Testimony of Deborah Chernoff
Before the Committee on Aging
Public Hearing January 27, 2009

P-1-10

In Re: Senate Bills 450 (AN ACT CONCERNING NURSING HOME OVERSIGHT) and 454 (AN ACT CONCERNING NURSING HOME STAFFING LEVELS)

My name is Deborah Chernoff. I am an Elected Organizer of the New England Health Care Employees Union, District 1199 and direct the research and communications departments for our union. 1199 represents 7,000 nursing home workers at 65 nursing homes in Connecticut. Our members include nurses, aides, housekeepers, dietary, laundry and maintenance workers. I also serve as a member of the Long Term Care Advisory Committee.

I am here to testify on Senate Bills 450 (AA Concerning Nursing Home Oversight) and 454 (AA Concerning Nursing Home Staffing Levels). My purpose today is to support the bills in concept but also to offer reasons why both bills must be amended if they are to accomplish their laudable purposes.

First, with respect to SB 450, which seeks to establish a Nursing Home Financial Advisory Committee to examine the financial solvency of nursing homes: Our union has much hard-won, if unsought, experience of what happens when nursing home become insolvent – closures, bankruptcies, receiverships, irrecoverable loss of jobs and care. We are surely more than simply "interested parties" – we are stakeholders. For that reason, we believe that there must be representation for caregivers on this Advisory Committee, just as there is proposed representation from both the for-profit and non-profit providers. When nursing home companies face financial shortfalls, our members are often the first to feel the pinch – through bouncing paychecks, layoffs, hours cuts, health insurance that goes unpaid, pension contributions that go unmade and even dues deducted from members' paychecks that is then not forwarded to the union but held onto for months by providers using our members' money as an illegal "loan" to pay outstanding bills.

We have a unique perspective on, and hands-on experience of, financial issues in nursing homes. For these reasons, we believe that caregivers must be represented on any committee established to monitor the financial solvency of nursing homes in Connecticut.

With respect to the critical issues of nursing home staffing as raised in Senate Bill 455, we believe this well-intentioned legislative initiative must also be amended. In our union, our members are black, white and Latino; young and old; immigrant and US-born. We are a diverse group with a wide spectrum of opinions about many things. But on one subject, our members speak with a single voice. Across the state, in every facility our union represents, **our members identify short-staffing as the number one barrier to quality care in Connecticut's long-term care facilities.**

I have been before this and many other legislative committees numerous times over the past ten years advocating for higher standards in our nursing homes. Over those years, our members have testified more eloquently than I could about the impact of short-staffing on resident care: the corners that get cut, the call bells that don't get answered, the baths that are not given, the meals served late. These problems will only continue to intensify as nursing home residents grow increasingly frailer, older and more medically y complex in their treatment needs. They will certainly intensify rapidly this year if Connecticut enacts the deep cuts to Medicaid funding now being contemplated by the Administration.

The case for better staffing leading to a higher quality of care has long been proven in the research literature. I have attached to my testimony several examples of that literature that speaks directly to this point. However, if the goal of this bill is to "improve the quality of care for nursing home residents by

increasing staffing levels," the bill does not go far enough to accomplish that purpose.

SB 454 would raise the current minimum staffing levels from a total of 1.9 hours of nursing care over a 24 hour period to the current Connecticut average, as reported to CMS, of 3.5 hours of care per resident per day. Of course we favor any and all steps towards improving staffing levels and quality of care but simply raising the floor won't do it. It's an admirable first step, but only a first tentative step towards improving the quality of care. If the legislature does not at least set in motion plans to go further, we run the very real risk of creating the illusion of progress without making real progress.

Dr. Charlene Harrington is a professor at the School of Nursing, University of California San Francisco, Associate Director of the UCSF John A. Hartford Center for Geriatric Nursing Excellence, and Director of the Nursing Health Policy Doctoral Program. She is widely recognized as the country's leading researcher on the relationship between staffing levels and quality of care.

As she wrote in 2007, research demonstrates that minimum of 4.1 hours per resident day is needed to prevent harm to residents with long stays (90 days or more) in nursing homes. Moreover, Dr. Harrington noted:

> A study of nursing homes in California also confirmed the threshold for nurse staffing hours needed to ensure high quality; the study found no differences in measurable outcomes until staffing was at 4.1 hours per resident day or higher. Nursing homes with high staffing (4.1 hours per resident day or higher) performed significantly better on 12 of 16 care processes (such as feeding assistance) compared to lower staffed homes.[1]

[1] *Proposals for Improvements in Nursing Home Quality*, Testimony prepared by Charlene Harrington, PhD, RN, May 2, 2007 (complete copy attached)

In other words, if our aim is to improve the quality of care, research indicates we won't see that improvement simply by enacting into statute the current status quo. We need to create a structure to move towards the higher minimums supported by organizations like NCCNHR – the National Voice for Quality Long-Term Care.

