a 100 bed facility and assumes each facility has at least two units. The author interprets whether or not the Director of Nursing and LN requirements for RNs and LVN/LPNs are separate or a subset of total LN requirements. States with separate requirements for Medicaid facilities are also listed.

Findings

At the time of the report's publication and according to the author's methods of characterizing states:

- Eighteen states have standards for LNs (i.e., RNs and LVN/LPNs) while 33 have specific standards for NAs or direct care staff (including NAs and LNs). Forty-five states established their standards in their administrative codes. Louisiana was the only state where staffing standards were established as a departmental policy.
- When total state hours are compared to the federal standard -- 25 states have higher LN standards than the federal requirements, 15 states have the same standard, and 11 have lower standards. Fifteen states required more RN staffing than the federal standard. Seven states (California, Colorado, Hawaii, Idaho, Ohio, Pennsylvania, and Wisconsin) and the District of Columbia require an LN on duty 24 hours a day for a facility with at least 100 beds. Thirty-three states have minimum staffing standards for direct care, with 18 states requiring more than 2.0 hprd for total direct care staff.
- Federal law and 33 states require that facilities provide sufficient staff to meet the needs of the residents in order to maintain the highest practicable functioning of residents.
- Four states have not changed their staffing standards since the 1970-1980s (Hawaii, Minnesota, Montana, and Wyoming).
- Eighteen states made changes to their staffing standards in the 1990s. Among these, five states (Nebraska, New Jersey, Rhode Island, Texas, Washington) made changes that were technical in nature or reestablished authorization of their standards; however, at the time of the report, Nebraska is developing new regulations. From 1999 to 2000, 13 states increased their staffing standards (California, the District of Columbia, Delaware, Iowa, Maine, Mississippi, Nevada, New Mexico, Pennsylvania, South Carolina, Tennessee, and Utah).
- Arkansas passed legislation to increase staffing levels; however, this legislation was neither funded nor implemented.
- Virginia passed legislation to conduct a staffing study.
- Eleven states (Florida, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Tennessee, Texas, and West Virginia) proposed staffing increases that were not passed.

Conclusions

The author asserts that state nursing staff standards are complex, vary widely, and are often difficult to interpret. Given that state standards frequently change, those interested in staffing standards should refer to a state's most recent legislative and regulatory statutes. While most states have minimum standards that are higher than the

federal guidelines, the author concludes that the trend among states appears to lean in the direction of adopting more stringent minimum staffing levels.

CRISIS IN CARE: A REPORT OF THE CNA STUDY GROUP

Long Term Care Coordinating Council
Providence, RI: Rhode Island Long Term Care Coordinating Council,
March 2001. 19 pages.

According to the authors, Rhode Island has the third highest percentage of persons age 65 and over in the nation. Like the rest of the country, Rhode Island is struggling with recruitment and retention of CNAs. The report notes the importance of nursing staff ratios with regard to quality, referring to the CMS Phase I report, but does not focus on this aspect of direct care as a key strategy to improve the quality of care being delivered.

EXPERTS RECOMMEND MINIMUM NURSE STAFFING STANDARDS FOR NURSING FACILITIES IN THE UNITED STATES

Charlene Harrington, Christine Kovner, and Mathy Mezey
The Gerontologist 40(1):5-16, 2000.

This article presents final recommendations from a one-day conference of nursing home experts held at the John A. Hartford Institute for Geriatric Nursing, Division of Nursing, at New York University in April 1998 to address the issue of nursing home staffing and quality of care. The panel of nursing home experts in attendance included consumer advocates, health economists, health service researchers, nurse researchers and educators, and government officials.

The panel was asked to consider and make recommendations on the following issues: whether nursing staff levels should be increased, and what the minimum standards for nurse staffing levels in nursing homes should be for different nursing staff (RNs, LVN/LPNs, and NAs). The expert panel reviewed four sources of information: previous studies on staffing and quality of care, then-current nursing staff levels for all nursing homes in the United States using data from OSCAR, HCFA staff time management studies on nursing care in nursing homes 1995-1997, and NCCNHR's minimum standard for nursing staff.

Of the 31 panel members, most experts serving on the panel approved the recommendations. Specifically, 17 individuals approved the recommendations, while three groups of members did not endorse the recommendations. One group (eight individuals) comprised of government officials, government contractors, or individuals on commissions generally supports the recommendations but cannot take an official position. A second group (three individuals) did not respond, and a third group (three individuals) did not support the recommendations. In the group not supporting the recommendations, two are nursing home administrators who are concerned about labor shortages and government funding for the proposal and one is an economist, concerned about the proposal's cost effectiveness.

