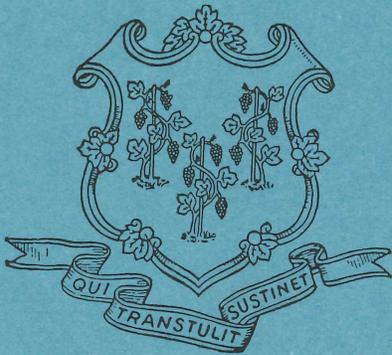


STAFFING IN NURSING HOMES

Connecticut
General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 2000

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

STAFFING IN NURSING HOMES

DECEMBER 2000

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Digest

Staffing in Nursing Homes

SURVEY PROCESS

FINDINGS

Few nursing facilities are issued deficiencies by Connecticut's Department of Public Health for nursing staff inadequacies.

A review of the adequacy of nursing staff is not a primary focus of the standard survey (i.e., inspection).

Even when serious quality of care problems are identified, it is difficult for DPH inspectors to link those to insufficient staffing because of subjective and immeasurable protocol requirements.

Neither the federal Health Care Financing Administration (HCFA) protocol nor state law provides a benchmark for surveyors to evaluate a facility's nursing staff levels based on a facility's resident case mix.

Connecticut must follow HCFA's protocol, thus, any additional state requirements to evaluate staffing, if too complex, would require additional staff resources for DPH.

RECOMMENDATION

1. The Department of Public Health should obtain a nursing facility's annual number of registered nurse, licensed practical nurse, and nurse aide hours and total resident days from the Department of Social Services as reported in the Medicaid cost report prior to conducting a federal standard survey or state licensure inspection. The Department of Public Health's inspectors should calculate, based on the annual hours, an average daily staff-to-resident ratio for each facility and compare it to actual nursing staff levels during the conduct of the survey and/or inspection.

The Department of Public Health, at the time it conducts the federal standard survey and/or state licensure inspection, shall, in addition to current protocols, assess residents' acuity to ensure sufficient numbers and levels of licensed nurses and nurse aides are provided by the facility to meet required resident care needs.

The basis for the acuity system shall be HCFA's published 1995 and 1997 Staff Time Measurement Studies which determine the nursing minutes needed to care for each resident, ranked into any of 44 established resource utilization groups (RUGs). As needed, the Department of Public Health shall update this requirement taking into consideration any future versions of Staff Time Measurement Studies or RUG reclassifications.

Each resident's acuity shall be based on the data results of the last full resident assessment, as required by the Minimum Data Set, the assessment instrument designed by HCFA to assign each resident into a RUG level.

The total number of care hours required by the RUG category scores shall be compared to the amount of care hours actually provided by licensed nurses and nurse aides. If the number of care hours is less than that provided for in RUG, DPH shall review the facility's documentation, as required by Connecticut State Agencies Regulations Sec. 19-13-d8t(m)(3), as to the methodology used to determine the number, experience, and qualifications of staff necessary to comply with federal and state staffing requirements. Results of the comparison may be used to document insufficient staffing.

FINDINGS

There is some predictability in the number of days between survey cycles with 8 percent of all surveys conducted occurring within seven days (plus or minus) of the facility's most recent survey cycle; 20 percent within 15 days; and more than one-third within 30 days.

It appears more difficult for facilities to predict when a survey might occur based on its geographic location.

An adequate number of night/weekend surveys are being conducted by DPH.

RECOMMENDATION

2. The Department of Public Health should track the date and location of each facility's federal survey and state licensure inspections to ensure more randomness in the number of days between cycles, with no survey or state licensure inspection occurring within 15 days before or after the previous survey or inspection date.

NURSING-STAFF-TO-RESIDENT RATIOS

FINDINGS

Connecticut's current nursing staff ratio requirements are confusing, administratively complicated, and limit a facility's flexibility - currently, there are eight separate nursing staff-to-resident ratios depending on:

- a facility's licensure category, and*
- the time of day.*

The current ratios were established in 1981, almost 20 years ago while from all accounts in the literature, the health care needs of residents have increased.

With the percent of total nursing home residents aged 85 and older increasing in Connecticut's facilities, other assisted living housing options available for individuals who do not need the

level of care provided for in a nursing home, and a trend of shorter hospital stays so that sub-acute care is being provided in nursing homes, homes increasingly care for the most frail and needy population.

DPH began revising the current regulations in 1995 and almost six years later they still have not been submitted to the Regulation Review Committee.

The only nursing staff ratios based on analysis of resident outcomes are those put forth by HCFA.

RECOMMENDATION

3. The state Department of Public Health shall not issue or renew the license of a nursing facility unless that facility employs the nursing personnel needed to provide continuous 24-hour nursing care and services to meet the needs of each resident in the nursing facility.

By October 1, 2001, aggregate licensed nursing and nurse aides staffing levels shall be maintained at or above the following standards for nursing facilities licensed by the Department of Public Health as chronic and convalescent nursing homes and rest homes with nursing supervision:

Over a 24-hour period, each facility shall provide:

- **At least 1.66 hours of direct care and services given by nurse aides per resident; and**
- **at least 0.7 hours of care and services given by licensed nurses per resident, of which 0.1 hours shall be provided by a registered nurse.**

By October 1, 2002, aggregate licensed nursing and nurse aides staffing levels shall be maintained at or above the following standards for nursing facilities licensed by the Department of Public Health as chronic and convalescent nursing homes and rest homes with nursing supervision:

Over a 24-hour period, each facility shall provide:

- **at least 2.0 hours of direct care and services given by nurse aides per resident; and**
- **at least 0.75 hours of care and services given by licensed nurses hours, of which 0.2 hours shall be provided by a registered nurse.**

The director of nurses shall not be included in satisfying the licensed nursing staff requirement for facilities with a licensed bed capacity of 61 or greater.

Facilities with a capacity of 121 licensed beds or greater shall employ a full-time assistant director of nurses who shall not be included in satisfying the licensed nursing staffing requirement.

“Direct care” means hands-on care provided to residents, including, but not limited to, feeding, bathing, toileting, dressing, lifting, and moving residents. Direct care does not include food preparation, housekeeping, or laundry services, except when such services are required to meet the needs of an individual resident on any given occasion.

Each nursing facility licensed by the Department of Public Health as a chronic and convalescent nursing home or a rest home with nursing supervision that fails to meet the minimum nursing staff-per-resident ratios on any day shall submit a quarterly report to the Department of Public Health. The report shall identify the day(s) and shift(s) the minimum nursing staff ratios were not met, how they were not met, and the reason(s) they were not met.

Upon determination by DPH that evidence exists of a pattern of failure to comply with mandated staff ratios, the Department of Public Health shall have grounds to take enforcement action in accordance with C.G.S. Sec. 19a-524.

WAGE, BENEFIT AND STAFFING ENHANCEMENT PROGRAM

FINDINGS

Since information in annual cost reports submitted to the Department of Social Services is increasingly being used for staff and wage analysis among nursing facilities, there is a need to refine the categories to more accurately distinguish nursing staff that provide direct resident care from those performing administrative tasks.

RECOMMENDATION

4. The Department of Social Services should amend pages 10 and 13 of the Medicaid cost report, beginning with the 2001 submission, so that salaries and wages, and hours for RN and LPNs involved in providing direct care to residents shall be reported separately from RNs and LPNs involved in administrative functions.

“Direct care” shall mean the provision of direct care and services to the resident, commonly referred to as hands on care services, including, but not limited to, the administration of medication and treatment, feeding, bathing, toileting, dressing, lifting, and moving residents. Administrative nurse functions shall include, but not be limited to, infection control, in-service training, and maintaining the federally required minimum data set.

STAFFING IN NURSING HOMES

- There were 262 licensed nursing facilities with a total of 32,080 beds in Connecticut as of March 31, 2000.
 - Under federal law, nursing homes must “provide nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”
 - No minimum nursing-staff-to-resident ratios are mandated under federal law or regulations. Federal law requires all certified nursing facilities have a licensed nurse on duty 24 hours a day; a registered nurse on duty at least eight hours a day, seven days a week, and an RN director of nursing.
 - Connecticut’s Public Health Code establishes specific nurse and total direct care staff-to-resident ratios.
 - The current minimum total nursing staff hours per resident in a chronic convalescent nursing home bed is 1.9 hours per day – an average of less than five minutes of care per resident, per hour.
 - Based on an analysis of Medicaid cost report data (submitted annually by facilities), all of Connecticut’s nursing facilities exceed the minimum nursing-staff-to-resident-day ratios. The majority of homes provide nursing staff between one-and-one-half to two-and-one-half times the threshold.
 - Information on actual nursing-staff-to-resident levels per shift is not readily available because there are no standardized data collected on a routine basis to monitor nursing staff levels in nursing homes.
 - The Department of Public Health has drafted proposed regulations that would increase the total nursing staff hours per resident day from 1.9 hours to 2.48 hours per day.
 - Connecticut’s average nursing-staff-hours-to-resident-day (3.16) is the second lowest in New England. Maine had the highest average staffing ratio at 3.86.
 - A recently released study by HCFA found a strong relationship between the number of nursing staff and the quality of care provided in nursing facilities. Preliminary findings suggest 2.75 may be the minimum staffing level that reduces the likelihood of quality-of-care problems and 3.00 is a “preferred minimum” ratio, which would contribute to improvements in quality of care.
 - Key barriers to increasing nursing staff are cost and shortage of trained personnel in the labor market.
-

Staffing in Nursing Homes

The Legislative Program Review and Investigations Committee voted to study Staffing in Nursing Homes in March 2000.¹ The study focuses on the current minimum nursing-staff-to-resident requirements, how actual staffing levels relate to the minimum standards, and how the Department of Public Health (DPH) monitors the adequacy of nursing staff. The impact of the 1999 legislative Wage, Benefit, and Staffing Enhancement Program was also included in the scope of the study.

