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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. press release	re: phone number (partial) (1 page)	09/16/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20472

FOLDER TITLE:
Nursing Homes [Folder 1]

2012-0463-S
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PRESIDENT CLINTON ANNOUNCES NEW, $1 BILLION INVESTMENT IN NURSING HOME QUALITY

Takes Additional Steps to Increase Staffing and Accountability in Nursing Homes
September 16, 2000

Today, in a live radio address broadcast from The Washington Home in Washington, DC, President Clinton will announce that he will be sending legislation to the Congress next week to improve nursing home quality nationwide. This initiative: (1) invests $1 billion over 5 years in a new grant program to increase staffing levels nationwide and improve quality of nursing home care; (2) imposes immediate penalties on nursing facilities placing residents at risk and reinvests these funds in the new grant program; (3) directs the Health Care Financing Administration to establish national minimum staffing requirements and complete recommendations for appropriate reimbursement within two years; (4) helps families make informed decisions by providing accurate information on staffing levels; and (5) launches a new campaign to identify and prevent unintended weight loss and dehydration among nursing home residents. He will state that these proposals can and should be included in any legislation that increases funding for health care providers being considered by the Congress. The President will praise Senators Grassley and Breaux, as well as Congressmen Gephardt, Waxman, and Stark, for their leadership on this issue and encourage the Congress to act quickly on this new initiative.

MORE MUST BE DONE TO IMPROVE QUALITY OF CARE IN NURSING HOMES. About 1.6 million older Americans and people with disabilities receive care in approximately 17,000 nursing homes. The Clinton-Gore Administration has made the health and safety of nursing home residents a top priority – implementing the toughest nursing home regulations in the history of the Medicare and Medicaid programs. Many nursing homes provide high quality care to the frail and vulnerable elderly individuals they serve. However, recent reports have demonstrated a strong correlation between inadequate staffing and poor quality of care. Specific findings include:

- **Over fifty percent of nursing homes do not maintain the minimum staffing levels necessary to ensure the delivery of quality care.** The Health Care Financing Administration (HCFA) recently released a report demonstrating that patients are significantly more likely to develop pressure sores, lose weight, and undergo unnecessary hospitalizations once staffing ratios fall below the level of two hours per resident for certified nurse aides daily. That amount of time is the minimum necessary for nursing staff to reposition residents and change wet clothes; assist residents with toileting; provide feeding assistance; provide morning care; and encourage or assist residents with exercise as appropriate.

- **Poor staffing results in many nursing home residents becoming malnourished or dehydrated, unnecessarily increasing their risk of infection and impaired mental function.** Certified nursing assistants (CNAs) typically help seven to nine residents with their daytime meals, and as many as 12 to 15 residents with their evening meals. A recent study by the Commonwealth Fund estimates that over 30 percent of nursing home residents are malnourished, placing them at risk for infections, pressure sores, depression, confusion and impaired cognition, and hip fractures. Compared with well hydrated and nourished residents, these nursing home patients have a five-fold increase in mortality when admitted to the hospital.

- **Nursing home staff often need additional training to carry out their assigned duties adequately.** A 93 percent turnover rate in CNAs compounds the problems caused by inadequate numbers of nursing home staff. A shortage of nursing supervisors leaves CNAs to do the best they can without assistance from registered nurses or physicians.

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  - Create a competitive grant program to increase staffing levels in nursing homes nationwide. States would be able to receive funds to provide financial and technical assistance to nursing facilities, unions, non-profit organizations, or community colleges. States applying for funds would be required to develop, through an open public process, a proposal to enhance staff recruitment and retention efforts; establish career ladders for CNAs; provide increased training for staff; or conduct other staffing initiatives to assure improved patient outcomes as approved by the Secretary of Health and Human Services. States may also use a portion of the funds to reward nursing facilities with exemplary quality of care records. At least 75 percent of funds are to be awarded to states whose current staffing levels are below two hours per resident for certified nurse aides daily, but who commit to raising their staffing levels to the two hour level within two years. Up to 25 percent of the funds are reserved for states whose staffing levels are currently at or above the two hour threshold. This legislation requires the Secretary to increase the staffing thresholds as recommended by the upcoming HCFA report on staffing levels with the goal of reaching the staffing level necessary to provide optimum care.

  - Imposes immediate penalties on nursing homes endangering patient safety. Currently, if a nursing home appeals the imposition of a fine for endangering patient safety (G level violation), the Federal government does not collect the fine until after the appeal is settled, allowing many facilities to avoid paying fines for years after the violation was committed. This initiative would require civil money penalties to be immediately withheld from future payments to the nursing home. If a nursing home appealed the imposition of the fine and won, the Federal government would return the funds with interest.

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  - Providing the public with accurate information on staffing levels. Nursing homes participating in the Medicaid and Medicare programs will be required to provide HCFA with detailed information on their current staffing levels, including the total number of hours; coverage levels per shift; identifying staff as CNAs, LPNs or RNs; and the average wage rate for each class of employees. This information will be posted for the public to review in individual facilities as well as on HCFA's *Nursing Home Compare* website.

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September 15, 2000

Clinton To Reveal Nursing Home Plan

A.P. INDEXES: TOP STORIES | NEWS | SPORTS | BUSINESS | TECHNOLOGY | ENTERTAINMENT

By THE ASSOCIATED PRESS

Filed at 7:00 p.m. ET

WASHINGTON (AP) -- President Clinton's weekly radio address will be broadcast live Saturday from a 200-bed nursing home in northwest Washington where he will announce a new initiative to improve care at the tens of thousands of nursing homes nationwide.

The White House on Friday did not release details of the president's proposal Friday, but it comes just weeks after a federal report revealed that some nursing homes are so understaffed that they may be endangering the welfare of their patients.

The report issued in late July by the Health Care Financing Administration said that at more than half -- 54 percent -- of the nursing homes surveyed nursing aides spent less than two hours a day with patients. The study examined 1,786 nursing homes in three states.

Sen. Chuck Grassley, R-Iowa, chairman of the Senate Special Committee on Aging, said Friday that Clinton is expected to discuss nursing home staffing shortages.

``I'm interested in the substance of the president's remarks," Grassley said. ``If he presents a staffing proposal and later approaches me with it, I'll take a careful look at it. We might share goals and priorities for improving the number of trained staff who care for nursing home residents."

In July, Grassley convened a hearing to release the long-awaited study, mandated by Congress back in 1990, that linked staff shortages to severe bedsores, malnutrition and dehydration. The study, mandated back in 1990, was originally due in January 1992.

About 1.6 million elderly and disabled Americans receive care in approximately 16,500 nursing homes across the United States.

Medicaid pays for the majority of nursing home patients. Sixty-eight percent of the patients at the Washington Home where Clinton will visit receive Medicaid benefits.

Grassley said Congress is considering a proposal that would give nursing homes some extra money, but has said that based on the report, he's not willing to ``give the nursing home industry a blank check.''

Rick Abrams, chief operating officer at the American Health Care Association, which represents 12,000 long-term care providers, said he hopes Clinton proposes training and staffing grants to help attract new workers to the industry. His organization has set a goal of bringing 250,000 new certified nursing assistants and another 60,000 licensed practical nurses and registered nurses to the industry by January 2002.

``These jobs (for assistants) are taxing physically and given the choice, the typical person will chose the retail establishment -- the food service job or Wal-Mart -- over the long-care facility,'' Abrams said.