There is also a very real danger that these improvements will become the ceiling instead of the floor, letting critics use a change in the statute that merely reflects the current, inadequate averages become a rationale for dropping the subject altogether. "This represents an 84% increase in staffing requirements," they'll say (1.9 to 3.5 hours) and the sound bite will displace the sound policy.

We appreciate and honor the efforts of the Select Committee on Aging to tackle this difficult subject in the most challenging of budgetary atmospheres and we look forward to working with Senator Prague, Representative Serra and the other members of the Committee on making these bills stronger, better and more effective. Thank you.

UCSF
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May 2, 2007

Proposals for Improvements in Nursing Home Quality

Testimony Prepared by Charlene Harrington, Ph.D., RN., Professor, School of Nursing, University of California San Francisco, and Associate Director, UCSF John A. Hartford Center for Geriatric Nursing Excellence, and Director of the Nursing Health Policy Doctoral Program

The quality of nursing homes continues to be a major problem in the US. I first became aware of the serious quality problems in 1976 when I was the Director of the California Licensing and Certification program. At that time, the program determined that about one-third of California nursing homes were providing substandard care. Today, over thirty-years later, California and the rest of the nation continue to have many nursing homes that offer substandard care resulting in harm, jeopardy, and even death to residents every year.

Literally dozens of studies by researchers, the US Government Accountability Office, the US Inspector General for Health and Human Services, and others have documented the persistent quality problems in a sizable subset of the nation's nursing homes since the US Senate Committee on Aging first began holding hearings on nursing homes.[1-4]. Even though some nursing homes offer high quality of care, the persistent quality problems continue to shock and dismay us.

I am going to argue that three areas need to be improved to ensure high quality nursing home care. These are: (1) the enforcement of existing laws, (2) adequate nurse staffing levels in nursing homes; and (3) financial accountability for government funding of nursing homes.

ENFORCEMENT

The most recent GAO (2007) report found that the number of serious deficiencies and sanctions declined in four states between 2000 and 2005 and that this decline is related to weaknesses in the survey system and the use of sanctions.[5] Often quality problems are not detected

and when they are, the scope and severity of problems are underrated. Nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm to residents. The report recommended similar findings to previous GAO reports[2-4] in that CMS should: (1) improve the immediate sanctions policy, (2) strengthen the deterrent effect of certain sanctions, (3) expand the enhanced enforcement for homes with a history of noncompliance, and (4) improve the effectiveness of the agency data reporting systems on enforcement.

Failure to Improve Quality and Enforcement Since the 1970s. The new GAO report is very similar to reports identified by the Institute of Medicine (IOM) Committee on Improving the Quality of Nursing Home Care in 1986.[6] As a member of the IOM committee that issued the 1986 report on widespread quality problems in nursing homes, we recommended stronger enforcement federal regulations by using intermediate sanctions of civil money penalties, holds on admissions, and temporary management/receiverships to force poor nursing homes to come into compliance.[6] These recommendations were adopted by Congress in passing a major reform of nursing facility regulation in the Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987).[7] OBRA (1987) required changes to strengthen the quality standards, the survey process, and the enforcement mechanisms for nursing facility regulation. OBRA (1987) and its subsequent regulations also mandated uniform comprehensive assessments for all nursing home residents and required the survey process to focus on resident outcomes.

Declining Sanctions Imposed Since 2000. Unfortunately, the bureaucratic nursing home enforcement procedures and the poor survey process overseen by the Centers for Medicare and Medicaid Services result in few deficiencies being issued (7.1 per facility in 2005) and a decline in deficiencies issued for harm of jeopardy (from 30.6 in 1999 to 16.9 in 2005).[8] Moreover, few civil money penalties (CMPs), holds on admission, and temporary management/receiverships, are issued for serious violations of federal regulations.[9-12] In 2004, 41 states collected 3,057 CMPs worth $21

million, but CMPs were given for only two percent of deficiencies issued.[12] As the new GAO report pointed out, few nursing homes are decertified from the Medicare and Medicaid programs or closed.[5]