Several factors impact the quality of nursing care provided to residents of nursing homes. Some, such as ensuring staff complete a certain number of training hours, are easier to legislate than others, like guaranteeing each resident is treated with compassion and kindness. A recent study released by the Health Care Financing Administration (HCFA) identified the type and number of nursing staff available to provide care to residents as a key measure of quality.² The study, the first to measure resident outcomes in relation to nursing staff levels, found residents were at increased risk for malnutrition, bedsores, dehydration, and preventable hospitalizations when nursing staff levels dropped beneath 2.75 hours per resident day.

Nursing-staff-to-resident ratios. The program review committee concludes the staffing ratios in Connecticut nursing homes need to be raised. Although regulations of Connecticut's Department of Public Health establish minimum nursing-staff-to-resident ratios (1.9 hours per resident day), these regulations were adopted over 20 years ago. From all accounts in the literature, health care needs of residents have increased. In recognition of this, revision of the regulations began in 1995 -- draft proposed regulations increase the ratio to 2.48 hours per resident day -- but the department has still not submitted them to the legislature's regulation review committee. Thus, although DPH initiated the move to increase the nursing-staff-per-resident-day ratio, the standard remains the same almost six years later.

In addition to the long delays, the proposed DPH regulations may not raise the minimum ratios to adequate levels and therefore the committee did not support that proposal. The committee found the HCFA nursing-staff-to-resident ratio is based on the most comprehensive and defensible research to date, and, therefore, believes it is the most valid. The committee therefore recommends the HCFA study standard, which requires:

¹ Nursing staff is defined as registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides.

² HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000.

-
- 2.0 aide hours per resident day; and
 - 0.75 licensed nurse hours per resident day (of which 0.2 must be provided by a registered nurse).

This recommended standard would require *minimum* nursing staff thresholds, merely establishing a floor below which a facility cannot drop. It does not negate the federal and state requirements that nursing facilities provide adequate nursing staff to meet residents' needs.

Medicaid costs to increase ratios. Government, mainly through Medicaid reimbursement to nursing facilities, pays a majority of the total nursing home expenditures. Connecticut General Statutes Section 17b-340 provides that nursing homes are eligible for direct reimbursement of costs added to comply with changes in the Public Health Code. If minimum nursing staff standards are raised, facilities' per diem Medicaid reimbursement rates would also have to be increased by the state.

The committee estimates the additional Medicaid costs to the state to implement the HCFA minimum staff ratio will be about \$6.8 million. The committee's estimates are contained in Chapter Three, and based on 1999 annual cost report information submitted to the Department of Social Services (DSS) by each Connecticut nursing facility that receives government reimbursement. Increasing nursing staff ratios to 2.75 hours-per-resident-day will require an addition Medicaid cost of \$13.7 million but half of that will be reimbursed to the state by the federal government. Because of these costs, and given Connecticut's budgetary constraints, a two-year phase-in of the standard is recommended. In addition, Congress may provide federal funding, as a result of HCFA's study, as an incentive for states to increase nursing staff ratios. The recommended phase-in would mean Connecticut would still be eligible for any federal funding if it was provided within the next two years.

Nursing staff shortages. Concerns also exist among industry representatives and some policymakers that higher nursing staff thresholds should not be mandated when facilities are having difficulty recruiting nursing staff, particularly licensed nurses. The committee believes its recommendation will not seriously impact that shortage. First, it should be emphasized many of the nursing homes in Connecticut already meet the recommended standard. Much of the staffing increase would be needed by facilities licensed as rest homes with nursing supervision (RHNS). There were 243 facilities with data on file at DSS -- 234 chronic and convalescent nursing homes (CCNH), and 63 RHNS, of which 52 are within a CCNH and nine are freestanding.

The committee found all nursing homes licensed as chronic and convalescent nursing homes (CCNH):

- meet the proposed 0.75 licensed nurse-to-resident ratio; and
- only 39 homes (based on a total of 234) need to increase aide hours to meet the proposed standard of 2.0 hours per resident day.

For rest homes with nursing supervision, 29 facilities would need to increase licensed nurse hours and 52 facilities need to increase nurse-aides-to-resident ratios.

Second, facilities not currently meeting the proposed ratio will benefit from the recommended two-year phase-in. This should provide facilities with some additional time to recruit staff, while DPH implements any recommendations put forth resulting from its study of the nursing shortage in Connecticut. In addition, the methodology used by the committee to calculate the cost estimate for increasing nursing staff to the HCFA ratio allows for the potential use of temporary agency nurses and aides by facilities to meet the new standard.

Turnover in staffing. The program review committee recognizes that one of the issues with staffing in nursing homes is the ability of facilities to retain personnel once hired. The Connecticut Department of Labor provided data for the study that measures overall turnover for *all staffing* in nursing facilities for each calendar quarter during 1998 and 1999. This would include turnover for staff in housekeeping, kitchen, laundry, and other indirect staff as well as for nurses and nurse aides. The committee averaged the leaving rate of all facilities for each year and determined the turnover rate was 43.3 percent in 1998 and 46.3 percent in 1999.

The committee understands these turnover rates are very high -- almost one of every two employees left during each of the two years -- and believes the rates are an indication of the extremely difficult and demanding nature of working in nursing homes. However, the committee believes raising the minimum ratios in nursing facilities may reduce job burnout by making the work environment less stressful and thus reducing turnover.

Assessment of staffing adequacy. The committee also examined how DPH determines, when conducting an inspection, if nursing staff is adequate to care for residents. Although both federal and state laws require nursing facilities to provide sufficient nursing staff to meet the needs of the residents, the committee found the department's ability to assess staffing, beyond determining if the minimum standards have been met, is extremely limited. The committee found there is a lack of federal and state guidance to inspectors on how to evaluate the adequacy of nursing staffing levels based on the needs of residents. A methodology to conduct this evaluation has been recommended by the committee.

Nursing Home Financial Advisory Committee. Finally, this study includes monitoring and reporting on recommendations proposed by the Nursing Home Financial Advisory Committee. This committee was charged with examining financial solvency of nursing homes on an ongoing basis, supporting the Department of Social Services (DSS) and DPH in their mission to provide oversight to the nursing home industry, and conducting a study of the nursing home rate-setting system.

The advisory committee held eight meetings and has been unable to reach any consensus or develop recommendations on how financial solvency of nursing homes should be monitored by DSS. The last meeting of the committee was July 18, 2000, and another was recently scheduled for January 31, 2001. The committee has not undertaken the rate-setting study because legislative funding was never provided.

Report organization. This report contains four chapters. The first presents general background information about nursing homes in Connecticut and the people who reside in them. The next two chapters focus on nursing staff -- what the requirements are, how they are monitored and enforced by Connecticut's Department of Public Health, and what efforts are underway to increase nursing staff. Chapter Two describes the inspection process used by the Department of Public Health to assess the adequacy of nursing staff. The committee's findings and recommendations to improve the inspection process are also provided. Chapter Three summarizes Connecticut's current regulatory nursing-staff-to-resident ratios, describes different nursing staff-to-resident proposals being discussed both nationally and in Connecticut, and presents findings and recommendations related to each proposal. The last chapter analyzes the impact of the Wage, Benefit, and Staffing Enhancement Program, approved by the legislature in 1999, to increase wages and benefits for nursing home employees.

Agency Response

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with an opportunity to review and comment on the recommendations prior to publication of the final report. The response from the Department of Public Health is contained in Appendix A and the Department of Social Services response is in Appendix B.

Background

When an individual becomes ill and needs 24-hour nursing care, or lacks family support and has substantial needs based on limitations in his or her capacity to perform certain activities of daily living (ADLs)¹, it often becomes necessary for that person to enter a nursing facility. The person's level of cognitive functioning and behavioral status are also important in determining if nursing home care is needed. Nursing facilities provide personal and skilled nursing care 24 hours per day. Residents are provided rooms, meals, assistance with daily living, and medical and other therapeutic treatments.

Although nursing home care is used by individuals of all ages, the risk of nursing home placement is greater for the elderly. Furthermore, individuals aged 85 and older are the most likely to need care provided in this setting. Factors influencing a greater demand for this type of care include:

- an ever-increasing elderly population;
- a declining average length of inpatient hospital stays for elderly patients who then receive sub-acute care in nursing facilities;
- social trends, with care no longer being provided by family members; and
- advanced technologies that increase life expectancy rates.

