

NASOP

NATIONAL ASSOCIATION OF STATE OMBUDSMAN PROGRAMS

June 10, 2022

Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
ATTENTION: CMS-1765-P
P.O. Box 8106
Baltimore, MD 21244-8106

RE: Request for Information on Minimum Staffing Standards in SNFs

In response to the CMS Request for input on the implementation of a minimum staffing standard and equity measures, the National Association of State Long-Term Care Ombudsman Programs (NASOP) offers the following recommendations and comments related to the seventeen questions posed in the April 15 Notice of Proposed Rule Making.

NASOP strongly supports the proposal for a minimum staffing standard and increased attention on disparities in nursing home care. Inadequate staffing is the primary driver of poor health outcomes in nursing homes. As CMS' request for information states, numerous studies have documented the relation between higher staffing and better health outcomes. Too often, the problems that accompany inadequate staffing fall disproportionately on communities who have historically been marginalized. This fact was evident during the pandemic, where nursing homes whose residents were predominantly people of color were affected disproportionately by COVID-19.

NASOP responses to questions:

1. Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?

- Previous staffing studies have recommended 4.1 hours a day of nursing services.
- NASOP recommends establishing a minimum staffing level based on the previous research and requiring facilities to complete an acuity-based assessment tool for each unit of the facility. This tool should assess whether the current needs of the residents require more hours than the minimum threshold to meet the needs of the residents in each unit. Every skilled nursing facility should be able to provide the minutes for each of the acuity assessment monthly meetings that include the administrator and director of nursing. For

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transparency purposes the results of these acuity studies should be de-identified, but project the hours needed per unit and be posted in a public area of the nursing home.

- We recommend that CMS request information from its state survey agencies about nursing home staffing strategies during an infectious disease outbreak for insight into both the successes and challenges they experienced. Many states implemented emergency staffing protocols that may provide critical information about how a state determines necessary staffing levels to meet a resident's needs.
- As CMS considers previous staffing studies, CMS should consider the increased acuity needs of the people who are appropriately choosing and accessing skilled nursing facilities as opposed to the acuity needs of individuals entering skilled nursing facilities 20 years ago. Minimum staffing standards need to reflect the level of need associated with a resident at that base acuity level.
- CMS must not set standards that allow some states to continue the practice of inappropriate placement of individuals whose needs are solely related to behavioral health supports, but who are otherwise physically capable of living in less restrictive settings. This practice perpetuates the inappropriate institutional placement, aka warehousing, of individuals with a diagnosis of significant mental illness (SMI) or substance use disorder in skilled nursing facilities. If the staff from the skilled nursing facilities were providing care to residents who met the appropriate level of care, then there would be a much higher number of staff available. Skilled nursing facilities are allowing admissions related to mental health and substance use disorder because many of these individuals require less hands-on care, yet the facilities receive the same daily rate of pay to house them in their facility. This dilutes the resources available and takes the focus off the specialized needs of residents living with dementia and other chronic diseases that require higher levels of care and physical support.
- The benefit of adequate staffing is improved quality of life and quality of care for the individuals living in skilled nursing facilities. This results in better overall physical and mental wellness outcomes and decreases the risk for hospitalization or the potential impact of other care issues.

2. What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?

- Federal minimum staffing requirements should be based on a national composite/average data that includes the total number of residents in the building and their level of acuity based on each resident's individual hands-on care needs. For example, amount of assistance required to perform activities of daily living, number of individuals required to

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safely transfer the resident, as well as resident's need for prompting and cueing due to cognitive impairments. It is critical that individual facility assessment of resident needs and acuity should determine what staffing is needed above a minimum federal requirement. Minimum staffing requirements should be a minimum not a ceiling.

- Residents who are at a skilled nursing facility for rehabilitation services require more staff time than the MDS may capture. The therapy service hours are counted, however for a comprehensive and efficient resident-centered rehab plan, CNA's require time to work with the resident on goals outside of therapy. Allowing CNA's the time to work with a resident to meet the desired ADL goal would potentially decrease the length of stay, reducing the risk of readmission, and ultimately maximizing the insurance benefit.
- Meeting the nutritional needs for some residents requires appropriate staffing. Each resident deserves the opportunity to be provided nutritional support one on one from a CNA at a pace that meets the resident's needs for optimal consumption of each meal. CNAs should not feel rushed or pressured to assist the individual resident to eat quickly and then move on to the next resident or task.

3. Is there evidence of the actual cost of implementing recommended thresholds, that accounts for current staffing levels as well as projected savings from reduced hospitalizations and other adverse events?

- NASOP does not have information for this question

4. Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?

- NASOP believes that there is a need for transparency related to all federal funds that are spent from the facility. For example –
 - Corporate salaries
 - Management fees
 - Real Estate fees
 - Other related companies (pharmacy/therapy/housekeeping)

5a. What factors impact a facility's capability to successfully recruit and retain nursing staff?