On the Net: Senate Special Committee on Aging: http://aging.senate.gov

Health Care Financing Administration: http://www.hcfa.gov

National Citizens' Coalition for
NURSING HOME REFORM
1424 16th Street, NW, Suite 202
Washington, DC 20036-2211

Margaret A. Farley, *President*
Elma Holder, *Founder*
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News Release

For Immediate Release
September 16, 2000

Contact: Janet Wells
Elma Holder
Randi Goldstein
(202)332-2275

Consumers Welcome President's Address as "First Step" In Addressing Critical Understaffing in Nursing Homes

Washington, DC—The National Citizens' Coalition for Nursing Home Reform today welcomed President Clinton's radio address to the nation on nurse staffing in nursing homes.

"There is no issue more important to the nursing home residents of this country, or to their families and friends, than having enough well-trained and experienced nurses and nursing assistants to care for them," said NCCNHR executive director Randi Goldstein. "Most of the neglect and abuse in nursing homes are directly related to the industry's failure to employ and retain a stable nursing workforce.

"We have not seen the President's legislative plan, but we are pleased that he has taken the first step in addressing this critical national problem," Goldstein added. "We look forward to working with President Clinton, Chairman Charles Grassley of the Senate Committee on Aging, and other members of Congress on the details of the President's proposal."

More than half of nursing homes provide residents less than 2 hours of nursing care a day, according to a report the Administration presented to Congress in July. At the 2-hour level, residents barely escape harm, and below 2 hours, harm is likely to occur. The Health Care Financing Administration will issue the second phase of the report next year with recommendations on the ratios of nursing staff to residents needed to provide quality care.

"Consumers' ultimate goal is to put minimum staffing standards in place for all nursing homes," said Elma Holder, who founded NCCNHR. "Right now the HCFA report and other research support the standard NCCNHR developed in 1998 – at least 3 hours of direct, hands-on care every day from nurses and nursing assistants. We believe this is the only way to absolutely assure that enough staff are available to provide the kind of care residents need and deserve."

NCCNHR also wants to add accountability provisions to Medicare and Medicaid that would require nursing homes to demonstrate that they allocate adequate funding to nursing services.

"One way to hold nursing homes accountable is to require them to post the number of nurses and nursing assistants they have on duty," said Holder. "That way, residents and families can determine for themselves whether the nursing home has enough staff."

NCCNHR is a national, non-profit membership organization founded in 1975, to improve the long-term care system and the quality of life for nursing home residents.

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American Association
of Homes and Services
for the Aging

September 16, 2000 FOR IMMEDIATE RELEASE

Contact: Robert Greenwood, (202) 508-9475

AAHSA WELCOMES PRESIDENT'S HELP ON NURSING HOME STAFFING CRISIS

Clinton proposes spending a billion dollars over five years

WASHINGTON, DC – The American Association of Homes and Services for the Aging welcomes President Clinton's proposal to spend $1 billion over five years in grants to states for recruitment, retention and training of new direct care nursing home staff. The proposal was announced this morning at the Washington Home, an AAHSA-member home in Washington, DC.

"Nursing home providers today are facing unparalleled challenges in caring for their residents," said Mary Alice Ryan, chair of AAHSA's board of directors and CEO of Saint Andrews Episcopal-Presbyterian Foundation in St. Louis. "Recent Medicare cuts, low Medicaid payments and today's tight job market make it difficult for nursing homes to find qualified staff."

Under the president's proposal, states would be able to use the funds to reward homes that staff at higher levels; have innovative programs to recruit, train and retain staff; or that demonstrate excellence in quality of care. A recent government report on nursing home staffing levels clearly found that not-for-profit homes staffed significantly higher.

"AAHSA appreciates the president's recognition that nursing homes that are doing a good job should be rewarded," Ryan said. "We should ensure that those providers who have earned it receive the resources they need to continue to set the standard for quality care to our nation's elderly."

Attending the ceremony today was AAHSA Board Chair Mary Alice Ryan; William L. (Larry) Minnix, Jr., president and CEO of AAHSA-member Wesley Woods, Inc. in Atlanta; and Michael Rodgers, AAHSA's senior vice president of government relations.

AAHSA is the national association of nonprofit long-term care and senior housing providers. Its members include over 5,600 nursing homes, assisted living facilities, continuing care retirement communities, senior housing, and home and community-based service organizations. More than half of its members are religiously sponsored; at the core of the work of all of AAHSA's members is a mission to serve older people by providing the means for them to live with the greatest level of self-determination, dignity and independence possible. AAHSA's Web site is at www.aahsa.org.

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NEWS

ahca

American Health Care Association

For Immediate Release
September 16, 2000

Contact: Berna Diehl
Phone: 202-326-1726
Pager: P6/(b)(6) [001]

Skilled Nursing Care Community Applauds Clinton Administration's Investment In New Nursing Staff

Administration Staffing Proposal Supports Goals Put Forward By American Health Care Association Initiative

Washington, DC -- Commenting on the new White House skilled nursing care staffing initiative announced during the President's national radio address today, the American Health Care Association (AHCA) released the following statement, made by AHCA's Chief Operating Officer, Rick Abrams:

"We believe that achieving optimal staffing in America's nursing homes is one of the most important health care challenges facing America. In light of the new staffing initiative AHCA put forward last month, we applaud the Clinton Administration for its proposal that advances the process of meeting this challenge. We look forward to working with the Administration and Congress, in a cooperative and positive manner, to achieve our mutual goal of providing the best possible health care for America's most vulnerable seniors."

In August, the American Health Care Association (AHCA) put forward a new staffing initiative that began to frame the debate outlining the principles by which the nation addresses nursing home staffing issues.

Said Abrams: "The skilled nursing care community is very pleased that not only has the debate started, but that the Administration has put before providers and patients alike a substantive proposal that begins to meet the national challenge now before us."

The American Health Care Association is a non-profit federation of affiliated associations representing 12,000 non-profit and for-profit sub-acute, assisted living and skilled nursing care providers nationally.

(See Attached AHCA Staffing Proposal, 4 Pgs. Total Document)

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NEWS

ahca

American Health Care Association

For Immediate Release
August 31, 2000

For More Information: Berna Diehl
202/326-1726

National Health Care Group Supports Creation of New Optimal Staffing Standard For Skilled Nursing Patients

American Health Care Association Initiates Policy Discussion To Help Solve Important National Problem

Cites Need To Attract 250,000 Certified Nursing Assistants Into Profession By 2002; Seeks Joint Venture With HCFA To Establish, Monitor Impact Of Standards

Washington, DC -- The President and CEO of the American Health Care Association (AHCA), Charles H. Roadman II, M.D., today released new guiding principles, recently approved by AHCA's Executive Committee, that, "supports the creation of an aggregate optimal staffing standard," that will be accomplished by, "working with government and consumer advocates to establish this aggregate optimal staffing standard and method."

Said Dr. Roadman: "Achieving a mutually agreed-upon aggregate optimal staffing standard for skilled nursing patients is a key public policy objective. With this declaration, we seek to initiate a national policy debate on how best to implement this important priority of increasing staff to ensure quality patient care."

The AHCA "Staffing Standards in Nursing Facilities" guiding principles also, "calls upon the Clinton Administration and the Congress to join us in a national crusade in establishing a goal of attracting over 250,000 new Certified Nursing Assistants (CNAs) to the profession, as well as 60,000 new Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) to the profession, by January 1, 2002," and notes that, "a national initiative on the order of President Clinton's call for 100,000 new police officers and 100,000 new teachers is in order." These bold numbers were calculated by AHCA from HCFA's proposed "optimal nursing standard" in a recent HCFA study.