The potential demand for care provided by nursing facilities has important fiscal consequences for states. While the elderly in nursing homes comprise a small percentage of the population, the Health Care Financing Administration (HCFA) projects federal, state, and local governments will spend \$58.1 billion on nursing home care in 2000, of which \$44.9 billion will come from Medicaid and \$11.2 billion from Medicare. In Connecticut, combined federal and state Medicaid expenditures for nursing home care in FY 00 are expected to reach \$985.5 million.

State Organization for Oversight of Nursing Facilities

The Department of Public Health and the Department of Social Services (DSS) are the two agencies in Connecticut overseeing nursing facilities. The Department of Public Health is responsible for regulating nursing facilities. The

¹ Need assistance with eating, transferring from bed to chair, bathing, walking, dressing and grooming, and toileting.

department ensures compliance with federal and state laws by conducting licensure inspections and investigating complaints.

The Department of Social Services establishes eligibility for Medicaid benefits. Within the department, the Certificate of Need and Rate Setting Division establishes the daily payment rates for individual nursing facilities and audits the cost reports submitted by homes. It issues new rates annually based on the costs incurred by nursing homes, subject to inflationary limits, holds hearings, and processes rate appeals. In addition, the Office of the Nursing Home Ombudsmen, required under federal law to advocate for nursing home residents, is also located within the Department of Social Services.

Facility and Resident Characteristics

A nursing facility provides a comprehensive range of services from rehabilitation to custodial care for people of all ages with chronic medical conditions and/or functional impairments. Federal and state law and regulation establish mandatory minimum operating standards. To receive Medicare or Medicaid reimbursement for care provided to beneficiaries of these programs, nursing homes must undergo an inspection (called a survey under federal law) and become federally certified (described in Chapter Two). In addition, all facilities, regardless of payer source, must undergo a state licensure inspection in order to operate.

Number of nursing facilities. As of March 31, 2000, there were 262 licensed nursing facilities with a total of 32,080 beds. The Department of Public Health licenses two categories of nursing facilities in Connecticut:

- **chronic and convalescent nursing homes (CCNH)** for skilled or rehabilitative care; and
- **rest homes with nursing supervision (RHNS)**, which provide personal care and nursing supervision under a medical director 24 hours a day.

The actual number of nursing staff required under Connecticut's regulations depends on the licensure category of the nursing facility. There were 253 CCNH facilities accounting for 93 percent (29,758) of all nursing home beds. A higher level of nursing-staff-per-resident is provided to occupants of these beds because they need more care than occupants of RHNS homes. There are nine free-standing RHNS facilities and 57 RHNS units attached to CCNH facilities. The average occupancy rate for all homes statewide was 95.2 percent.

Ownership. The nursing home marketplace is largely proprietary. In Connecticut, 77 percent of the facilities are operated by for-profit organizations; 23 percent are nonprofit; and a local government operates one facility. In addition, half are independently owned and half are under multi-facility ownership.

Resident demographics. Although other long-term care alternatives exist, nursing homes continue to provide care to many frail elderly. Connecticut regulations require nursing home administrators to submit an annual patient roster and census report to the Office of Policy and Management (OPM) each year. The roster, a list of patients who resided in a nursing facility between October 1 and September 30 of a given reporting year, contains demographic and health

status information about each resident. The analysis below is based on demographic data provided by OPM. Information on admissions is based on 1996 nursing home submissions.

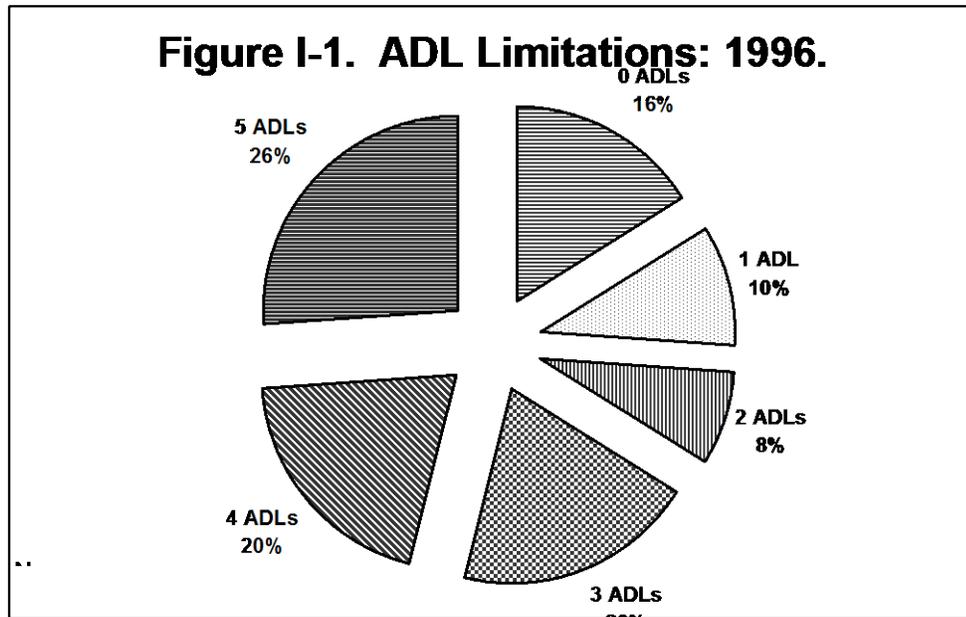
- *Admissions.* The majority (73 percent) of 1996 residents had been admitted to a nursing home from a hospital. The next most common admission origin, accounting for 12 percent of all nursing home admissions, was directly from home. Other sources included rest homes with nursing supervision, mental health hospitals, and residential care homes.
- *Age.* There were 30,591 individuals residing in nursing homes on September 30, 1996. Table I-1 compares the age of residents between two periods -- 1987 and 1996. The number of residents grew 14 percent, while the number of residents aged 85 or older grew 25 percent between the two periods examined. Residents in the 85 and older age group accounted for 48 percent of the nursing home population in 1996.

Age Group	1987	1996
<55	1,163	1,075
55-64	1,370	1,132
65-74	3,613	3,640
75-84	8,665	9,944
85+	11,852	14,800
Total	26,663	30,560

Source: State of Connecticut Nursing Facility Registry, Office of Policy and Management.

- *Gender.* The state's elderly population as a whole, and especially those in nursing homes, is predominantly female. Female residents far outnumber males, representing 74 percent of all nursing home patients.
- *Race.* In 1996, the majority of nursing home residents were white (almost 95 percent). African-American and Hispanic or Latino residents comprised only 5.4 percent, and 1.5 percent, respectively.
- *Activities of daily living dependencies.* The majority of nursing home residents had three or more limitations in performing activities of daily living. Information on the ADL status of nursing home residents was limited to five measures -- ambulating, continence, dressing, feeding, and transferring. The number of ADL limitations each resident has is shown in Figure I-1. In 1996, nearly 8,000 residents needed assistance with all five ADLs, and 6,100 with four. Approximately 3,000 had only one ADL deficiency. Although 5,000 of the residents had no limitations, 200 of these residents exhibited disruptive behavior; 300 wandered or had other passive behaviors; and 800 displayed

other inappropriate behavior that may have contributed to the need for institutionalization.



- *Continence.* In terms of continence, 48 percent of residents had difficulty controlling bladder function, while 41 percent of the residents had difficulty controlling bowel function.
- *Discharges.* Information has also been compiled on all discharges that occurred during 1996. There were 46,336 residents discharged. Thirty-six percent of the residents went to a hospital, 35 percent went home, and 19 percent died. The remaining 10 percent were discharged to veterans', mental health, or chronic disease hospitals, residential care homes, or other nursing homes.

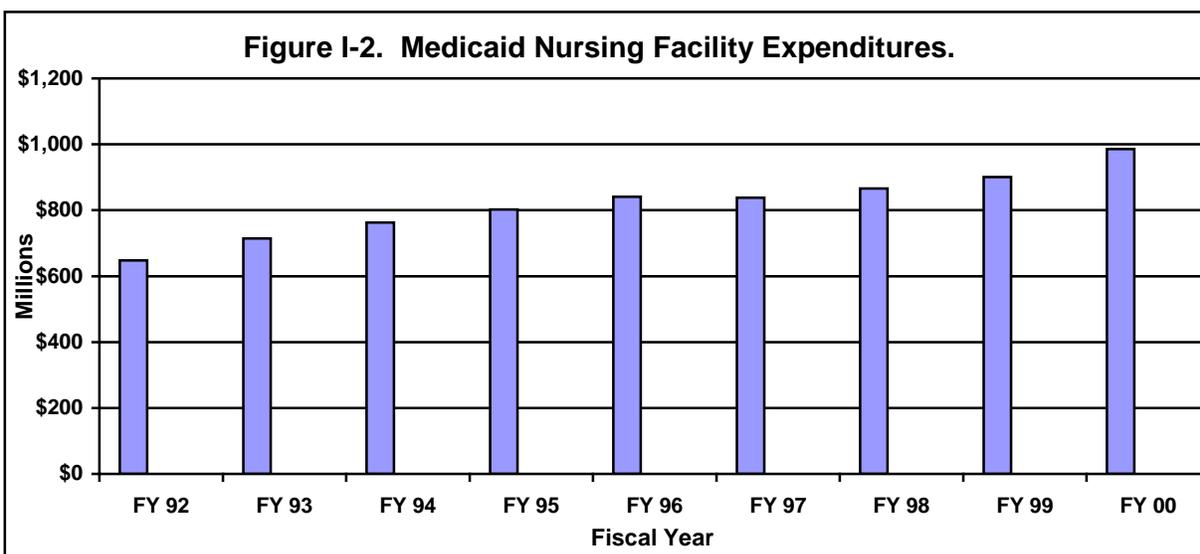
Revenues and Expenditures

Payment Source. The Medicaid program, jointly funded by federal and state government, is the major public program providing coverage for nursing home care. Limited coverage is available under the Medicare program and through private insurance. The average client mix is shown in Table I-2.