The panel members who approve of the recommendations conclude, in general, that nursing facilities are operating with inadequate levels of staffing and are in need of substantial improvement. The proposed minimum total number of direct nursing care staff is 4.13 hprd. The recommendation for total administrative and direct and indirect nursing hours is 4.55 hprd. Staffing should be adjusted upward for residents with higher care needs. The report suggests that the recommendations be used as general guidelines for stakeholders in implementing minimum staffing standards.

STAFFING IN NURSING HOMES REPORT

-- FINAL

Legislative Program Review and Investigations Committee
Hartford, CT: Connecticut Legislative Program Review and Investigations
Committee, 2000.

This study by Connecticut's Legislative Program Review and Investigations Committee, a joint, bipartisan, statutory committee of the Connecticut General Assembly, examines current minimum staffing ratios in Connecticut, compares actual nursing staff levels to the minimum standards, and examines how the Department of Public Health (DPH) monitors nursing staff.

The report analyzes deficiency data, including deficiencies due to inadequate staff, from nursing home surveys conducted between May 28, 1998, and March 7, 2000, obtained from OSCAR. The OSCAR database and the Annual Report of Long-Term Care Facility (Medicaid Cost Reports) are the only sources of staffing data available in Connecticut; data from these sources are self-reported and not audited by an independent party or validated against another source.

Findings

Federal Nursing Staff Requirements: According to the authors, few Connecticut nursing homes are issued deficiencies for inadequate staffing, and the standard survey process does not focus on adequate nursing staff levels. It is difficult to link quality of care outcomes to insufficient staff because the survey process is subjective with numerous requirements. There are no benchmarks, either in CMS protocol or state law, for surveyors to evaluate staffing levels based on casemix of residents. The state must follow CMS' protocol, thus any additional state requirements to evaluate staffing, if complex, would require additional staff resources. Nursing homes appear able to predict the number of days between survey cycles.

The Committee found no relationship between the number of deficiencies issued to a facility and the ratio of direct care hours (nursing and aide) to nursing home residents. However, one limitation of the data is the inability to control for casemix for each facility.

Nursing Staff Ratios: Based on an analysis of 1999 Medicaid cost reports, staffing levels at all of Connecticut's licensed nursing homes exceed the minimum number of nursing hours required (calculated on an annual basis). However, the data are limited to 226 of 253 licensed Connecticut nursing homes and estimates are based on a 95% occupancy rate. The methods for reporting nursing and aide hours are not uniform across nursing facilities. Some facilities may report paid hours which include vacation and sick leave, while others report actual hours worked. Since nursing staff hours are

reported on an annualized basis, they do not take into account fluctuations in daily, weekly, or monthly staff hours.

Connecticut currently has eight separate nursing staff-to-resident ratios that vary depending on a facility's licensure category (chronic/convalescent homes vs. rest home with nursing supervision) and the time of day. The current ratios for chronic/convalescent homes are 0.47 hprd (day) and 0.17 hprd (night) for licensed staff, and 1.4 hprd (day) and 0.5 hprd (night) for direct care staff. According to the authors, these standards are confusing, administratively complicated, and limit staffing flexibility. These ratios were established 20 years ago and health care needs of residents have increased. Revisions to the current regulations began in 1995, but have not been submitted to the Regulation Review Committee.

Recommendations

Federal Nursing Staff Requirements: The Committee recommends that surveyors obtain nursing staff data and calculate an average staff-to-resident ratio for nursing homes as reported in the Medicaid cost report prior to inspections. This calculation should be compared to the actual nurse staffing level during the inspection. Surveyors should also assess resident acuity during the survey or inspection process based on the HCFA Staff Time Measurement Studies published in 1995 and 1997. These results can be used to document potential staffing problems. DPH should randomize timing in the number of days between survey cycles.

Nursing Staff Ratios: The Committee recommends a two-year phase-in of a 24-hour ratio for both facility types, chronic and convalescent nursing homes and rest homes with nursing supervision, with elimination of the segmented day and night shift requirements. The Committee also recommends increasing the minimum number of hours of direct care per resident day to 1.66 for nurse aides and 0.7 for LNs by October 1, 2001, and, by October 1, 2002, increasing the minimum number of hours of direct care per resident day to 2.0 hours for nurse aides and 0.75 hours for LNs.

STUDY CONCERNING THE SHORTAGE OF NURSES AND THE QUALITY OF PATIENT CARE IN CONNECTICUT: A REPORT TO THE CONNECTICUT DEPARTMENT OF HEALTH

The Healthcare Decisions Group
Washington, DC: Healthcare Decisions Group, December 2000. 60 pages.