The guiding principles specifically state that the creation of an optimal staffing standard must be based on patient's acuity, that, "Any standard enacted by legislation or adopted by regulation must impact all patients regardless of payor source," that, "any staffing standard cannot be 'Medicare specific'," and, that, "States must fully fund any staffing standard in their Medicaid reimbursement methodologies."

"The bottom line," said Dr. Roadman, "is that all parties involved in this matter have an obligation to America's seniors, and to the public at large, to put solutions on the table in order to move forward in a positive and constructive manner."

See Attached AHCA Staffing Standard Guiding Principles (3 Pages Total Document)

-###-

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

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

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

2. **AHCA calls upon the Clinton Administration and the Congress to join us in a national crusade in establishing a goal of attracting over 60,000 licensed nurses and 250,000 Certified Nursing Assistants (CNA) to the profession by January 1, 2002.** Our CNA 's are the long term care profession's critically important first line of safety and service for our patients. Accordingly, a national initiative on the order of President Clinton's call for 100,000 new police officers and 100,000 new teachers is in order. AHCA proposes the following steps to assist in accomplishing this initiative:

   a. The Clinton and successor administrations must lead and exhort the public to action. The employment environment in the profession is condition critical. It requires an immediate, aggressive and effective response.

   b. Our immigration laws must be liberalized to attract qualified professional and para-professional help to the long term care profession from outside the country.

   c. Congress and the Administration must help to reduce the use of a temporary work force for the profession. Nationally, the profession has had to use temporary employees because it has been unable to attract and keep a permanent work force. The use of temporary employees is unnecessarily expensive and, more importantly, destroys the continuity of long term care delivery which is so critical to successful patient outcomes.

d. Funding must be provided for training grants to providers and organizations that represent them so that the profession can keep its qualified people and establish rewarding career paths for them.

e. A national criminal background check registry must be created to ensure the safety of long term care patients and personnel.

f. Medicare and Medicaid funding systems must be fully funded to give the long term care profession the resources to attract and keep qualified people.

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

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

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

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18 states
below 2 hrs.

APPENDIX B2: Distribution of Staffing by State, 1996-1999

Table B2.a: Staffing levels in U.S. Nursing Homes: By State, 1996-1999

State	Mean hours per resident day											
	1996			1997			1998			1999*		
	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide
AK	1.11	0.66	3.19	1.45	0.62	3.42	1.15	0.54	3.23	0.98	0.67	3.09
AL	0.26	0.93	2.36	0.26	0.93	2.37	0.26	0.99	2.47	0.25	0.97	2.37
AR	0.25	0.80	1.72	0.33	0.83	1.86	0.31	0.83	1.97	0.35	0.89	1.94
AZ	0.68	0.77	2.07	0.84	0.85	2.01	0.78	0.80	2.16	0.56	0.72	1.97
CA	0.58	0.74	2.20	0.62	0.73	2.22	0.58	0.73	2.21	0.55	0.72	2.14
CO	0.74	0.70	1.83	0.74	0.76	1.90	0.64	0.70	1.96	0.60	0.69	1.93
CT	0.53	0.47	2.00	0.53	0.48	2.10	0.57	0.50	2.09	0.52	0.52	2.11
DE	0.71	0.67	2.35	0.77	0.68	2.37	1.03	0.65	2.73	0.75	0.66	2.47
FL	0.58	0.88	2.14	0.65	0.87	2.12	0.64	0.88	2.06	0.59	0.84	2.06
GA	0.21	0.82	2.00	0.21	0.82	2.06	0.24	0.84	2.01	0.24	0.85	1.97
HI	0.83	0.67	2.43	0.90	0.63	2.61	0.88	0.55	2.68	0.78	0.82	2.24
IA	0.49	0.48	1.70	0.47	0.49	1.69	0.52	0.51	1.66	0.53	0.55	1.66
ID	0.62	0.81	2.54	0.72	0.96	2.59	0.65	0.75	2.65	0.57	0.86	2.84
IL	0.57	0.53	1.76	0.62	0.53	1.78	0.65	0.54	1.83	0.67	0.54	1.88
IN	0.41	0.84	1.55	0.45	0.85	1.53	0.46	0.87	1.54	0.49	0.87	1.58
KS	0.40	0.54	1.62	0.44	0.57	1.61	0.48	0.57	1.59	0.50	0.53	1.66
KY	0.49	0.96	2.05	0.58	0.98	2.16	0.56	0.92	2.11	0.58	0.96	2.06
LA	0.34	0.87	1.87	0.39	0.91	1.91	0.34	0.85	1.96	0.37	0.94	1.83
MA	0.62	0.59	2.24	0.69	0.56	2.21	0.74	0.58	2.24	0.70	0.58	2.18
MD	0.51	0.60	1.96	0.57	0.64	1.99	0.62	0.63	2.08	0.73	0.60	2.10
ME	0.53	0.47	2.62	0.65	0.47	2.60	0.71	0.49	2.68	0.57	0.48	2.65
MI	0.35	0.60	2.25	0.43	0.61	2.29	0.42	0.61	2.29	0.43	0.67	2.22
MN	0.35	0.67	1.83	0.36	0.66	1.84	0.37	0.66	1.80	0.33	0.68	1.81
MO	0.46	0.80	1.81	0.50	0.77	1.78	0.49	0.76	1.76	0.49	0.76	1.84
MS	0.42	0.88	2.00	0.55	0.95	2.02	0.51	0.91	2.03	0.45	0.84	1.99
MT	0.60	0.56	2.35	0.61	0.60	2.26	0.63	0.59	2.35	0.66	0.53	2.21
NC	0.48	0.74	2.24	0.53	0.76	2.35	0.55	0.83	2.32	0.52	0.81	2.25

Table B2.a: Staffing levels in U.S. Nursing Homes: By State, 1996-1999

State	Mean hours per resident day											
	1996			1997			1998			1999•		
	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide
ND	0.43	0.63	2.18	0.43	0.64	2.21	0.38	0.58	2.25	0.54	0.70	2.28
NE	0.42	0.67	1.74	0.47	0.68	1.79	0.51	0.66	1.81	0.56	0.72	1.76
NH	0.60	0.50	2.39	0.62	0.56	2.43	0.65	0.55	2.53	0.70	0.57	2.56
NJ	0.55	0.56	2.05	0.56	0.55	2.08	0.62	0.57	2.08	0.66	0.66	2.05
NM	0.59	0.59	2.09	0.76	0.56	2.08	0.59	0.55	2.09	0.46	0.53	2.05
NV	1.01	0.91	1.98	1.04	0.75	1.91	1.14	0.74	1.94	1.67	0.55	2.52
NY	0.38	0.64	1.99	0.36	0.65	1.99	0.37	0.66	2.03	0.38	0.66	2.02
OH	0.52	0.81	2.10	0.57	0.82	2.09	0.55	0.80	2.05	0.58	0.85	2.09
OK	0.22	0.64	1.45	0.28	0.78	1.59	0.30	0.75	1.57	0.21	0.73	1.53
OR	0.55	0.40	2.24	0.55	0.42	2.18	0.57	0.42	2.11	0.54	0.42	2.11
PA	0.67	0.71	2.05	0.75	0.75	2.07	0.80	0.78	2.11	0.75	0.76	2.08
RI	0.51	0.35	2.01	0.60	0.31	2.09	0.65	0.32	2.06	0.73	0.31	2.07
SC	0.41	0.89	2.26	0.46	0.88	2.31	0.50	0.92	2.25	0.59	0.84	2.23
SD	0.48	0.31	1.86	0.49	0.34	1.89	0.53	0.34	1.90	0.49	0.32	1.85
TN	0.33	0.80	1.80	0.34	0.79	1.89	0.44	0.87	1.90	0.37	0.85	1.84
TX	0.43	0.87	1.83	0.45	0.90	1.86	0.40	0.88	1.83	0.34	0.89	1.78
UT	0.70	0.64	1.87	0.73	0.59	1.96	0.76	0.69	2.01	1.06	0.79	1.98
VA	0.40	0.81	1.99	0.41	0.84	2.06	0.41	0.91	2.07	0.43	0.94	2.04
VT	0.38	0.72	2.20	0.49	0.66	2.17	0.38	0.75	2.21	0.41	0.70	2.23
WA	0.66	0.60	2.30	0.77	0.59	2.44	0.72	0.58	2.45	0.73	0.62	2.38
WI	0.52	0.43	2.07	0.60	0.44	2.14	0.60	0.44	2.10	0.53	0.44	2.02
WV	0.34	0.91	2.12	0.51	1.01	2.17	0.43	0.72	2.20	0.43	0.86	2.12
WY	0.82	0.68	2.03	0.64	0.65	1.96	0.70	0.56	2.02	0.66	0.58	2.00