Payment Source	Residents	Percent
Medicaid	19,912	68%
Medicare	3,223	11%
Other	6,313	21%

Total	29,448	100%
Source: American Health Care Association, Research and Information Services: March 2000.		

Expenditures. Figure I-2 shows Medicaid expenditures for nursing facilities over the last nine fiscal years. The overall increase in expenditures from FY 92 to FY 00 was 52 percent. The greatest annual percentage increase occurred between FY 92 and FY 93 when expenditures grew 10 percent; followed by FY 99 to FY 00 when they grew 9 percent (including the 8 percent allocated for the Wage, Benefit and Staffing Enhancement Program described in Section IV). There was a slight decline in expenditures from FY 96 to FY 97, with the decrease less than 1 percent.



Another way to examine long-term care expenditures is in relation to total Medicaid expenditures for long-term care (i.e., long-term care provided in settings other than nursing homes). Table I-3 shows that care provided in CCNHs and RHNSs accounts for 83 percent of all Medicaid dollars expended for long-term care and 42 percent of total Medicaid expenditures.

Type of Service	Medicaid Expenditures	Percentage of Medicaid LTCExpenditure
CCNH	\$809,224,468	78%
RHNS	\$56,561,392	5%
Nursing facilities for persons with mental retardation	\$46,494,579	4%
Chronic Disease Hospitals	\$44,242,814	4%
Home Health Care	\$38,541,239	4%
Home and Community-Based Care	\$45,318,814	4%
Total LTC	\$1,040,383,306	100%
Total Medicaid for all Programs	\$2,040,004,240	

Percentage of CCNH and RHNS	42%	
Source: CT Long Term Care Plan, 1999, Appendix D.		

Summary

This introduction provides an overview of the nursing home market in Connecticut, including a snapshot of characteristics of nursing home residents, as well as information on the growth in Medicaid expenditures to pay for resident's care. The remainder of this report focuses on nursing staff – what the requirements are, how they are monitored and enforced, and what efforts are underway to increase nursing staff.

Federal Nursing Staff Requirements

Introduction

Federal and state laws require nursing facilities be inspected regularly. The federal survey (i.e., inspection) process evaluates nursing homes' compliance with federal health, safety, and quality standards. The Health Care Financing Administration (HCFA), which funds the Medicare and Medicaid payments to nursing homes, contracts with Connecticut's Department of Public Health to conduct the federal surveys of nursing homes and report the results. Surveys must occur on average every 12 months, and the time between a facility's inspections cannot be less than nine months or exceed 15 months.

Connecticut's DPH surveys nursing facilities under the federal program, as well as conducts inspections of nursing facilities for state licensure biennially. While there are separate and more specific regulations for state licensure, inspections for state licensure are conducted jointly, and the federal survey process is used for both federal certification and state licensure. If a violation is found during an inspection, separate statements are sent to the facility – one cites deficiencies under federal regulation; the other cites violations under state regulations. The nursing facility must respond separately to each letter – one plan of correction for any federal deficiencies, the other for any state violations.

This chapter provides background information on federal nursing home inspection mandates, describes how DPH carries out those requirements, and contains findings related to the inspection process. In addition, the chapter contains committee recommendations to improve surveys of nursing homes in two ways:

- require a more thorough review of nursing staff adequacy during a facility's standard survey and state licensure inspection by establishing a methodology for DPH to examine the number of nursing staff in relation to resident acuity; and
- make the survey cycle less predictable.

Background

In 1986, the Institute of Medicine (part of the National Academy of Sciences) conducted a landmark study, *Improving Quality of Care in Nursing Homes*, that found widespread abuses and substandard care being provided in nursing homes. This report, in conjunction with general population concerns over inadequate care, led Congress to adopt the Nursing Home Reform Act as

part of the broader Omnibus Reconciliation Act of 1987 (OBRA 87). The act and its accompanying regulations (adopted in 1990 and 1995) instituted major reforms in how nursing homes are regulated. Requirements of the act and accompanying regulations include provisions relating to:

- quality of care, quality of life, resident rights, and resident assessment;
- mandated use of a standardized health assessment instrument for all nursing home residents;
- an inspection process focused on evaluating resident outcomes;
- training standards and competency evaluations for nursing assistants; and
- enforcement sanctions for facilities not in compliance.

A facility's compliance with the regulations is measured through a federal survey process conducted by state inspectors. The focus of the inspection is on ensuring residents are properly assessed, individual plans of care are developed and implemented, and residents receive care to avoid negative outcomes, such as preventing pressure sores and dehydration.

Although no minimum nursing-staff-to-resident ratios were mandated by the 1987 federal law or regulations, Congress recognized nurse and nurse aide staffing are key factors in the provision of quality care to nursing home residents. In 1990, Congress directed the Department of Health and Human Services to conduct a study and report back by January 1, 1992, on the appropriateness of establishing minimum ratios for nursing supervisors to direct care staff and direct care staff to residents and to provide recommendations on such ratios.³ An interim report was issued in 1996, but it was not until July 2000 that phase one of the report was released. The complex nature of the topic and a lack of reliable and uniform data available were cited as the reasons for the delay.

Phase one of the study found a strong relationship between the number of nursing staff and the quality of care provided in nursing facilities. (See Appendix D for the executive summary of the report.) The report's preliminary analysis indicates there are critical ratios of nursing staff to residents below which nursing home residents are at substantially increased risk of quality problems. These ratios are presented in Chapter Three. The second phase of HCFA's study is expected to contain specific recommendations on whether the federal government should adopt minimum standards, and, if so, what those ratios should be and the cost to implement them.

The issue of whether nursing staff ratios should be federally mandated was also the subject of hearings held by the U.S. Senate Special Committee on Aging in November 1999. The hearings were held in reaction to the release of several reports in the late 1990s that criticized the quality of care provided in nursing homes. One report, by the U.S. General Accounting Office, found that of more than 17,000 nursing facilities inspected under the federal survey process, more than one-fourth had deficiencies that caused actual harm to residents or placed them at risk of serious injury or death. The senate hearings "pointed to nurse staffing as

³ Direct care is provided by licensed nurses and nurse aides, and can include hands-on assistance with certain activities of daily living such as bathing, feeding, ambulating, and incontinence care. Nurse aides provide the bulk of ADL assistance to residents. (See Appendix C for a list of activities performed by nurse aides.)

a potential root cause of many of the problems observed. As a result, staffing has emerged as the largest single concern of many consumer advocacy and labor groups.”⁴

Many factors influence the quality of resident care provided in nursing facilities. (See Figure II-1.) Nursing home provider associations believe the issue is far more complex than merely implementing minimum nurse and nurse aide staffing ratios. Their position is that providing quality care to nursing home residents encompasses a wide variety of factors. These include ensuring nursing staff are:

- properly trained and appropriately supervised in their assigned tasks;
- motivated to care for elderly and disabled residents; and
- correctly assess residents’ needs and implement the individualized plans of care.

In addition, nursing facility providers question the policy of raising nursing staff thresholds when they are experiencing difficulties in recruiting nursing staff now because of a nationwide shortage. They also cite retention of nursing staff as problematic, given the demanding nature of the work and opportunities for employment with managed care organizations, other health care facilities, or in other fields. Finally, economic factors are major forces shaping nursing home quality and staffing. The impact of Medicare reductions in 1998 on facility revenues, combined with low Medicaid reimbursement rates and shrinking payments from private payers, make nursing staff increases, without any additional public funding, unlikely.

Identified below are the current federal nursing staff requirements for nursing facilities. In addition, a description of how regulators monitor the quality of care in nursing homes and how the adequacy of nursing staff is determined as part of that process is presented.

Federal Staffing Requirements

The federal government has broad authority to govern nursing homes as a principal payer of services through both the Medicare and Medicaid programs. The 1987 Nursing Home Reform Act mandates nursing homes “*provide nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident*” in accordance with regular assessments and a written plan of care.” Although this requires a facility to ensure sufficient nursing staff to achieve the mandate, there is no definition of the term “sufficient” and there are no set minimum nursing-staff-to-resident ratios. The only federal nursing staff requirements are that all certified nursing facilities have:

- a licensed nurse (either RN or LPN) on duty 24 hours a day;
- an RN on duty at least eight hours a day, seven days a week; and
- an RN director of nursing (in facilities with 60 beds or fewer, the director of nursing and the RN on duty at least eight hours a day may be the same person).

⁴HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, p. I-2.