- The primary factor we have identified as related to retention is low and inadequate compensation. CNAs do not always receive a family sustaining or livable wages and are often paid at a much lower rate than other jobs with the level of responsibility or years of service they provide if they were to work outside of the healthcare sector. The reimbursement for these positions needs to reflect how essential it is that they provide

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high quality care to the resident. To support their households many CNA's have several jobs or work a great deal of overtime. This puts residents at risk for abuse and neglect due to burnout and overall exhaustion.

- Turnover is a serious problem including turnover in management positions. Such high turnover does not sustain a team-oriented environment which is needed to retain quality care team members at all levels.
- Facilities/Industry need to establish/re-establish a career ladder that provides individuals with opportunities and upward mobility. Additionally, they must provide quality and ongoing training that advances the individual caregiver's skills while promoting career development.
- Social justice issues for direct care workers stemming from racism, sexism, nationalism, and class is also an issue. The impacts of the historic treatment of direct care workers and the lack of socio-economic support for low wage earners was confirmed by the flight of low wage long-term care workers during the pandemic. Historically, caregiving has been viewed as "domestic" work done by immigrants and BIPOC groups, undervaluing the skills and knowledge needed to work in the field of long-term care. This undervaluing has led to decades of poor compensation, high staff turnover, and a lack of meaningful policies to promote a pipeline of workers to meet the increasing needs in the aging population. As noted in PHI's recommendations to address the problems in the LTC workforce, the drive to increase wages is needed. However, increased wages alone are not enough; Other support is also needed, for example, in Washington State, during the pandemic, the need for quality, reliable and affordable childcare impacted workers, and their ability to return to work. One solution is for financial assistance for essential workers in long-term care.

Resources: <https://www.phinational.org/issues/>
<https://centerfortcequity.org/policy-briefs/>

5b. What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff?

- Much of what was conveyed above with the addition of work-life balance and being seen as a valued member of the team.

5c. What risks are associated with these strategies, and how could nursing homes mitigate these risks?

- The biggest risk is that large corporations and companies heavy with management overhead would have to reduce the pay of corporate oversight and managers to ensure

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that the direct care workers were receiving appropriate compensation. A balance needs to be struck between the pay expectation and the value of a direct care worker.

6a. What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers?

- Although it is incredibly difficult, due to the change in time and expectation of individuals requiring long term services and support, it might be necessary to see a consolidation of skilled nursing facilities. It is understood that this would impact individuals that might be required to move or change their job location; however, the skilled nursing facility with a healthy census can provide high quality care, appropriate wages, and overall benefits to the individuals both living and working there.
- Allowing owners of skilled nursing facilities to run these buildings on incredibly low margins while they are still pulling out money in rent, management fees and salaries to corporate staff is incomprehensible. When this happens residents and direct care workers often report a decrease in staffing levels, the quality of the food, general care of the overall facility, and decline or lack of general supplies. This has a direct impact on the quality of life and quality of care for the residents.
- CMS should extend the Certificate of Need process to all nursing homes participating in Medicare and Medicaid settings, to ensure that there is adequate staff available to meet the needs of residents.

6b. How would CMS define and assess what constitutes a good faith effort to recruit workers?

- CMS should not allow waivers to the minimum staffing levels. Setting up regulations or sub-regulatory guidance about a good faith effort will encourage facilities to direct time and money to create reasons that the facility cannot recruit workers, instead of directing time and money to the actual recruiting for and retaining direct care staff.

6c. How would CMS account for job quality, pay and benefits, and labor protections in assessing whether recruitment efforts were adequate and in good faith?

- CMS should not establish a good faith effort criterion because it will encourage a facility to lose focus on a staffing standard that provides residents with good quality care.
- CMS should consider how other countries have dealt with this issue and consider how other industries assess quality, pay and benefits, and labor protections.

7. How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, traveling or agency) nurses?

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- CMS should not allow different standards based on staff turnover. It has been well documented and established that when a skilled nursing facility provides quality management, pay, work-life balance and career ladder it increases the longevity of staff and decreases the impact of turnover or resignations. Every state has examples of long-term care facilities with staff that have long tenures. CMS should evaluate those examples to encourage facilities to utilize these best practices. The standards for employment in these settings must be improved to see stability in the workforce.
- Advancing Excellence focused an enormous amount of attention on reducing turnover of staff positions. It was apparent how complicated it was to teach nursing facilities a consistent way to calculate turnover, and NASOP believes it may prove challenging for CMS to set standards related to turnover. This is especially true when it is common for a facility to experience 100% or 200% turnover in a year. With the bar that low, goal setting may be unproductive.
- NASOP recommends requirements for a minimum direct care/nursing staff to resident ratio to be reported on the CMS Compare website with a section reporting the facility's turnover based on PBJ data.
- Per the required facility assessment, if a facility is unable to provide enough staff, the facility must limit admissions to only the number of residents for whom they can safely provide adequate care.