•: 1999 data were available only for assessments completed before July 1, 1999
Note: Sample sizes can be found in Table 3.7
Source: OSCAR

APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES

EXECUTIVE SUMMARY

Background

Purpose

The purpose of this study and Report to Congress is to examine the analytic justification for establishing minimum nurse staffing ratios for nursing homes. This report was mandated by Public Law 101-508 which required the Secretary to report to the Congress on the feasibility of establishing minimum caregiver ratios for Medicare and Medicaid certified nursing homes.

The issue of minimum nurse staffing for nursing homes has been debated since the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). Nursing home resident advocates tend to believe that poor care is directly tied to inadequate staffing. Provider associations are more likely to view staffing problems as a series of complicated interactions involving the short supply of nursing home workers, facility differences in resident acuity and functional limitations, and Federal and State reimbursements.

The examination of this issue has been divided into two phases. This report on Phase 1 examines whether there is a real association between staffing levels in nursing homes and quality of care. The second phase of the report will: 1) examine the cost and benefits associated with establishing staffing minimums; 2) expand the data used in the multivariate analysis from three States to a more representative national sample; 3) explore more refined case mix classification methods; 4) do case studies to validate the Phase 1 findings; and 5) examine other issues which impact the recruitment and retention of Certified Nursing Assistants. The results of these studies will provide the formulation for policy decisions on whether and how to implement a minimum staffing requirement at the individual nursing home level.

Public Concern and the Role of the Health Care Financing Administration

Public and congressional concern about staffing has been heightened by the Health Care Financing Administration's (HCFA's) comprehensive 1998 nursing home Report to Congress that identified a range of serious problems including malnutrition, dehydration, pressure sores, abuse and neglect, as well as similar reports from the U.S. General Accounting Office, and the Office of the Inspector General.

This concern across the country regarding adequate staffing in nursing homes has been reflected in several States among both those responsible for licensure standards and rate-setters. At least 37 States

have imposed new, more stringent staffing requirements under their State licensure

authority and 19 States have introduced State legislation in this area. (See attachment). Further, at least 10 States now explicitly tie some portion of rates to staff levels or wages.

Over 95% of the 16,480 nursing homes in the United States participate in the Medicare and/or Medicaid program(s). Under the statutory authority of the Omnibus Budget Reconciliation Act of 1987, HCFA issued regulations and program guidance that included a *general* requirement that nursing homes must provide ". . . sufficient nursing staff to attain or maintain the highest practicable . . . well-being of each resident . . ."

This general requirement, as well as the minimum requirement of 8-hour registered nurse and 24- hour licensed nurse coverage per day outlined in regulation, has been criticized as too vague. In addition, because this minimum requirement is the same for all nursing homes, from 60 bed facilities to 600 bed facilities, many advocates and professionals view this standard as inadequate. For these reasons, increasing minimum nurse staffing ratios has been proposed as a way to improve the quality of care for residents. However lack of information on the relationship between ratios, quality and cost have, to date, limited policy development.

Research Objectives and Study Approach*

Study Objectives

We are submitting this report to Congress in two phases. The Phase 1 and Phase 2 reports will determine: 1) if minimum nurse staffing ratios are appropriate; and, if appropriate; 2) what the alternative minimum staffing ratios may be, and the potential cost and budgetary implications of minimum ratio requirements; and 3) if there are nurse staffing ratios that strongly determine good or *optimal* resident outcomes. The Phase 1 report will address the first and third study objectives. The Phase 2 report will provide a broader validation of the Phase 1 results, including the results of qualitative case studies and site visits to nursing homes. In addition Phase 2 will include an assessment of costs, benefits and feasibility of implementing minimum ratio requirements.

In both Phase 1 and Phase 2 reports, the phrase "nurse staffing" refers to all three categories of nurses: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides/Nursing Assistants.

It is important to acknowledge that HCFA contracted with a number of research firms to conduct this study. We also convened a panel of nationally recognized experts in the fields of long-term care, nursing economics, and other disciplines to review the literature on staffing. In addition, we consulted extensively with a number of stakeholders, including consumer advocates, nursing home industry officials and representatives from labor unions. A full discussion of our consultation process is

described in Chapter 1.

Report Layout

Chapters 2 through 6 provide additional background and policy context for the study, including an examination of staffing citations and the results of focus group discussions with direct care workers, nurse aides, and nursing facility management. Chapters 9 through 12 present the results of multivariate analyses on the effects of nurse staffing on selected quality measures derived from a number of data sources. Chapter 13 examines three specific time-motion methods for setting nurse staffing levels, and Chapter 14 presents the results of a simulation analysis that estimated the amount of nurse aide time required to implement five specific daily care processes that have been linked to good resident outcomes.

Study Approach

In this report, we used three basic research strategies for addressing the key study question of whether there are appropriate minimum nurse staffing ratios:

Review of Prior Research and Expert Consensus Evaluation of that Research

This strategy included a literature review and consultation with experts in the field. The research we examined evaluated the relationship between staffing and resident outcomes. Under the first research strategy, a review of literature indicated no consistently strong positive association between staffing and resident outcomes. Results of the literature review are detailed in Chapter 6. However, none of the studies specifically reviewed the link between quality of care and staffing ratios.

Empirical Determination (Multivariate Analysis) of the Relationship Between Staffing and Quality

Measures of nurse staffing and outcome measures were obtained for a large number of nursing homes, and the relationship between the two were examined using multivariate analysis. The analyses were designed to identify potential critical ratio thresholds. This approach focused directly on the examination of whether there is a correlation between staffing and quality, the first analysis to evaluate this relationship.

Some of the outcomes examined included avoidable hospitalizations, improvement in activities of daily living (ADLs) functioning, incidence of pressure sores, weight loss, and resident cleanliness and grooming. Strong associations between low staffing and the likelihood of quality problems across these measures, adjusted for risk, were found for all nurse staffing. Results of this analysis are detailed in Chapters 9 through 12 of the text.