State Survey Agency Problems. The weak survey process is related to a number of factors including poorly trained surveyors, shortages of survey staff, high survey agency staff turnover related to poor salaries, the lack of timely surveys, the lack of timely complaint investigations, the predictability of surveys, and other problems.[3-5] These problems are sometimes compounded by the negative attitudes of federal and state survey officials to enforcement activities.[11,12] Some state officials have reported that they are opposed to federal enforcement actions and they either do not implement the federal requirements (like CMPs) or only implement sanctions for the worse facilities.[11,13] Others report federal officials sometimes overrule state sanction recommendations which also results in weak enforcement.[11]

Interviews with state survey agency officials have identified their strong frustration with the CMS regulatory process. Some states described the federal enforcement system as an administrative nightmare and most prefer their own state procedures for CMPs.[11,13] One state (Maryland) issues and collects state CMPs fines immediately and puts the fines in a special account until the final adjudication process is complete in order to make the penalties more timely.[12] This approach could be taken by CMS. Most states (73 percent) reported inadequate federal funds to carry out their regulatory activities, while about half reported inadequate state funds for regulatory activities.[11,13]

CMS should revise its enforcement procedures and practices to increase the size of the penalties and to take swift action against poor performing nursing homes. Those nursing homes with repeated serious violations should be forced out of business using receiverships and temporary management procedures so that new high-quality owners can be found without having to close

nursing homes. Implementation of the recommendations by the GAO (2007)[5] is of critical importance.

State Enforcement Variation. Our studies have examined the wide variations in enforcement procedures across the US. Studies have found that states that taken more enforcement actions and issue more CMPs are those that have higher state survey agency budgets from CMS.[12,14] State survey agencies with more staff and resources to implement the federal requirements can be more effective with the enforcement process, which can be time consuming and expensive. We conclude that the state variations in enforcement practices could be addressed in part by increased funding for state survey agencies, at the same time that other improvements are made in the enforcement policies.

STAFFING ISSUES

Relationship of Nurse Staffing and Quality

Nursing home quality rests entirely in the hands of nurses, nursing assistants, and other providers who deliver formal care and assistance. Nursing homes are labor intensive and require nursing staff that are well educated, with experience and compassion. The processes of care include assistance with activities of daily living (such as bathing and dressing) and special nursing services such as wound care, nutrition and incontinence management, medication and behavioral management, chronic disease management, and other complex care processes.

The positive relationship between nurse staffing and quality of care in nursing homes has been shown in a number of studies reported by the Institute of Medicine.[15-16] Higher staffing hours per resident, particularly Registered Nursing (RN) hours, have been consistently and significantly associated with overall quality of care including: improved resident survival rates, functional status, and incontinence care; fewer pressure sores and infections; less physical restraint, catheter and antibiotic use; less weight loss and dehydration; less electrolyte imbalance; improved nutritional

status; lower hospitalization rates, improved activity participation rates, and a higher likelihood of discharge to home. [15-19] Better staffing is associated with lower worker injury rates and less litigation actions. Studies have also found that gerontological nurse specialists and geriatric nurse practitioners contribute to improved quality outcomes in nursing homes and lower risk-adjusted hospitalization rates.

Safe Staffing Levels

A study by Abt Associates for CMS (2001) reported that a minimum of 4.1 hours per resident day were needed to prevent harm to residents with long stays (90 days or more) in nursing homes.[17] Of this total, .75 RN hours per resident day, .55 LVN hours per resident day, and 2.8 NA hours per resident day were reported to be needed to protect residents.[17] The report was clear that residents in homes without adequate nurse staffing levels faced substantial harm and jeopardy. In order to meet the total 4.1 hours per resident day, 97% of homes would need to add some additional nursing staff. [17] A study of nursing homes in California also confirmed the threshold for nurse staffing hours needed to ensure high quality; the study found no differences in measurable outcomes until staffing was at 4.1 hours per resident day or higher. [18] Nursing homes with high staffing (4.1 hours per resident day or higher) performed significantly better on 12 of 16 care processes (such as feeding assistance) compared to lower staffed homes.[18]

Two IOM reports have recommended increased federal minimum staffing standards for nursing homes because the federal standards are so low (one RN on duty 8 hours a day for seven days a week and a licensed practical nurse on duty on evenings and nights per nursing home). [15,16] In 2003, an IOM committee report on Keeping Patients Safe recommended that CMS adopt the minimum staffing levels from the Abt study for all nursing homes in the US, along with 24 hour RN coverage.[16,17] The IOM report identified the strong relationship between higher resident casemix

(acuity) and the need for higher nurse staffing levels and greater nursing expertise when residents have higher acuity.