This study examines the issue of nursing shortages in the state of Connecticut in order to determine: (1) whether nursing shortages exist, and (2) potential policy responses. The report addresses causes for disequilibrium in the market for nursing staff and identifies data collection and analytic strategies that address quality of care in hospitals, nursing homes, and home health agencies.

The report describes a conceptual framework to address the issue of supply and demand for nurses. The study examines state reports and research studies on issues such as quality of care, nursing workforce issues, and market dynamics. Interviews were conducted with state informants both within Connecticut and outside the state. Analyses of data provided by the Connecticut DPH and the National Council of State Boards of Nursing's (NCSBN) Nurse Information System as well as publicly available data from Connecticut Colleagues in Caring appear in this report.

There are limitations in the available data on characteristics of the Connecticut nursing home population. A survey of the population conducted by Connecticut nursing population by Connecticut Colleagues in Caring was not available except for previously released summaries. NCSBN data were collected from nurses voluntarily. However, this data set was compared to the Connecticut DPH's LN database for the same timeframe and was determined to be representative of the Connecticut nursing population.

Findings

Government and regulatory factors are components of the Healthcare Decisions Group's conceptual framework to evaluate the demand for nursing services. The group reports that Connecticut's minimum staffing standards are lower than typical nursing home staffing patterns in the state and do not affect demand for direct care workers. Staffing needs are related to resident acuity levels, so that the staffing needs in a rehabilitation hospital, for example, are different than those in an Alzheimer's unit. Therefore, establishing a single ratio will not guarantee quality of care and may be problematic if higher acuity facilities choose to staff at the mandated ratio level which may be lower than good resident care would require.

Recommendations

The Healthcare Decisions Group recommends that Connecticut create a nursing staff-to-resident ratio database for use by state regulators in monitoring and enforcing mandated nurse-to-resident ratios in facilities. However, the Group has reservations about the use of such a database without a means of relating staffing ratios to resident outcomes, thus pointing to the need for a resident outcomes database. In addition, the Group recommends compilation of a workforce database based on information from educational institutions, professional licensing databases, and compensation surveys among other sources. This type of database would allow state officials to consider the effects of certain policy initiatives.

NATIONAL SURVEY ON STATE INITIATIVES TO IMPROVE PARAPROFESSIONAL HEALTH CARE EMPLOYMENT: OCTOBER 2000 RESULTS ON NURSING HOME STAFFING

Paraprofessional Healthcare Institute and National Citizens' Coalition for
Nursing Home Reform
Bronx, NY: PHI, October 2000. 20 pages.

This report summarizes findings from a national survey on state initiatives to improve paraprofessional health care employment. PHI and NCCNHR sent surveys to the ombudsman's offices in all 50 states and the District of Columbia in the fall of 1999 and again in the summer of 2000. Additional data were collected from follow-up phone calls and secondary sources. Forty states responded to the survey.

States indicate they are pursuing a number of policy options that would improve paraprofessional health care employment. These options include legislation to improve staff-to-resident ratios, reforms that would address recruitment and retention of workers, increases in CNA wages, and improvements in benefits, training, and opportunities for advancement. Those findings related to nursing staff ratios are summarized below.

Staffing Ratios

States that adopted changes to their staff-to-resident ratios between 1999 and 2000 include Maine and Oklahoma with further increases in Oklahoma scheduled to take effect in 2001 and 2002. States that passed legislation mandating minimum hours of care per resident day include California by 2004 unless a study commission develops an alternative by that date, and Delaware by 2001. Legislation to strengthen staffing ratios was introduced in Michigan, New Jersey, New York, and the District of Columbia in the 1999-2000 session, but failed. In Rhode Island, a proposal was stalled in session at the time of the report's publication. Arkansas passed legislation to strengthen its standard, however, the measure was derailed in July 2000 due to lack of departmental funding. The requirement to publicly post the number of staff on duty is included in most legislation, reflecting consumer demand.

Table 1 of the report summarizes each state and the District of Columbia's activities to improve staffing levels including the number of hours of nursing staff required, any efforts to change standards for CNAs in 1999 or in 2000, and whether or not the change was through legislation, regulation, or budget. Descriptions of pending actions and their status at the time of publication are also included.

NURSING HOME STAFFING

John Kasprak

Connecticut's Office of Legislative Research: Research Report.
Hartford, CT: Office of Legislative Research, October 23, 2000. 3 pages.