Figure II-1. Measures of Quality of Care in Nursing Homes

Structural Measures

- staffing levels
- staffing mix
- staff turnover
- wages/benefits
- management/leadership
- availability of private rooms
- volunteers
- Governance
- Age/condition of plan, equipment
- Payer mix
- Case mix
- Accreditation
- Teaching status

Process-of-Care Measures

- Assists with ADL
- Injury
- Infection control
- Resident services
- Overuse of restraints
- Use of urinary catheters
- Bladder training
- Delivery of hotel services
- Assessment of residents
- Abuse prevention
- Quality assurance
- Access and use of medical care
- Resident rights

Outcome Measures

- Mortality
- Hospitalization
- Facility-acquired pressure sores
- Functional status change
- Pain control
- Depression
- Injuries
- Urinary incontinence
- Weight loss
- Infectious disease
- Patient satisfaction
- Family satisfaction
- Thefts/abuse
- Staff injuries/illness
- Staff satisfaction

Source: Nursing Staff in Hospitals and Nursing Homes: Is it Adequate, Institute of Medicine, National Academy of Sciences, 1996, p.130.

Thus, although nursing homes may vary based on the physical size or layout of the facility, the severity of residents' illnesses, or the number of residents being cared for, the federal law does not account for these differences by requiring additional nursing staff. Rather, each facility determines the number and mix of nursing staff to meet the broad mandate of sufficiency, although in reality many state laws have established minimum nurse staffing ratios.⁵

The 1987 federal act also allows nursing facilities to request waivers from the RN staffing requirements in areas where nursing shortages exist. If a waiver is granted by the state (under Medicaid) or the secretary of HCFA (under Medicare) the long-term care ombudsman must be notified, and the facility must notify its residents and their families. No facilities in Connecticut have such waivers.

Inspection Process Required by Federal Law

Federal survey and certification process. The federal government's survey and certification process is used to measure and ensure quality in nursing homes for those homes that receive Medicaid and/or Medicare reimbursement. There are three different types of surveys, and their use depends on the reason for the inspection. They include:

- ***standard survey*** - a yearly comprehensive inspection for facilities that receive Medicare or Medicaid reimbursement in order to obtain or keep federal certification;
- ***abbreviated standard survey*** - a focused inspection on a particular area of concern conducted when a complaint is received and/or a facility's ownership, management, or director of nursing changes; and
- ***extended survey*** - if during a standard or abbreviated survey a nursing facility is found to have provided substandard quality of care the survey team reviews and identifies policies and procedures that produced the substandard quality of care and determines if a facility has complied with quality of life, resident rights, and administration requirement; must include a review of the sufficiency of nursing staff.

Facilities found to be out of compliance with any regulation during the survey process are issued a deficiency. Facilities may be subject to a penalty, but are often given an opportunity to correct the deficiency based on a written plan of correction the home submits to the state agency responsible for the survey. Federal penalties include: a civil monetary penalty; a ban on payments for new admissions; or termination of the facility from the Medicaid and/or Medicare programs. In most cases, such penalties are rarely used, if a facility corrects the deficiency.

⁵ According to a survey conducted by the National Citizens' Coalition for Nursing Home Reform in 1999, 37 states have gone beyond the minimum federal staffing requirements and have specific nurse and nurse aide staffing standards either in statute or regulation. (See Appendix E for listing of states with minimum nursing staff standards.)

Standard survey. HCFA has a highly developed protocol that inspectors must follow when conducting surveys. The protocol requires surveyors to assess resident outcomes (i.e., maintain weight, prevent bedsores, etc.) to determine a facility's compliance status. In addition to federal mandates, there are state licensure requirements, and DPH issues a license to nursing homes every two years. The federal protocol is followed by DPH for both the survey and state licensure inspections.

The standard survey is required for certification for Medicaid and Medicare reimbursement and is used to determine whether nursing facilities are in compliance with federal health, safety, and quality of care standards. It consists of seven tasks (shown in Figure II-2). A survey is conducted by a team of surveyors (one of whom must be a registered nurse) using a federally established protocol. The survey focus is on four areas:

- quality of resident care and services provided;
- accuracy of the mandated standardized resident assessment instrument (RAI) and adequacy of the residents' plans of care;
- review of compliance with residents' rights; and
- safety of the physical environment.

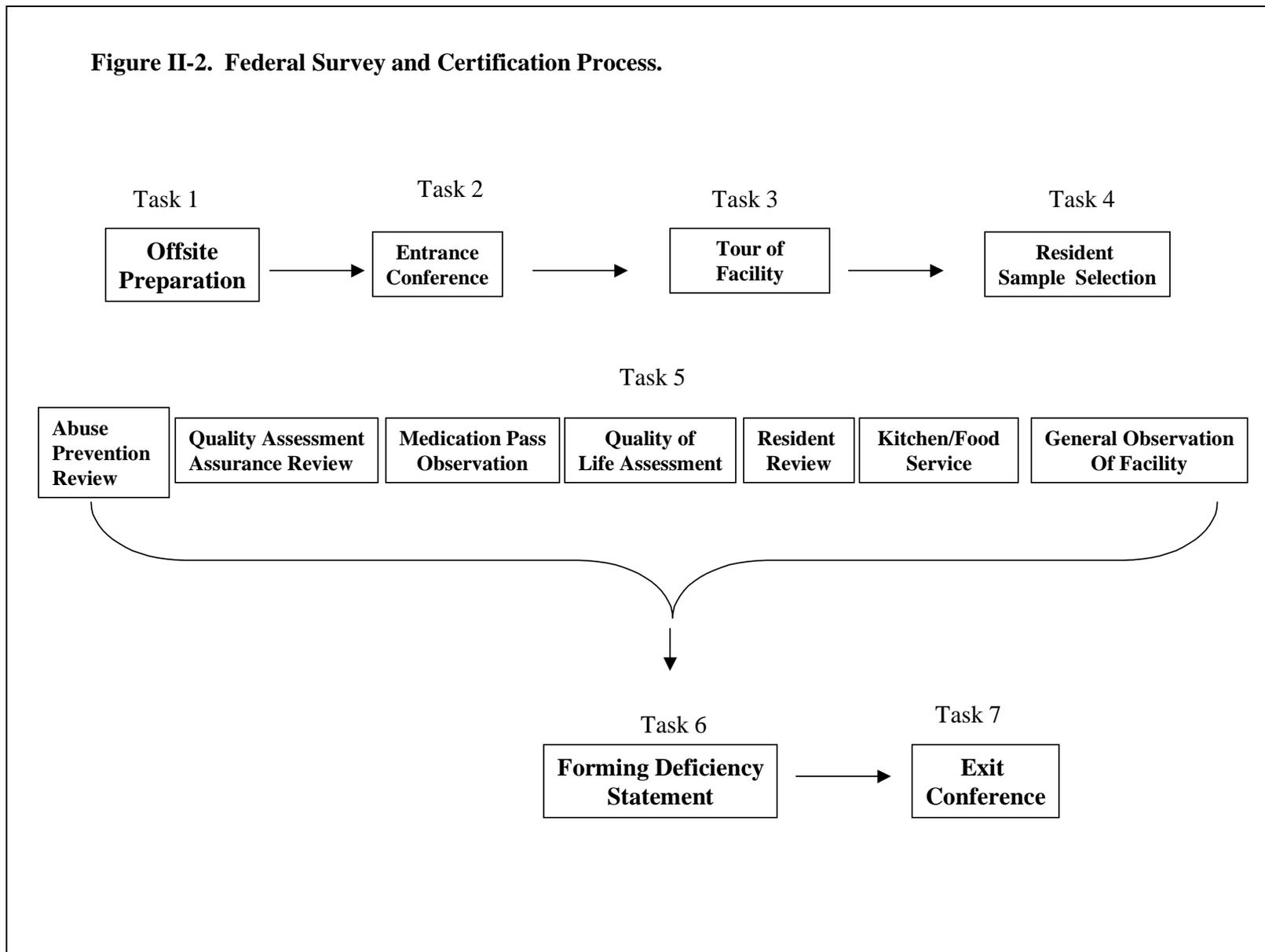
Surveyors develop a sample of residents and conduct intensive reviews of those resident's records. Surveyors directly observe the care provided to the residents in the sample and then evaluate whether the needs of the residents are being met. As part of the review of each facility, the team of surveyors interviews residents, family members, caregivers, and administrative employees.

A typical survey lasts from two to four days. Following the completion of the survey, the team conducts an exit interview with the facility's administration and, if the facility is out of compliance with any of the regulations, a statement of deficiencies is issued to the facility. The facility must respond to any deficiencies with a written plan of correction addressing how the deficiencies will be corrected within 10 days of receipt of survey results. A nursing facility is required to post results of the most recent survey in a place that is readily assessable to residents, family members, and legal representatives of residents.