Nursing Home Staffing Levels

In spite of recent efforts to increase nurse staffing levels in nursing homes, the total average staffing has remained flat, at 3.6 to 3.7 hours per resident day (hprd) rsince 1997, and well below the recommended levels.[8] Staffing levels vary widely across nursing homes, and some homes have dangerously low staffing levels.[8]

The shocking situation is that the RN staffing hours per patient in US nursing homes have declined by 25 percent since 2000.[8] The decline in staffing levels is directly related to the implementation of the Medicare prospective payment system (PPS) for skilled nursing homes and this in turn has led to a reduction in nursing home quality outcomes.[20,21] Under PPS, Medicare rates are based on each facility's resident needs for nursing and therapy services but skilled nursing homes do not need to provide the level of care that is paid for by the Medicare rates. The declining RN levels in nursing homes and quality of care shows the need for regulatory standards and incentives to improve staffing levels.

Minimum Federal Staffing Standards. Unfortunately, the Centers for Medicare and Medicaid Services has not agreed to establish minimum federal staffing standards that would ensure that nursing homes meet the 4.1 hours per resident day (hprd), mostly because of the potential costs.[17] Considering that most nursing homes are for-profit and have significantly lower staffing and poorer quality of care,[22,23] these facilities are unlikely to voluntarily meet a reasonable level of staffing. If staffing levels are to improve, minimum federal staffing standards are needed along with additional funding.

State Standards. Many states have begun to raise their minimum staffing levels since 1999 (e.g. California (3.2 hprd) and Delaware (3.29 hprd)).[24] Recently, Florida established a 3.9 hprd

total licensed and licensed minimum standard. Except for Florida, most of these new standards are improvements, but they are still well below the 4.1 hprd level recommended by the CMS 2001 report.[17] When standards are established, states need to monitor the standards. After five years, 22 percent of California nursing homes still do not meet the state's 3.2 hrpd minimum standard in 2005.[25] Efforts to improve the minimum staffing standards that are case mix adjusted should continue to have the highest priority at the state and federal levels.

State Minimum Licensed Staffing Standards. Studies have shown that increasing state Medicaid reimbursement rates is one approach to improve staffing levels in nursing homes.[26] A new study also shows that higher Medicaid nursing home reimbursement rates are related to higher RN and total nursing hours per resident, but state minimum licensed staffing standards are a stronger predictor of higher RN and total nursing hours.[27] To increase staffing levels, average Medicaid reimbursement rates would need to be substantially increased, while increasing the state minimum RN staffing standards would have a stronger positive effect on RN and total nursing hours.[27]

Staff Turnover Rates. Nursing home turnover rates range from 50 to 75 percent of staff leaving employment each year, showing that retention is major problem.[17] High turnover rates reduce the continuity and stability of care, lead to miscommunications, and result in patient safety problems as well as worker injuries and poor morale. High nursing turnover has been found to be related to decreases in nursing home quality.[28] Moreover, turnover of nursing aides is estimated to cost billions per year in the US. Turnover is directly related to heavy workloads (inadequate staffing levels), low wages and benefits, and poor working conditions.[16, 17, 28, 29] The goal should be to stabilize the LTC workforce by investing in the workers in increased wages and benefits.

Accurate and Timely Staff Reporting Requirements. The current CMS reporting system, which requires nursing homes to report on two weeks of nurse staffing at the time of the

annual survey, is inadequate and sometimes inaccurate.[17] These reports are not audited and are collected during annual state surveys when nursing homes often increase their staffing. Complete daily reporting for all types of staff and for total staff from payroll records should be required of nursing homes on a quarterly basis, using a standard reporting format that requires nursing homes to certify the accuracy of their reports.

Consumer Report Cards on Staffing. One important strategy for improving quality of care is to provide consumers with information about quality of care as a means for making more informed decisions about health care. Public reporting and ratings of nursing homes based on key indicators including nurse staffing levels as well as turnover, wages, and benefits are strongly recommended. One model for such a report card was developed by the University of California and the California Health Care Foundation (www.calnhs.org).

Payment Incentive Systems. As interest has grown in payment incentive systems, it is important to consider what indicators of quality are the most appropriate to consider. At this point, staffing levels, turnover rates, wages, and benefits are all concrete measures that are directly related to quality. These indicators can be accurately and reliably measured. As noted above, these indicators are more directly related to care than many clinical measures (such as pain) which are sometimes inaccurately measured and reported, are difficult to risk adjust, and can be easily gamed by providers.[18] If we want to give human resources top priority, incentives that encourage more staff, better education and training, and workforce stability should be considered.

Staff Screening and Training. Another approach to improving quality is to have criminal background checks for all nursing home employees. A number of states require criminal background checks but there is no federal requirement. The federal government should make this a minimum requirement for working in nursing homes. The training of nursing home assistants has

also been weak with only 75 hours required by the federal government.[15,16] This amount of training should be doubled or tripled to improve the quality of care.