A Time-Motion Approach to Setting Nurse Staffing Standards

Time-motion studies are designed to determine the amount of time it takes to perform certain functions or tasks. In this report, we examined three specific time-motion methods for setting nurse staffing levels: the U.S. Army Workload Management System for Nursing, William Thoms' "Management Minutes" system, and HCFA's own Staff Time Measurement studies on nursing care in nursing homes performed from 1995-1997. These analyses are presented in Chapter 13. This approach simulated the nurse aide time necessary to implement certain essential tasks that have been linked to good resident outcomes.

Finally, we estimated the nurse aide time required to implement five specific daily care services that have been linked to good resident outcomes: repositioning and changing wet clothes; repositioning and toileting; exercise encouragement/assistance; feeding assistance; and ADL independence enhancement (morning care). A simulation analysis estimated these times for six major categories of residents with different functional limitations and care needs that broadly define the nursing home population. Results of this analysis are detailed in Chapter 14.

Other Policy Issues

Apart from the empirical findings in this report, we also examined several specific policy issues. They include: 1) the potential impact of a specific minimum standard recommended by the Hartford Institute conference; 2) whether raising the current minimum requirement levels have the unintended consequence of lowering the staffing levels of other facilities that, in the absence of the new higher minimum, would staff at relatively higher levels; 3) whether nursing homes affiliated with chains experiencing financial difficulties have reduced their nurse staffing levels in an effort to control costs; 4) whether State surveyors can typically meet the considerable burden of documentation required to determine compliance with the HCFA's general nursing home staffing requirement, and; 5) whether nursing homes comply with HCFA's general staffing requirement. This study does not focus on alternative policies, such as increased public dissemination of performance data or enhanced intensity of survey and certification practices.

III. Findings

Strong findings on the relationship between staffing and quality were derived from the multivariate analysis and the time motion studies. The details of these findings are below.

- ***Findings from the Literature Review***

A review of the literature revealed no consistently strong positive or negative association between

staffing levels and patient care outcomes. In addition, even if the evidence had been stronger and more consistent, none of the reviewed studies were designed to identify a critical ratio of nurses to residents below which nursing home residents are at substantially increased risk of quality problems.

- ***Findings from the Multivariate Analysis of the Relationship between Staffing and Quality***

The analysis of the data from three States demonstrated that after controlling for case mix, staffing thresholds exist below which quality of care may be seriously impaired. These thresholds were at staffing levels that were above staffing ratios for a significant percentage of facilities. In addition, the analyses suggested that minimum levels may reduce the likelihood of quality problems in several areas, but higher "preferred minimum" levels existed above which quality was improved across the board. These levels are outlined below.

Staff	Minimum Staffing Level	Below Standard
Aide	2.00 hrs/resident day	54%
RN and LPN	.75 hrs/resident day	23%
RN	.20 hrs/resident day	31%
	Preferred Minimum Level	
Aide	2.00 hrs/resident day	54%
RN and LPN	1.00 hrs/resident day	56%
RN	.45 hrs/resident day	67%

Higher or lower thresholds were identified for different case mix categories. This empirical analysis provides the core approach for developing minimum nurse staffing ratios. Further analyses involving more States, facilities that were certified only for Medicare (which were excluded from this analysis), and refinement of methods for taking case mix into consideration will be required to establish national critical staffing levels.

- ***Findings from the Time-Motion Studies***

The minimal nurse aide staff necessary to provide optimal care in delivering the five specific daily care services outlined above is 2.9 hours per resident day. This time-motion derived standard should be viewed as a condition for optimal care by nurse aides. Over 92% of nursing homes in the United States fall below the 2.9 hours per resident day standard. In addition, nearly half of these facilities would need to increase nurse aide staffing by 50% or more to reach this threshold.

- ***Findings of the Other Policy Issues Examined***

We analyzed a proportion of facilities that would be affected by the 4.55 minimum total hours per

resident day recommended by the Hartford Conference. We found that only 11% of facilities had more than 4.55 total hours in 1998, and many facilities would have to increase staffing by 50% or more to be in compliance with this requirement. A complete discussion of this analysis is presented in Chapter 6.

We also compared a variety of measures of the State-level distribution of staffing across three groups of States --those with no requirement, those with a less demanding standard, and those with the more demanding standard. The analysis, conducted with an inherently limited study design, found that States with more demanding minimum standards had higher average staffing levels. However, the evidence was mixed and inconclusive as to whether higher-staffed facilities reduced their staffing when the State implemented a more demanding minimum standard. Results of this analysis are presented in Chapter 3.

We found that total nursing hours for chains with financial difficulties and other large chains decreased relative to other facilities. Total hours for facilities associated with bankruptcy-filed chains decreased by 2% for 1998 and 3.5% for 1999. This analysis is more fully explained in Chapter 3.

The new mandatory protocol for surveyors to use in assessing the adequacy of staffing was introduced in July 1998 through HCFA's State Operations Manual (SOM). Unfortunately, this appears to have had no effect. Additionally, the analysis of staffing citations, both before and after the State Operations Manual release, and an analysis of the HCFA 2567 ("Statement of Deficiencies and Plan of Correction"), raised doubts that surveyors can typically meet the considerable burden of documentation required to determine compliance with the *general* staffing requirement that staffing must be sufficient to meet resident needs. In contrast, when surveyors have a very *specific* requirement to enforce, the determination of compliance is more easily and accurately made. A more thorough discussion of the results is presented in Chapter 4.

IV. Conclusions

The analyses conducted for this Report have established that there may be critical ratios of nurses to residents below which nursing home residents are at substantially increased risk of quality problems:

- Using multivariate analysis and limited data from a few states, the minimum staffing level associated with reducing the likelihood of quality problems is approximately 2.0 hours per resident day for nurse aides, regardless of facility case mix.

- Using multivariate analysis, the preferred minimum staffing levels for RN and total licensed staff (RN and LPN) in which quality was improved across the board are .45 and 1.0 hours per resident day, respectively.

- Using a time-motion derived standard, the minimal nurse aide time necessary to provide optimal care in delivering five specific daily care processes is 2.9 hours per resident day.

These estimated staffing thresholds are relatively high, and a considerable number of facilities will be impacted if these thresholds were to become minimum requirements.

Next Steps

This report does not include any specific recommendations. The potential establishment of a regulatory minimum ratio requirement will require further research on more states in order to identify alternative minimum thresholds and optimal case-mix adjusters, and to assess relative costs and benefits of such thresholds. In addition, more research will be required to assess the feasibility of implementing minimum ratio requirements.

Phase 2 will more fully examine empirically-derived minimum staffing levels and methods for case-mix adjustment as suggested by Phase 1. We will conduct five basic analyses in the Phase 2 report. First, in order to identify specific ratios, we will analyze more current staffing data, in more States, and with more refined case-mix adjustments. We will also conduct case studies in a sample of nursing homes in targeted States to better understand the relationship between staffing and quality found in the Phase 1 study. This includes examining other issues that may affect quality of care-- turnover rates, amount of staff training, and management of staff resources.

The Phase 2 analyses will also examine the costs and benefits associated with possible study recommendations for a regulatory requirement of minimum nurse staffing ratios. We expect this cost analysis to include an assessment of the impact of regulatory changes on providers and payers, including Medicare and Medicaid. We also expect to integrate a workforce analysis with the cost analysis because, even if cost increases associated with higher staffing levels could be absorbed, it may not be possible to secure the necessary nursing staff at realistic wage levels.

* Attribution and Phase 1 Analyses

A footnote on the first page of each of the 14 chapters details the appropriate attribution and acknowledgments for all of the analyses contained in the chapter. Although this is a HCFA Report for which it alone is responsible, *each of the reports received from contractors and subcontractors has not been changed or altered in any way*, other than minor editing.