Deficiencies. There are more than 175 deficiencies surveyors may find and issue to a nursing facility. The extent and type of enforcement actions depend on the scope of problems (whether deficiencies are isolated, constitute a pattern, or are widespread) and the severity of violations (whether there is harm or jeopardy to residents). The scope and severity a deficiency may be assigned range from A (least serious) to L (most serious). Certain deficiencies of H or higher indicate substandard quality of care. These 12 categories can be grouped into four broad classes of violations:

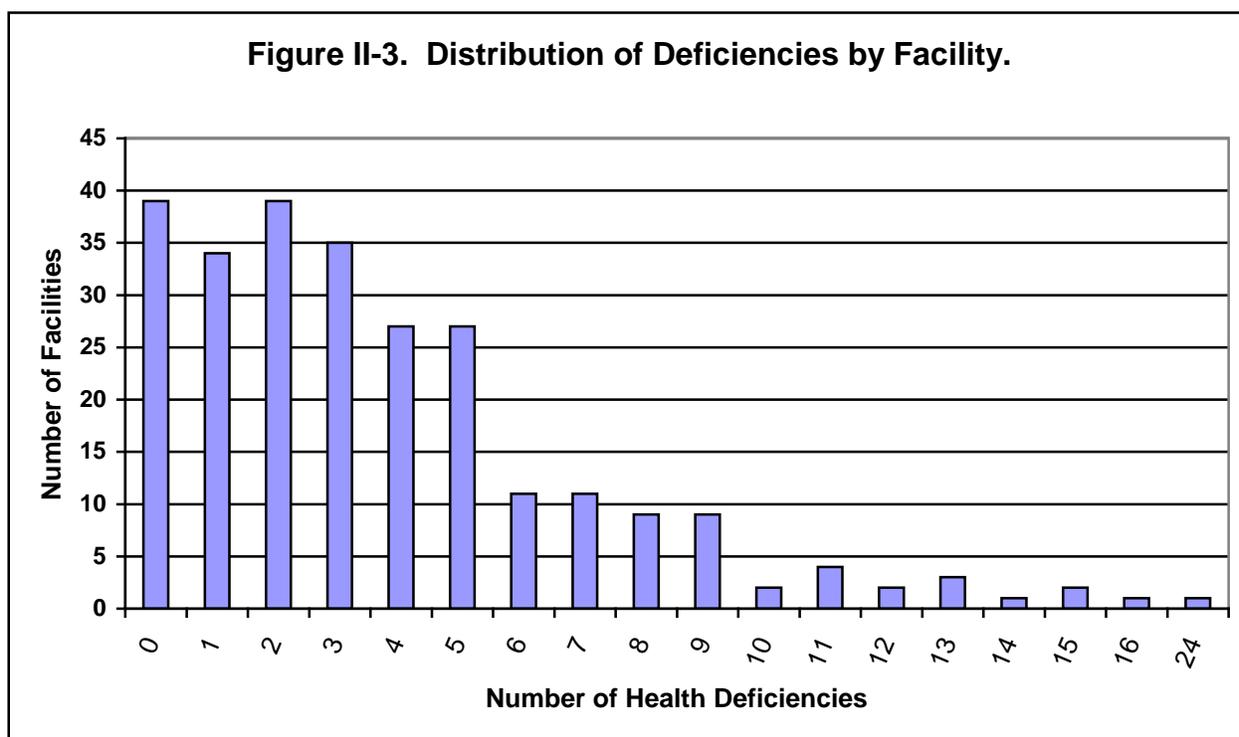
- 1) violations that have the potential for minimal harm (A, B, C);
- 2) violations that have the potential for more than minimal harm (D, E, F);
- 3) violations that cause actual harm (G, H, I); and
- 4) violations that cause actual death or have the potential to cause death or serious injuries (J, K, L).

Figure II-2. Federal Survey and Certification Process.



Connecticut nursing home deficiencies. The program review committee examined data from nursing home surveys conducted between May 28, 1998 and March 7, 2000, to determine the number of health deficiencies issued by the Connecticut Department of Public Health. The data were obtained from the Online Survey and Certification Reporting System (OSCAR) database maintained by HCFA, which contains information on survey results for nursing facilities nationwide. The OSCAR database contained 259 Connecticut facilities.

Figure II-3 shows the distribution of deficiencies among Connecticut's nursing facilities. There were a total of 969 health deficiencies issued to homes statewide. There are eight areas contained in the database from which facilities could receive deficiencies. They include: mistreatment, resident assessment, quality of care, pharmacy, nutrition and dietary, environmental, administrative, and residents' rights.



As shown in the figure, 39 of the 259 facilities (15 percent) had zero deficiencies. The average number of deficiencies issued per facility was three (compared to a national average of five). The majority of facilities receive less than five deficiencies, while one facility earned 24 during its last survey. Of the 969 deficiencies issued, 429 were for quality of care reasons. Deficiencies for quality of care can be an indication nursing staff is insufficient.

Insufficient-staffing deficiency. A review of the adequacy of nursing staff is not a primary focus of the standard survey unless serious quality of care problems are identified prior to or during the course of the survey. State surveyors, as part of the standard survey process, request both the facility's current staffing schedule as well as those for the prior two weeks when they enter the home. Surveyors use the schedule to determine if the facility is in compliance with the federal requirement of 24-hour licensed nurse coverage, and whether there is a licensed

nurse designated on each shift. However, it should be noted there is no other ongoing data collection by DPH on staffing levels over regularly scheduled periods of time.⁶

If states have minimum nursing staff ratios, surveyors would also determine whether the state minimum ratios have been met. Under federal law, facilities must also be in compliance with state and local laws and regulations.

Federal investigative protocol for evaluating adequacy. In July 1999, the Health Care Financing Administration established an investigative protocol that defines procedures to be used for determining sufficiency of staff (see Appendix F). The protocol is triggered when residents experience quality of care problems such as:

- development of pressure sore/ulcer(s);
- unintended weight loss or dehydration;
- declines in functional status such as the ability to bathe, dress, groom, transfer, ambulate, toilet, and eat;
- complaints from residents or their families concerning call lights not being answered in a timely fashion; and/or
- residents not being assisted to eat.

The protocol is used in conjunction with HCFA's "Guidance to Surveyors," a manual for surveyors that provides guidelines and questions to help determine if a facility meets the regulations. According to the protocol, meeting a state's mandated nursing staff ratio does not rule out a deficiency from being issued if care and services are not being provided to residents. In order for a surveyor to issue a deficiency to a nursing facility for insufficient nurse staffing, HCFA's "Guidance to Surveyors" manual states:

the determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat.

To determine if the facility has sufficient nurse staff, there are also a number of "probes" contained in the HCFA guidelines to assist surveyors. The probes are formulated as questions and include the following:

- Is there adequate staff to meet direct care needs, assessments, planning, evaluation, and supervision?

⁶ Public Act 00-216 requires DPH to conduct a study for collecting and analyzing standardized data concerning the linkage between nurse staffing levels and the quality of acute care, long-term care and home care, including patient outcomes. A study of the shortage of nurses in the state is also required under the act. DPH received \$200,000 to fund the study. Findings and recommendations must be reported to the public health committee by December 31, 2000.

- Do work loads for direct care staff appear reasonable?
- Do residents, family, and ombudsmen report insufficient staff to meet resident needs?
- Are staff responsible to residents' needs for assistance and are call bells answered promptly?
- Do residents call out repeatedly for assistance?
- Are residents, who are unable to call for help, checked frequently (e.g., every half hour) for safety, comfort, positioning, and offered fluids and provision of care?
- Are identified care problems associated with a specific unit or tour of duty?
- What does the charge nurse do to correct problems in nurse staff performance?

In addition to a review of these areas, the HCFA investigative protocol states if surveyors identify problems with implementation of a resident's plan of care, surveyors should discuss with supervisory nursing staff how they monitor nursing assistants, ensure adequate numbers of assistants are knowledgeable about the needs of residents, and assure they are appropriately deployed and trained. The protocol also requires surveyors to interview nursing assistants to ensure they are knowledgeable about resident care.

In its recent report on nurse staffing ratios, HCFA found the mandatory protocol introduced in July 1999 for surveyors to use in assessing the adequacy of staffing had no effect. In addition the report states:

the analysis of staffing citations raises 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.⁷

Staffing deficiencies in Connecticut. The program review committee also determined the number of deficiencies that have been issued for insufficient staff by the Department of Public Health between October 1998 and June 2000. As shown in Table II-1, the department cited facilities for insufficient nursing staff only 12 times – with three facilities receiving a deficiency on two separate occasions. Six of the 12 deficiencies cited were based on findings at the time of a survey; five of these occurred exclusively in federal fiscal year (FFY) 2000. Six nursing staff deficiencies resulted from complaint investigations, three of which occurred in FFY 00.

Table II-1. Insufficient Staffing Deficiencies Issued by DPH	
<i>Federal Fiscal Year</i>	<i>Number Issued</i>
FFY 99	3
FFY 00	9
*The scope and severity that a deficiency may be assigned range from A (least serious) to L (most serious). Source: Department of Public Health.	

⁷ HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, p. E-S.-7.

Of the twelve staffing deficiencies issued, five had a scope and severity of "D" and six had a category of "F". A "D" category means the scope of the problem was isolated and there was no actual harm to residents. An "F" category means the scope of the problem was widespread but there was no actual harm to residents. There was one "I" deficiency. This category means the scope of the problem was widespread and there was actual harm to residents but they were not in immediate jeopardy.

Connecticut compared to other states. According to the HCFA report released in July 2000, there is great variation in the rate at which states cite facilities for nurse staff deficiencies. Table II-2 shows the top and bottom five states that issue insufficient staffing deficiencies. Nationally, 6 percent of the facilities in the U.S. were cited for insufficient nursing staff. However, Florida, for example, cited almost 15 percent of the state's 619 facilities surveyed during July 1998, and July 1999, while Arkansas, Connecticut, Rhode Island, and West Virginia issued no citations. Across the states, citation rates range from 0 to 15.4 percent.