8. What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?

- NASOP believes that accountability related to how the reported number of direct care staff in a skilled nursing home is accounted for is imperative. We believe that only individuals who are directly interacting, assessing, and providing hands-on care throughout their shift should be counted toward this requirement. This should not include a director of nursing, assistant director of nursing, Medicare/MDS nurse or other individuals whose primary role is not to provide direct care to the resident. NASOP believes it is also inappropriate to include individuals who are working light duty or taking residents out for medical appointments as they are not able to provide full and complete care to the individuals on the unit as needed.
- The care provided by CNA's is separate and distinct. Traditionally CNA's account for the assistance provided to a resident to meet their activities of daily living (ADL'S). NASOP believes there should be a minimum federal staffing ratio for CNA's who provide hands

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on care, or the prompting/queuing required for individuals with a memory care diagnosis. Once there has been a minimum requirement established, the facility acuity tool should be required to access the number of CNA's necessary to meet the residents' individual needs and provide person centered care on the unit.

- Nurses should have a separate minimum staffing requirement that allows them to provide each resident with medications, complete treatments, and make necessary assessments to meet the individual residents' needs. As an example, we have provided the following Maryland state regulations:

<http://www.dsd.state.md.us/comar/comarhtml/10/10.07.02.19.htm>

- Multiple states have staffing ratios, yet still report significant care issues. This justifies the need for nursing assistants and nurses to have separate staffing requirements based on the overall acuity of the unit that is based upon individual resident needs, individual acuity levels, and care that is provided as directed by the resident.
- NASOP does not believe that individuals supporting a resident's mental wellness should be counted towards a minimum staffing requirement. These types of staff/contractors provide support to individual residents to achieve mental wellness. They do not help with activities of daily living, prompting/queuing to meet individualized needs, nor do they provide medication or medically necessary treatments. However, NASOP does support a requirement that facilities should have qualified social services staff available to all residents.

9. How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?

- Administrative nursing time should be separated from direct care.
- CMS should be establishing an expectation for time and type of administrative nursing that is required to appropriately manage the needs of a skilled nursing facility.

10. What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

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- NASOP recognizes the importance of the quality of care and supervision provided to the direct care team. NASOP acknowledges that an RN supervisor may have some administrative work in combination with direct care work but believes the emphasis of that work is on the daily needs of the residents and that it is critical that an RN is available 24/7 to support necessary resident assessments during critical incidents, provide ongoing training, and support for the care team members in the facility.
- NASOP acknowledges that implementation of a 24/7 RN requirement may need to be accomplished in phases, or that a state may require a waiver allowing RN telehealth if a state is experiencing a critical shortage of RNs in a specific area. However, CMS should require that the facility posting in a conspicuous public place in the facility that it does not have a registered nurse on site 24/7. CMS should also require the facility to disclose the lack of 24/7 RN coverage at the time of admission and should include the information on the CMS facility compare website. This would allow residents and family members to make an informed decision when choosing a skilled nursing facility.
- NASOP recommends consider using consumer-friendly language in staffing standards. For example, studies about staffing use the terminology “HPRD” as being a precise measure of direct care time provided per resident, per day. This term and concept is not well understood by consumers, advocates, non-administrative paid facility staff and even by some licensing regulators. “HPRD” is reviewed through payroll journal documentation and staffing records, valuable proof for monitoring and audits. But not readily observable in the moment by nursing home residents and their families. For these reasons, we ask CMS to examine converting “HPRDs” to “ratios” as a more consumer friendly, and a common concept understood by many. HPRDs should continue to be used as a “paper” for providers, accountants, academia and by regulators. But a “ratio” could be used as the front-facing measurement that makes better sense to the average consumer.

11. How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? We currently require that facilities have ‘sufficient nursing staff’ based on a facility assessment and patient needs, including but not limited to the number of residents, resident acuity, range of diagnoses, and the content of care plans. We welcome comments on how facilities have implemented this qualitative requirement, including both successes and challenges and if or how this standard should work concurrently with a minimum staffing requirement. We would also welcome comments on how State laws limiting or otherwise restricting overtime for health care workers would interact with minimum staffing requirements.

- The current requirement for staffing based on resident needs is subjective and problematic, as individuals outside of the facility management team do not have

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transparent accountability to ensure there is adequate staffing levels. A minimum staffing ratio would be easier to apply and access for accuracy.

- Facilities should also be required to post the additional staff that are on shift.

12. Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.