ATTACHMENT

Staffing Ratios

The majority of States, 37, have established some type of nurse staffing requirements. However these requirements vary considerably. The three categories below group states according to type of nurse staffing requirement. Note that some states appear in more than one category because they may have more than one type of requirement. This information is included in Appendix A1 of this Report. HCFA obtained this data from the National Citizens' Coalition for Nursing Home Reform.

Hours of Nursing Care Per Patient Day:

California	Illinois	Michigan	Pennsylvania
Colorado	Indiana	Minnesota	Tennessee
Connecticut	Iowa	Mississippi	Texas
Delaware	Kansas	Montana	Washington
Florida	Louisiana	Nevada	West Virginia
Georgia	Maryland	New Jersey	Wisconsin
Idaho	Massachusetts	North Carolina	Wyoming

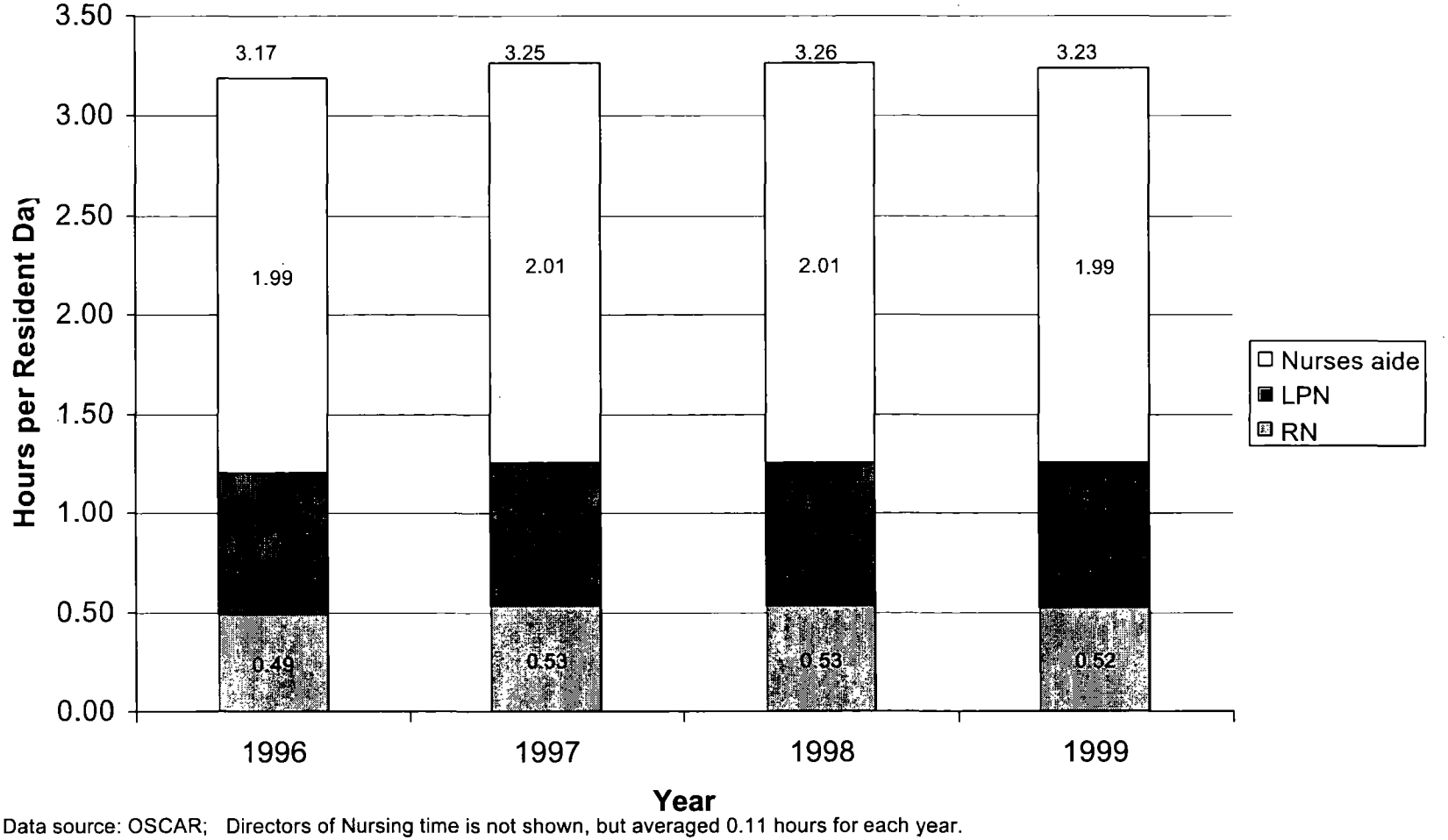
Staff Members to Resident Ratio:

Arkansas	Maine	Oklahoma	Texas
Kansas	Michigan	Oregon	West Virginia
Louisiana	Ohio	South Carolina	

RN 24-hours 7-days a Week:

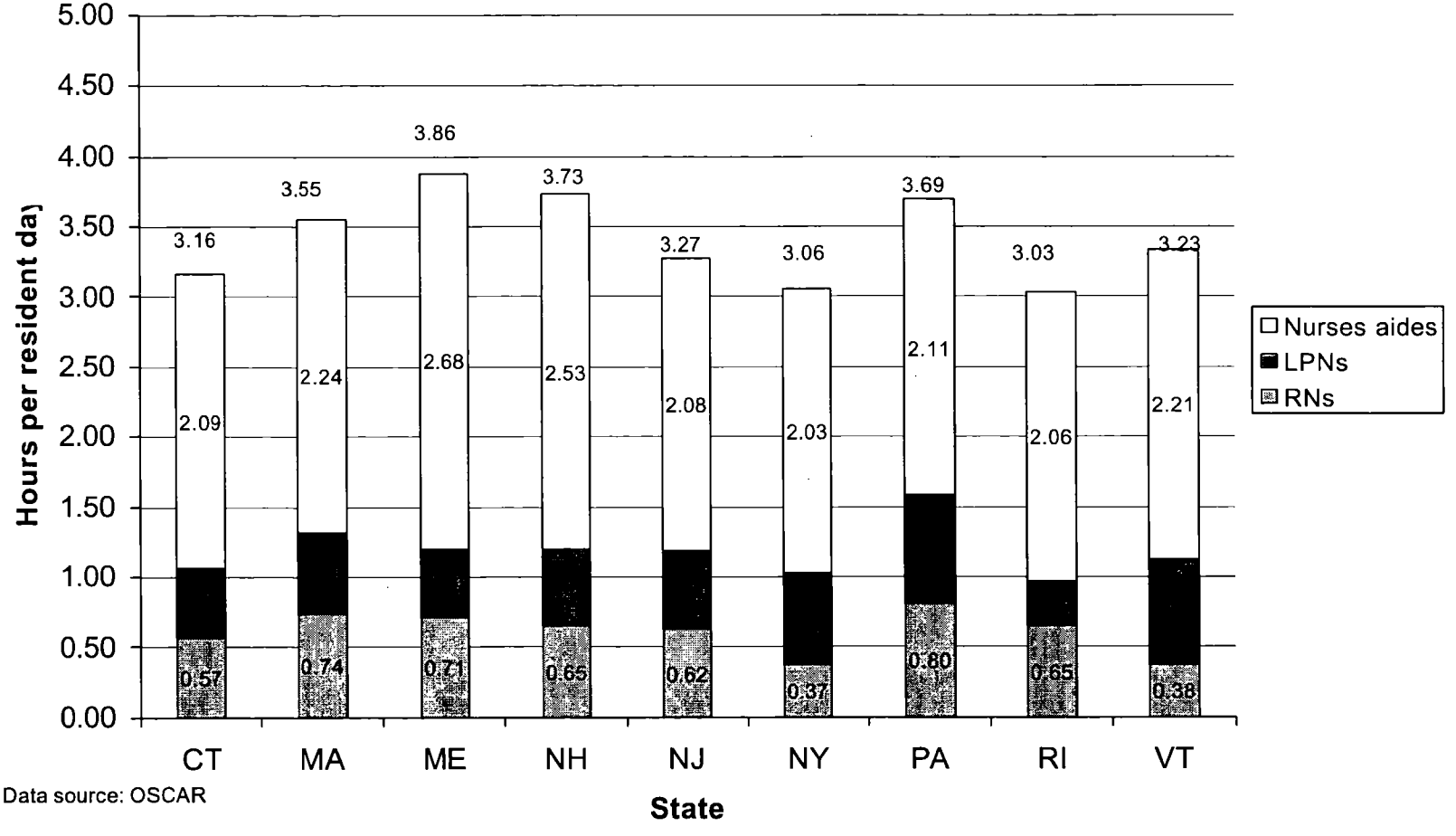
California	Hawaii	Rhode Island
Colorado	Maryland	
Connecticut	Pennsylvania	