Table II-2. Top and Bottom Five States Issuing Deficiencies for Insufficient Staffing, July 1998 and July 1999.			
State	Total Facilities	Number Deficiencies	% Facilities with Staffing Deficiencies
<i>Top Five States</i>			
FL	619	91	14.7%
NM	59	8	13.6%
MI	428	48	11.2%
NH	48	5	10.4%
IN	501	51	10.2%
<i>Bottom Five States</i>			
AK	12	0	0%
CT	212	0	0%
RI	78	0	0%
WV	116	0	0%
NY	429	1	0.2%
Source: HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, pp. 4-12.			

It is important to note, the deficiencies shown in the table are prior to introduction of the investigative protocol established by HCFA. The HCFA study found the mandatory protocol for in-depth review of the number and type of nursing staff, which was adopted in July 1999, had no effect in increasing the rate of citing for nurse staffing deficiencies. However, the study found the protocol is too subjective and not specific enough for surveyors to adequately document insufficient staff.⁸

⁸ HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, pp.431-433.

Post-survey revisit. In most cases, the Connecticut Department of Public Health conducts an on-site, follow-up visit to ensure correction of deficiencies identified by the three types of surveys. Although no time frame is specified in the regulations, DPH indicated to the program review committee this visit generally occurs about eight weeks after the exit conference. If the follow-up visit determines the deficiency has not been corrected, or if any new deficiencies are discovered, the facility must submit another plan of correction, and the department will re-inspect and initiate enforcement action.

Enforcement process. A nursing facility may be subject to a penalty, but is given an opportunity to correct any deficiencies within a specified period of time based on a written plan the facility submits to DPH. HCFA considers the extent of harm (scope and severity) caused by the failure to meet requirements when it takes an enforcement action. Federal penalties include:

- temporary management;
- denial of payment for new admissions;
- civil monetary penalties;
- transfer of residents;
- closure of the facility and/or;
- state monitoring.

In addition, optional remedies are available under federal regulation and include: mandating directed plans of correction; directed in-service training; and additional state remedies. States also have several remedies available and impose sanctions under state law.

To date, the majority of federal enforcement activities in Connecticut have been civil monetary penalties. Denial of payment for new admissions has also been imposed twice. Table II-3 shows the number of enforcement actions by calendar year. As of January 2000, HCFA began requiring a civil monetary penalty be imposed if a facility receives two deficiencies of “G” or higher. The large increase in enforcement activities for the year 2000 is attributable to the rule change. In addition, although more facilities are paying fines, the fines are lower, with the average only slightly more than \$1,000. Only one of the 49 enforcement activities taken in 2000 was for insufficient staffing.

Calendar Year	Number of Facilities	Total Penalties
1996	4	\$21,190
1997	2	\$16,289
1998	2	\$10,920
1999	0	\$0
2000	49	\$51,600

Source: Department of Public Health.

Federal validation surveys. The secretary of the Department of Health and Human Services (DHHS) is required to conduct on-site surveys of a representative sample of nursing facilities in each state within two months of the date the surveys were conducted by the state.

The survey must be conducted in sufficient numbers to allow inferences about the adequacy of a state's survey. According to the Connecticut Department of Public Health, the federal DHHS has conducted these audits, but has not issued a written audit report. However, the department did receive verbal approval its survey findings were valid.

Evaluating Sufficiency of Nursing Staff during the Survey: Findings

Survey protocol for in-depth review of nursing staff. A surveyor's determination of sufficient staff is based on the nursing staff's ability to provide needed care to enable residents to reach their highest practicable physical, mental, and psychological well-being. As noted above, the federal standard survey protocol requires only a cursory review of nursing staff adequacy during a facility's standard inspection. More detailed review of nursing staff sufficiency does not occur under the federal protocol unless serious quality-of-care problems are identified prior to or during the annual survey process, or if a complaint about inadequate nursing staff is received. If surveyors find, during the course of an in-depth review, there is insufficient nursing staff (in terms of the number and/or qualifications), then a deficiency is issued to the facility. However, the protocol does not require the number of nursing staff available to care for residents to be evaluated in relation to residents' acuity.

Sources of staffing data. Prior to conducting a survey, surveyors gather several types of information about the facility and its residents from DPH files. These include a facility's prior survey results; complaints received by DPH from family members, residents, and advocates; any incident reports (e.g., if a resident has fallen, a facility must file a report with DPH); and aggregated resident assessment profiles that measure specific quality indicators (such as the number of residents in the facility who have: had accidents and falls; infections; experienced weight loss or become dehydrated; or have pressure sores). Gathering this information prior to beginning the inspection helps focus it on particular areas of concern. For example, if a high percent of residents are reported to have pressure sores, inspectors would closely examine the facility's policies and treatment protocols, and records of residents with pressure sores to determine if treatment has been provided, and observe care to ensure it is appropriate. The committee found, however, surveyors do not collect any information on nursing staff levels as part of off-site preparation for the survey.

In the opinion of the committee, inspectors need to have a better indication of staffing levels prior to entering the facility to begin a survey. Each facility submits an annual cost report to the Department of Social Services. The report contains the total annual nursing staff hours for RNs, LPNs, and nurse aides. Nursing staff under contract (i.e., pool nurses) are provided for in a separate category. The committee finds that surveyors should obtain this information, along with the total number of resident days from DSS to calculate and compare the average staffing levels as reported in the cost report to actual levels during the survey. If staffing levels are inconsistent, the facility should be able to provide the reasons for the difference.

Measuring resident acuity. Another limitation of the current survey process is its failure to recognize the importance of resident case mix and its relationship to the number and type of nursing staff needed. Case mix is a method of classifying nursing home residents based on their conditions and expected use of nursing and therapy resources. The number of activities of daily living (e.g., dressing, eating, mobility, etc.) with which residents need assistance, as well as other

resident characteristics, has a major impact on facility resource requirements. The level of care needed varies among facilities, with those caring for residents having greater care needs requiring more nursing staff than those with residents with fewer needs.

Under federal law, nursing facilities are required to conduct a “comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.” An assessment of the resident must be conducted: no later than 14 days after the date of admission; if a significant change in the resident’s physical or mental conditions occurs; and at least annually. Facilities use a standardized resident assessment instrument, mandated by HCFA, which includes three components:

- the Minimum Data Set (MDS);
- Resident Assessment Protocols; and
- Utilization Guidelines.

The Minimum Data Set is a core set of screening and assessment elements that forms the foundation of comprehensive assessments for all residents of long-term care facilities. It includes common definitions and coding categories and ensures uniformity in resident assessment across facilities.

Currently the MDS categorizes each resident of a nursing home into one of 44 Resource Utilization Groups, Version III (RUGs III). The bases for the RUG groupings are three staff time measurement studies commissioned by HCFA in 1990, 1995, and 1997. The purpose of the studies was to define the relationship between resident clinical characteristics and nursing staff (both nurse and nurse aide) time consumed for each resident. These RUG groups were used to develop a Medicaid payment system for use by the four states participating in the Multi-State Case Mix Demonstration Project in 1995 and for the development of the Medicare prospective payment system implemented by HCFA in July 1998.

Following the protocols of HCFA’s study, nursing home residents are grouped and assigned to corresponding RUGs III, based on the data results of their last full resident assessment. Similar residents are grouped together into one of the 44 categories. The groups are in seven general categories (in general order of use of nursing time): special rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems and reduced physical function. Classification is based on a resident’s clinical condition, the extent of the services needed, such as rehabilitative services or tube feedings, and functional status. Using HCFA’s pre-determined nursing minutes (both licensed and aide) for each RUG III, the total amount of care time needed per resident can be determined (see Appendix G).

The program review committee believes the RUG-III methodology could be adopted by surveyors as an assessment tool -- along with direct observations, record reviews, and resident/family interviews -- to measure nursing staff sufficiency. For example, if combined resident assessment RUG scores for a facility yield a high score in terms of the number of nursing staff minutes required, but cost report data from DSS and actual staffing schedules reviewed by surveyors indicate the facility’s nursing staff is below the RUG minutes required, a more thorough review of its nursing staff -- including how the facility establishes its staffing needs -- would be triggered.

Summary of Committee Findings:

- *few nursing facilities are issued deficiencies for nursing staff inadequacies;*
- *a review of the adequacy of nursing staff is not a primary focus of the standard survey;*
- *even when serious quality of care problems are identified, it is difficult to link those to insufficient staffing because of subjective and immeasurable protocol requirements;*
- *neither HCFA protocol nor state law provides a benchmark for surveyors to evaluate a facility's nursing staff levels based on a facility's resident case mix; and*
- *Connecticut must follow HCFA's protocol, thus, any additional state requirements to evaluate staffing, if too complex, would require additional staff resources for DPH.*

Given these findings, **the program review committee recommends:**

The Department of Public Health should obtain a nursing facility's annual number of registered nurse, licensed practical nurse, and nurse aide hours and total resident days from the Department of Social Services as reported in the Medicaid cost report prior to conducting a federal standard survey or state licensure inspection. The Department of Public Health's inspectors should calculate, based on the annual hours, an average daily staff-to-resident ratio for each facility and compare it to actual nursing staff levels during the conduct of the survey and/or inspection.