FINANCIAL ACCOUNTABILITY

Nursing home reimbursement methods and per diem reimbursement rates are of great importance because they influence the costs and quality of care. Medicaid and other public programs paid for 47 percent of the nation's total $115 billion nursing home expenditures, while Medicare paid for 14 percent, with the remainder paid by consumers, private insurance, and other payers in 2004.[30] Because of its high proportion of total nursing home expenditures, government reimbursement policies have primarily focused on cost containment rather than quality of care. Government's cost containment goals often conflict with quality goals.

Medicaid Rates. Medicaid reimbursement rates in states are substantially lower than other payers. Medicaid nursing home payments were an average of $115 per day across the nation, while Medicare rates for freestanding nursing homes were $269 in 2000.[31,32] Medicaid rates fell short of costs by $9.78 per day in 2000.[31] Low Medicaid reimbursement rates can result in nursing homes discriminating against Medicaid residents and in poor quality of care for facilities with high percentages of Medicaid residents.[33,34] An increase in Medicaid reimbursement rates improved quality as measured by an increase in the use of RN staff and reduced deficiencies in the tightest regional markets.[26] Nursing homes are not likely to increase staffing without adequate Medicaid reimbursement rates.

Prospective Reimbursement Rates to Control Costs. The majority of states have adopted Medicaid prospective payment systems (PPS) for nursing homes and Medicare adopted PPS in 1998. PPS sets rates in advance of payments, based on past allowable costs, whereas a retrospective payment system is one in which payment is based on actual past costs. PPS methodologies are successful in controlling reimbursement growth rates[35] but nursing homes tend to

respond by cutting the staffing and may reduce the proportions of debilitated patients nursing homes will accept.[35] PPS can have negative effects on quality of care unless accountability is ensured.

Medicare Prospective Payment Systems (PPS). Congress passed prospective payment system (PPS) reimbursement for implementation starting in 1998 to reduce overall payment rates to skilled nursing homes.[31,32] Following provider pleas to Congress, additional Medicare payments improved the revenues for many nursing homes. In spite of the reimbursement changes, excess profits have grown. A GAO study of Medicare profit margins found that the median margins for freestanding SNFs were 8.4 percent in 1999 and increased to 18.9 percent in 2000.[32] The 10 largest for-profit chains had margins of 18.2 percent in 1999 and 25.2 percent in 2000.[32] Medicare PPS does not limit the profit margins that nursing homes can make.

Medicare developed a complex and elaborate system for establishing its PPS nursing home payment rates, but little financial accountability. As noted above, under Medicare PPS, nursing homes do not need to ensure that the amount of staff and therapy time is equal to the amount that is allocated under the Medicare rates. Nursing homes may spend the funds they receive without being required to spend the funds on direct care. This is also the case in many states under Medicaid payment rules. As noted above, after the adoption of Medicare PPS, RN staffing levels declined by 25 percent and poor quality of nursing home care increased.[21,22]

Cost Centers. One approach to make nursing homes more financially accountable under Medicare and Medicaid PPS systems is to establish cost centers. Four general cost centers could be established: (1) direct care services (e.g. nursing, activities, therapy services), indirect care (including housekeeping, dietary, and other services), capital costs (e.g. building and land costs), and administrative costs. Medicaid and Medicare should determine prospectively the amount of funds allocated for each of these costs centers. Nursing homes should then be prevented from shifting funds across cost centers. This would require nursing homes to target funds for direct care

(nursing and other direct care providers) and for indirect expenditures to those services. Funds should not be diverted from direct and indirect services to pay for administrative costs, capital costs, and profits. Moreover, nursing homes should have to report nursing hours separately on the Medicare cost reports.

To ensure that the reimbursement rates are used for the intended purposes, retrospective audits should be conducted to collect Medicare and Medicaid funds not expended on direct and indirect care. Penalties should be issued for diverting funds from direct and indirect services.

Summary

In summary, the most important measure of quality of care is the amount of nursing staff available to provide care. In nursing homes, the decline in registered nurses and the failure to improve staffing shows the need for greater regulatory standards and incentive systems. Turnover rates, wages, and benefits must be improved to address nursing home quality. Greater financial accountability is needed to ensure that Medicare and Medicaid funds are spent on direct and indirect care and not diverted to paying for real estate, administration, and profits. We must invest in our long term care workforce so that high quality providers will be available to provide care for our family members, friends and ourselves when we need such care.

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