According to this report published by Connecticut's Office of Legislative Research, 36 states have established minimum staffing requirements for nursing homes. These states are listed in Table 1, which is divided into states that have staffing requirements stated either as hours of nursing care per resident day, staff-to-resident ratios, an RN on duty 24-hours a day/7 days a week, or some combination of the three. The report discusses recent state activity in five states (California, Delaware, Kentucky, Maryland, and Minnesota) that enacted legislation in 2000. The report also outlines the federal guidelines for nursing facilities and highlights findings from the federal nursing home study issued by CMS in 2000.

APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES; REPORT TO CONGRESS: PHASE I

Health Care Financing Administration
Washington, DC: HCFA, July 2000.

This CMS Phase I report examines the "appropriateness" of establishing minimum nursing staff ratios in nursing homes and finds a relationship between staffing ratios and quality of care. Based on new empirical analyses, the Phase I Report finds that there are critical nursing staff ratios, or thresholds, for CNAs, LNs, and RNs below which nursing home residents are at risk for serious quality of care problems. However, the findings are preliminary due to data and sample limitations.

In Chapter 2.0 - Public Policy and Nursing Home Nurse Staffing, Section 2.6 - State Licensure Minimum Nurse Staffing Requirements, the authors discuss state licensing requirements in general, specific state licensing requirements for the study states (New York, Ohio, and Texas), and state legislative activities in 1999 related to nursing staff.

Based on the authors' summary of the October 1999 NCCNHR report of state nursing staff standards, 37 states including the District of Columbia have staffing standards above the federal requirement, while 14 states have imposed no additional nursing staff standards.

Table 2.3, derived from NCCNHR's October 1999 draft report, compares state staffing requirements to federal standards. According to this comparison, 14 states (Alabama, Arizona, the District of Columbia, Kentucky, Missouri, Nebraska, New Hampshire, New Mexico, New York, North Dakota, South Dakota, Vermont, Virginia, and Utah) do not have any additional nursing staff requirements above the federal standard. States with additional standards are divided into those with "less demanding" standards (states with nursing staff requirements in addition to the federal requirement), and "more demanding" standards (2.25 hprd or more than 1:9 staff-to-residents during the day shift, 1:13 in the evening, and 1:22 at night). The 22 states with "less demanding" standards are Alabama, Colorado, Connecticut, Delaware, Hawaii, Indiana, Kansas, Louisiana, Maryland, Minnesota, Montana, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Washington, West Virginia, and Wyoming. The 15 states that meet the "more demanding" criteria are Arkansas, California, Florida, Georgia, Idaho, Illinois, Maine, Massachusetts, Michigan, Mississippi, Nevada, New Jersey, Pennsylvania, South Carolina, and Wisconsin.

According to this report, 28 states express their requirements in terms of hprd, while 11 express their requirements in terms of a ratio. Some states have established other policies related to staffing; for example, seven states require an RN on duty 24-

hours per day/7 days a week. Although 21 states grant Medicaid and/or Medicare facilities waivers from the nursing requirement, very few nursing facilities currently receive such waivers.

Appendix A1 provides state-by-state descriptions of nursing staff standards. This document is the same report as the October 1999 Draft from NCCNHR on "Federal and State Minimum Staffing Requirements." (Reference #21 in this bibliography.)

Appendix A2 lists state activities as of November 1999. This document is the same report as that prepared by PHI on "State Activities in 1999 Related to Staffing: Working Update." (Reference #20 in this bibliography.)

Appendix A3 discusses other state methods to attract direct care workers. This document is the same as the September 1999 report by the North Carolina Division of Facility Services (NCDFS).

Appendix A4 outlines state legislative initiatives in the CMS Phase I study states Ohio, Texas, and New York. These proposed initiatives were neither passed nor implemented for the Phase I study period.

PRINCIPLES FOR NURSE STAFFING

American Nurses Association
Washington, DC: ANA, 1999. 8 pages.

Adequate staffing levels are of high priority for the American Nurses Association (ANA). This report describes ANA's nine principles for nurse staffing in hospitals and nursing homes, identified by an ANA expert panel and adopted by the ANA Board of Directors in November 1998. The nine principles are organized into three categories that are patient care unit related, staff related, and institution/organization related.

ANA questions the usefulness of measuring nurse staffing by the number of hours of nursing care per patient day, arguing that a measure of unit intensity that considers patients' needs and the associated roles of nursing staff would be a more appropriate measure. According to ANA, four factors must be considered in determining appropriate staffing: the number of patients within the unit, level of intensity of care being provided to all patients, contextual setting for the delivery of care (i.e., geographic dispersion of patients, size and layout of patients rooms, technology), and expertise of the entire staff.