Figure 3.1: Staffing Levels in U.S. Nursing Homes: 1996-1999



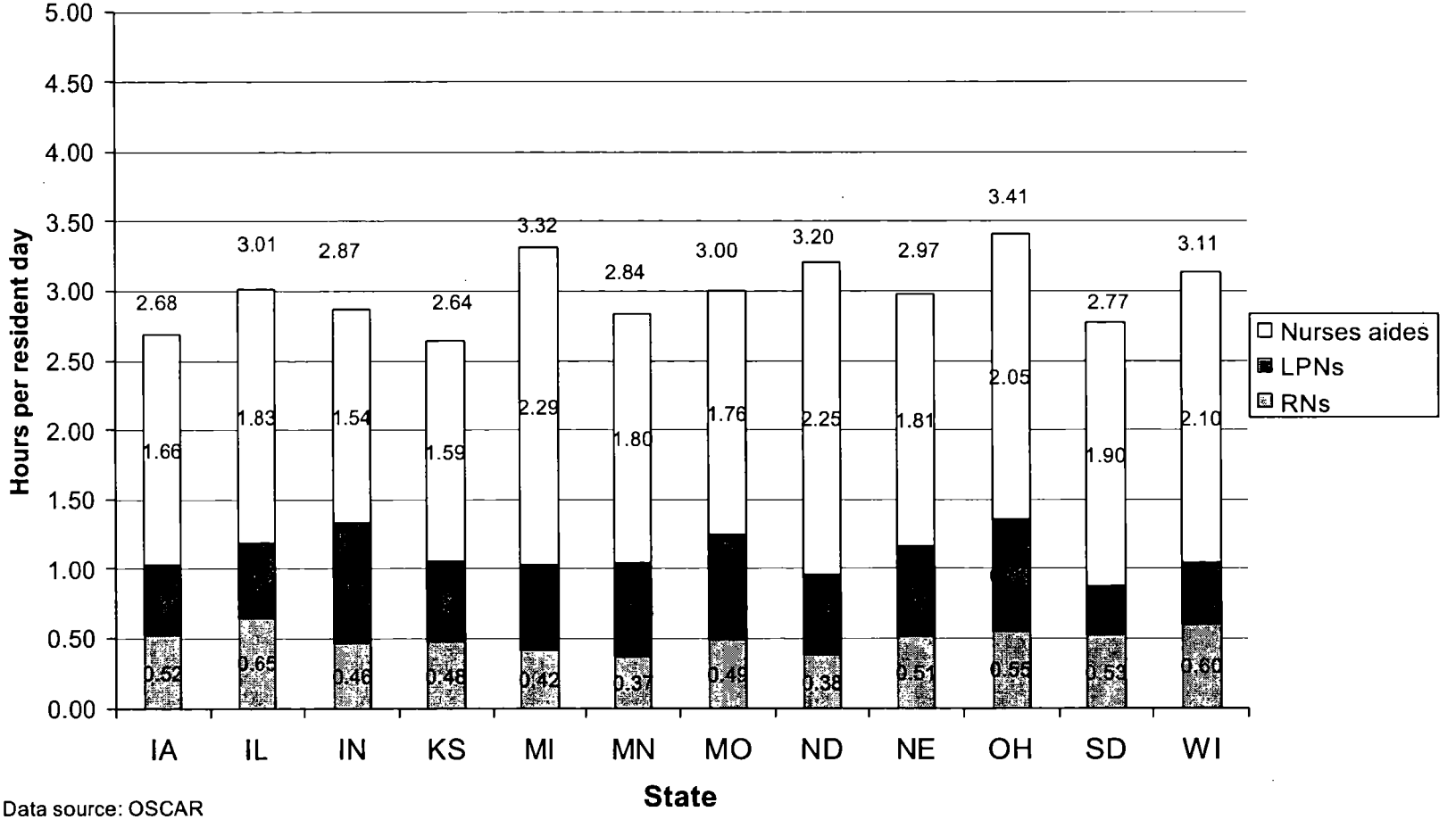
Data source: OSCAR; Directors of Nursing time is not shown, but averaged 0.11 hours for each year.
N=14,335 for 1996, 13,598 for 1997, 13,005 for 1998, 7,019 for 1999 (includes assessments completed prior to July 1, 1999 only).