- Existing state minimums are traditionally very low and create little to no threshold for accountability. Survey and certification agencies do not seem to regularly issue citations to skilled nursing facilities for staffing below state minimum standards.
- It is also extremely hard to prove that they did not meet a resident's individualized need even when a resident has vocalized what care or services were denied due to insufficient staffing.
- When calculating the staff in the facility ombudsman report the actual number of staff working at the time of their visit is not accurately reflected in the number of staff that are working at that time.

13. Are any of the existing State approaches particularly successful? Should CMS consider adopting one of the existing successful State approach or specific parts of successful State approaches? Are there other approaches to consider in determining adequate direct care staffing? We invite information regarding research on these approaches which indicate an association of a particular approach or approaches and the quality of care and/or quality of life outcomes experienced by resident, as well as any efficiencies that might be realized through such approaches.

- NASOP does not have a response to this question.

14. The IOM has recommended in several reports that we always require the presence of at least one RN within every facility. Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? We also invite comment on the costs and benefits of a mandatory 24-hour RN presence, including savings from improved resident outcomes, as well as any unintended consequences of implementing this requirement.

- NASOP acknowledges that for some areas in the country implementation of a 24/7 RN requirement may need to be accomplished in phases, or by allowing access to an RN using telehealth. CMS should require that staffing to be posted publicly and should report it on the nursing home compare website.

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15. Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? For example, how would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff to offset additions to nursing staff by reducing other categories of staff?

- More than sufficient evidence exists to indicate that care improves in a linear fashion with an increase in staffing. However a significant concern is that the minimum, as a floor, will become the ceiling, and providers will only look to staff to that minimum level. Continuing to require facilities to provide person-centered care, focused on the needs and preferences of the resident should mitigate this by requiring the facility to hire additional staffing beyond the minimum standard, as needed. In addition, to avoid the reduction of other services, or the shifting of responsibilities (e.g., activities, social services, etc.) to nursing and direct care staff, to offset additions to nursing staff, CMS should continue to require separate staff for those non-nursing activities and requirements. Nursing and direct staff are not qualified to provide these services and doing so would be contrary to trying to develop a minimum nursing/direct care staffing standard.

Unintended Consequences:

- Some skilled nursing facilities make close.
- Waiting lists may be necessary if SNFs must reduce admissions to be able to provide adequate care given the staff they are able to hire.
- Some skilled nursing facilities may only admit residents who have lower acuity, or easier care needs.
- The goal is to improve the access to staff, not shift the tasks to make the current numbers work.

16. Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?

- Yes, geographic disparity has an impact on the workforce members across the country, but that does not change the individual needs of the residents living in those skilled nursing facilities. It is imperative that the owners of these facilities establish a threshold for what is needed to appropriately engage individuals to work there. This reflects directly back to the questions about pay equity, access to a career ladder and overall work environment.

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- CMS should evaluate studies of staffing in underserved areas. How have some homes been successful in recruiting and retaining staff in these areas? The skilled nursing facilities should be working with their local community to develop how they are going to be able to meet the needs of these individuals.
- In addition to the primary challenge of low population to fill the staffing roles of facilities in rural and frontier areas are the affordable housing and childcare challenges.
- CMS should assess the impact pool/temp/traveling staffing agencies have had on full time permanent staffing.
- Mitigation possibilities:
 - Employment agreements in exchange for education/tuition forgiveness
 - Building/providing affordable housing
 - Pay incentives for low absenteeism
 - Greater recognition of nurse aides as a profession
 - Providing appropriate pay and benefits for staff

17. What constitutes “an unacceptable level of risk of harm?” What outcomes and care processes should be considered in determining the level of staffing needed?

- NH regulations already require facilities to “...have sufficient staff...with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).”
- Maybe the more appropriate question should be, “What is the minimum level of staff necessary in order to
 - avert injuries which should be avoidable,
 - prevent a resident’s deterioration in functioning
 - provide the necessary care and services the law and the regulations already require facilities to provide?”
- The minimum staffing level needed to provide the care and services should be able to be quantified. According to the OAA proposed regulations, “... a minimum standard set by DHHS need not approach the threshold level above which there is no further benefit. In fact, such a standard would go beyond the expectation for a minimum, which is intended to identify situations in which facilities unequivocally place residents at an unacceptable level of risk. The challenge is that there is no absolute minimum level of risk for untoward events that is considered acceptable.”

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- Since facilities are required to develop a comprehensive person-centered care plan for each resident, the facility should be required to have whatever staff is needed to accomplish that plan of care.
- Staffing must be measured based on individualized comprehensive care planning while providing competent nursing staff to provide care and services for residents to attain and maintain their highest practicable physical, mental, and psychosocial well-being.
- There should be requirements to ensure staff can demonstrate their skills and competencies to appropriately care for residents.

Respectfully submitted,

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