Additionally, the needs of patient populations should determine nursing requirements with well defined responsibilities and competencies of nursing staff. The organizational climate should value RNs and other employees and, to the extent possible, offer opportunities to involve staff in decision-making at all levels. Finally, staffing levels should be evaluated based on the analysis of nursing-sensitive indicators (ANA 1997) and their impact on other patient care trends.

ANA also recommends developing a standardized definition of unit intensity as well as gathering data to address the relationship between staffing and patient outcomes.

STATE ACTIVITIES IN 1999 RELATED TO STAFFING: WORKING UPDATE

Paraprofessional Healthcare Institute
Bronx, NY: PHI, November 1999.

This report, prepared by PHI, is a "working update" of state activities regarding nursing staff legislation and policy initiatives in the 50 states and the District of Columbia. State information was gathered from the NCCNHR advocacy network (which includes the State Long-Term Care Ombudsman Programs and Citizen Advocacy Organizations), the Service Employees International Union, and a September 1999 report issued by NCDFS.

As of this report's publication, Arkansas, California, South Carolina, and Wisconsin passed or enacted legislation increasing nursing staff. Another 19 states (Connecticut, the District of Columbia, Delaware, Florida, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maine, Michigan, Mississippi, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Texas, and West Virginia) are considering legislation or changing requirements through regulation to increase nursing staff standards. Other recent state activities include forming a task force to examine direct care workforce issues and looking at increasing wages to direct care workers primarily through wage pass-throughs.

This document appears as Appendix A2 of the CMS Phase I Report to Congress, July 2000 (Reference #17 in the bibliography).

FEDERAL AND STATE MINIMUM STAFFING REQUIREMENTS FOR NURSING HOMES -- OCTOBER 1999 DRAFT

National Citizens' Coalition for Nursing Home Reform
Washington, DC: NCCNHR, October 1999. 60 pages.

This report summarizes the 1987 federal standard for LN services related to Medicare and Medicaid certification of nursing homes contained in the 1987 Nursing Home Reform Act. Summaries of each state and the District of Columbia's standard including the regulation or authorization code, the professional nurse and/or staff coverage, the staff counted in the ratios, as well as any nursing waivers are also included. A state-by-state summary table comparing the federal requirement with any additional state standards appears at the end of the document.

The Nursing Home Reform Act of 1987 (Public Law 100-203) states that each nursing home resident has the right to expect a level of nursing home care that would allow them to "attain or maintain his/her highest practicable level of physical, mental, and psychosocial functioning." However, Congress does not mandate a specific staff-to-resident ratio or a minimum number of hprd for resident care. In 1990, Congress did require HHS to conduct a study and report back in 1992 on the appropriateness of establishing minimum staff-to-resident ratios. In 1999 the Phase I study was completed, and a report and recommendations were sent to Congress in 2000.

Prior to completion of the federal Phase I study, states were left to develop and implement specific standards, with most states having a specific minimum standard in state law, regulations, or code. According to this report, 35 states have set additional state standards that either include state minimum staffing standards, hprd, or staff-to-resident ratios that are beyond the federal requirement. Another 12 states have no additional state standards and follow the federal requirement, while four states' information remains unreported as of October 1999. However, none of the state standards meet the standard developed by long-term care nursing professionals and adopted by the NCCNHR membership, first in 1995 and then updated in 1998. According to the authors, the Consumer Minimum Staffing Standard is also endorsed by the John A. Hartford Foundation. The Consumer Minimum Staffing Standard minimum requirements include:

- Direct caregivers (RN, LPN, LVN, CNA): 1:5 residents (day); 1:10 residents (evening); 1:15 residents (night).
- Licensed nurses (RN, LPN, or LVN): 1:15 residents (day); 1:25 residents (evening); 1:35 residents (night).

The authors state that adequate nursing home staffing is of great interest to state legislatures, with approximately 66% of states in the past two years introducing new legislation or regulations or establishing committees to study the issue.

This document appears as Appendix A3 of the CMS Phase I Report to Congress, July 2000 (Reference #17 in the bibliography).

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STATE-INITIATED NURSING HOME STAFFING RATIO REQUIREMENTS

Reports Available

State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from Case Studies of Eight States

Executive Summary <http://aspe.hhs.gov/daltcp/reports/2003/8statees.htm>

HTML <http://aspe.hhs.gov/daltcp/reports/2003/8state.htm>

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State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from the Research to Date and a Case Study Proposal

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State-Initiated Nursing Home Nurse Staffing Ratios: Annotated Review of the Literature

HTML <http://aspe.hhs.gov/daltcp/reports/2003/ratiolit.htm>

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