Figure 3.11: Staffing Levels in U.S. Nursing Homes: Northeast Region, 1998



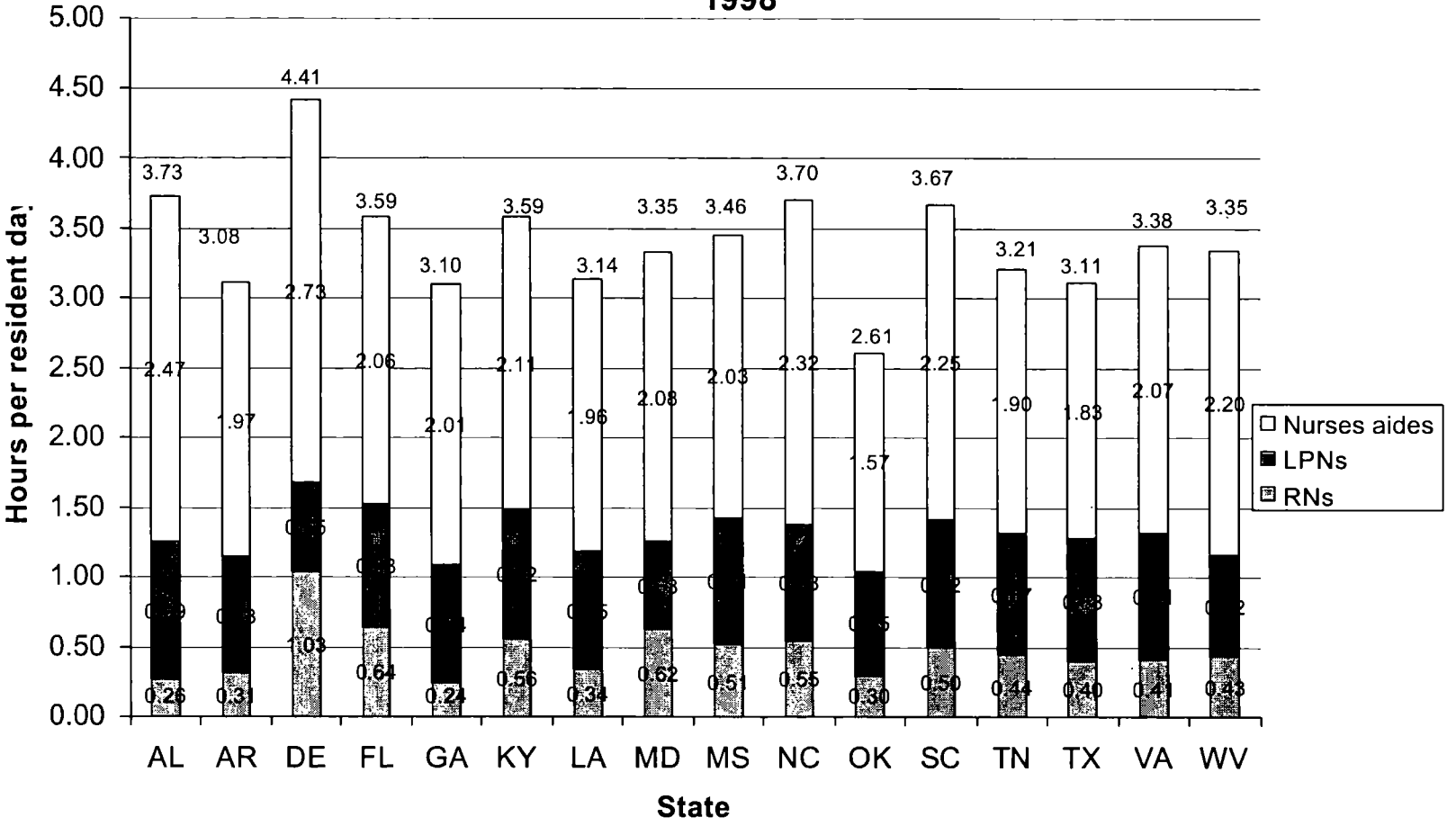
Data source: OSCAR

Figure 3.12: Staffing Levels in U.S. Nursing Homes: Midwest Region, 1998



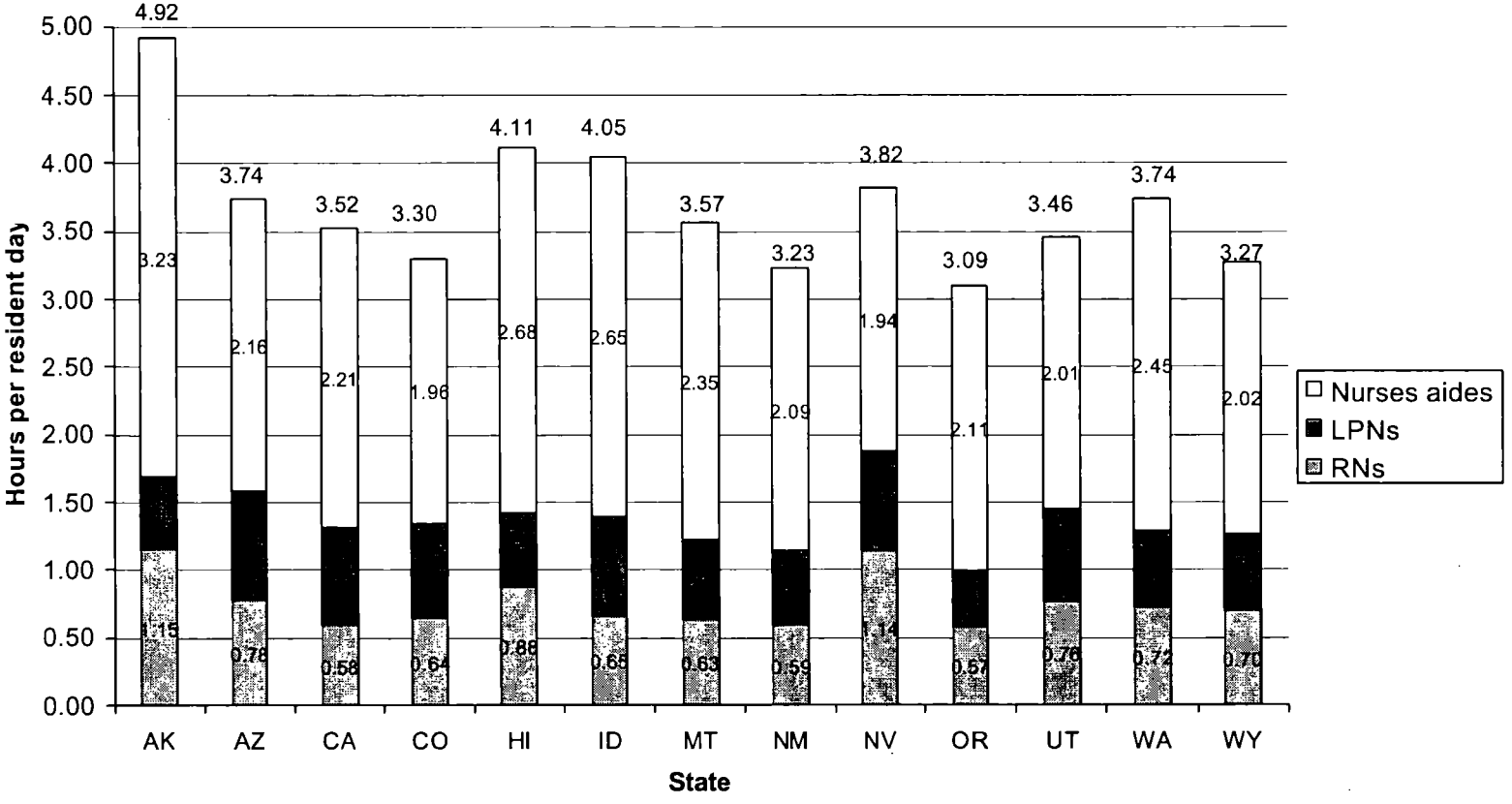
Data source: OSCAR

Figure 3.13: Staffing Levels in U.S. Nursing Homes: South Region, 1998



Data source: OSCAR

Figure 3.14: Staffing Levels in U.S. Nursing Homes: West Region 1998



Data source: OSCAR

Severity				
	Immediate Jeopardy to Resident Health or Safety	J Group 3 Sanctions	K Group 3 Sanctions	L Group 3 Sanctions
	Actual Harm that is Not Immediate Jeopardy	G Group 2 Sanctions	H Group 2 Sanctions	I Group 2 Sanctions
	No Actual Harm with Potential for More than Minimal Harm	D Group 1 Penalties	E Group 1 Penalties	F Group 2 Penalties
	No Actual Harm with Potential for Minimal Harm	A No Sanctions	B No Sanctions	C No Sanctions
		Isolated	**Pattern**	**Widespread**
	Scope			

Group 1 sanctions are directed plan of correction, directed in-service training, and / or state monitoring.

Group 2 sanctions are denial of payment for new admissions or all individuals and / or civil monetary penalties of $50 to $3,000 per day of noncompliance.

Group 3 sanctions are temporary management, termination, and / or civil monetary penalties of $3,050 to $10,000 per each instance of noncompliance. Sanctions for Level I violations also include the option for temporary management.