The Department of Public Health, at the time it conducts the federal standard survey and/or state licensure inspection, shall, in addition to current protocols, assess residents' acuity to ensure sufficient numbers and levels of licensed nurses and nurse aides are provided by the facility to meet required resident care needs.

The basis for the acuity system shall be HCFA's published 1995 and 1997 Staff Time Measurement Studies which determine the nursing minutes needed to care for each resident, ranked into any of 44 established resource utilization groups (RUGs). As needed, the Department of Public Health shall update this requirement taking into consideration any future versions of Staff Time Measurement Studies or RUG reclassifications.

Each resident's acuity shall be based on the data results of the last full resident assessment, as required by the Minimum Data Set, the assessment instrument designed by HCFA to assign each resident to a RUG level.

The total number of care hours required by the RUG category scores shall be compared to the amount of care hours actually provided by licensed nurses and nurse aides. If the number of care hours is less than that provided for in

RUG, DPH shall review the facility's documentation, as required by Connecticut State Agencies Regulations Sec. 19-13-d8t(m)(3), as to the methodology used to determine the number, experience, and qualifications of staff necessary to comply with federal and state staffing requirements. Results of the comparison may be used to document insufficient staffing.

Evaluating whether nursing staff levels in nursing homes are sufficient requires a methodology that is flexible, easily calculated, reasonable, and based on established care standards. The best way to assess the adequacy of a nursing home's staffing level is to observe whether all required care tasks can be reasonably completed on each shift. If short cuts are employed or care is not performed timely, then DPH needs to evaluate how the facility establishes its nursing staff levels to ensure appropriate resident outcomes.

The above recommendation provides another assessment tool, along with direct observation, record reviews, and resident interviews to assist surveyors in evaluating nursing staff adequacy. In addition, given DPH staff resources and the other tasks that must be completed under the federal survey protocol, the recommendation should not place extensive additional burdens on DPH staff.

Timing of Surveys by DPH

Another issue identified by the program review committee regards the survey cycle and whether the arrival of surveyors to inspect a facility constitutes a surprise visit or whether the facility can anticipate the inspection. To obtain an accurate picture of a facility's operations, the element of surprise is key for a valid inspection. The committee examined the inspection dates and locations for the last three cycles to evaluate the variability in the survey cycle.

Federal requirements. Under federal law, DPH is required to survey nursing homes on average every 12 months, and the time between inspections cannot be less than nine months or exceed 15 months. A facility is not notified of the date and time of a survey – surveyors arrive unannounced. In 1998, HCFA instructed states to stagger surveys and conduct visits on weekends, as well as early mornings and evenings, when quality, safety and staffing problems may be more likely to occur. However, despite these federal requirements, anecdotal information given by consumer advocates and labor groups during public hearing testimony contends that:

- the survey cycle is still too predictable;
- facilities increase nursing staff around the time of the survey; and
- more night/weekend surveys need to be conducted.

Survey timing. The program review committee examined the number of months between each facility's survey for the past three inspection periods to determine if the survey cycle could be predicted by a facility. Survey schedules examined by the committee occurred between October 1996 and June 2000. Table II-4 presents the analysis.

<i>No. of Days (+/-) of Previous Survey Date</i>	<i>Most Recent Survey Cycle</i>		<i>Previous Survey Cycle</i>	
	<i>No. of Facilities</i>	<i>Percent of Total</i>	<i>No. of Facilities</i>	<i>Percent of Total</i>
W/in 7 days	20	8%	21	8%
Greater than 7 days to 15 days	28	11%	29	12%
Greater than 15 days to 30 days	43	17%	32	13%
Greater than 30 days to 45 days	41	16%	36	15%
Greater than 45 days	118	47%	131	53%
Total	250	100%	249	100%

Source: LPR&IC Analysis.

As the table results show, more than one-third of all surveys conducted occurred within 30 days (plus or minus) of the facility's most recent survey cycle, and 8 percent of inspections were within seven days of the previous inspection date. Evaluation of the variability in the previous survey cycle yielded similar percentages – one-third occurred within 30 days of the prior year's survey, and 8 percent were within seven days.

Multiple surveys within town borders. Another issue raised regarding the inspection process was that surveys were being conducted in given geographic areas during the same cycle periods, making the inspection date more predictable and, therefore, eliminating the element of surprise. To assess this, the committee examined if surveys were conducted in the same town within 30 days of each other. Although there was some variability, the committee found several instances where surveys were performed within 30 days of each other within the same town. For example one town, with three facilities had two surveys conducted in November, and one in February. In another town with seven facilities, four inspections were between August 27, 1999 and October 1, 1999. The other three inspections occurred from February 1999 through July 1999.

Night/weekend surveys. In January 1999, the state DPH began staggering surveys and conducting a set number on weekends, early mornings, and evenings, when quality and safety and staffing problems often occur. Table II-5 shows DPH conducted 13 night/weekend inspections for the last nine months of FFY 99 and 25 in FFY 2000. The selection of facilities for night and/or weekend surveys, according to DPH was based on:

- a facility's compliance history;
- if a complaint was received concerning weekend or night coverage and the facility was due for its survey; and
- whether DPH staff had volunteered for this off-time schedule.

In FFY 00, about 10 percent of all surveys occurred on nights and/or weekends, a fairly reasonable percent in the opinion of the committee.

Table II-5. Night and Weekend Surveys Conducted by DPH.				
<i>FFY</i>	<i>No. Weekend Surveys</i>	<i>No. Evening Surveys²</i>	<i>No. Night Surveys³</i>	<i>Total</i>
FFY 99 ¹	5	5	3	13
FFY 00	7	9	9	25

¹Federal requirement began January 1, 1999, so only 9 months of data represented.
²Evening Shift is from 3:00 p.m. to 11:00 p.m. Surveyors worked second shift because HCFA required some hours after 6:00 p.m.
³Night shift is 11:00 p.m. to 7:00 a.m. Surveyors began at 4 a.m.

Summary of Committee Findings:

- *there is some predictability in the number of days between survey cycles with 8 percent of all surveys conducted occurring within seven days (plus or minus) of the facility’s most recent survey cycle; 20 percent within 15 days; and more than one-third within 30 days;*
- *it appears more difficult for facilities to predict when a survey might occur based on its geographic location; and*
- *an adequate number of night/weekend surveys are being conducted by DPH.*

Because inspections are only a point-in-time snapshot, and most facilities are inspected only annually, the key to DPH inspectors viewing a “typical” day in a nursing facility is to ensure an element of surprise. Although there is some variability in the inspection cycles, there also appears to be a measure of predictability. To correct this, **the program review committee recommends:**

The Department of Public Health should track the date and location of each facility’s federal survey and state licensure inspections to ensure more randomness in the number of days between cycles, with no survey or state licensure inspection occurring within 15 days before or after the previous survey or inspection date.

Nursing Staff Ratios

Over the last several years much interest has been focused on the quality of care provided to residents of nursing homes. One area receiving particular attention among policymakers in many states is legislation that establishes or increases a state's minimum number of nursing-staff-to-residents standards in nursing homes. Advocacy efforts by the National Citizen's Coalition for Nursing Home Reform (NCCNHR), a national consumer advocacy group with state chapters, have been successful in bringing the issue of staffing in nursing homes to the forefront. In addition, a recent study by the Health Care Financing Administration also spotlighted the issue, finding a relationship exists between the number and type of nursing staff in a facility and the quality of resident care.

One area in which most states have imposed a stricter standard than required under federal law is in establishing minimum nurse-staff-to-resident ratios. By establishing higher thresholds, states have recognized there is a relationship between the quality of resident care and nursing staff levels. In addition, the ratios have provided regulators with a specific standard to measure whether facilities meet at least the minimums established by the state.

This chapter describes Connecticut's mandatory nursing-staff-to-resident minimum ratios, summarizes other proposals to increase the ratios, and estimates the costs associated with implementing each proposal. The committee's findings and recommendations are presented at the end of this chapter.

Nurse Staffing Regulatory Requirements in Connecticut

Public Health Code nursing staff requirements. Similar to the federal law, Connecticut's Public Health Code requires each nursing home to "employ sufficient nurses and nurse aides to provide appropriate care of patients housed in the facility 24-hours per day, seven days a week." However, Connecticut's PHC also establishes specific nurse and total direct-care-staff-to-resident ratios. In addition, the code requires the actual number, qualifications, and experience of such personnel be "sufficient to assure" that each patient:

- receives treatment, therapies, medications, and nourishments as prescribed in his/her patient care plan;
- is kept clean, comfortable, and well-groomed; and
- is protected from accident, incident, infection, or other unusual occurrence.

The actual number of nurse and nurse aide staff required under the

Public Health Code depends on whether the home is licensed as a chronic and convalescent nursing home or a rest home with nursing supervision. As noted in Chapter One, CCNH beds represent 93 percent of the total (32,080) nursing home beds in the state. The nurse-to-resident-hours per day are much less for residents of RHNSs because a much lower level of care is needed by those residents.

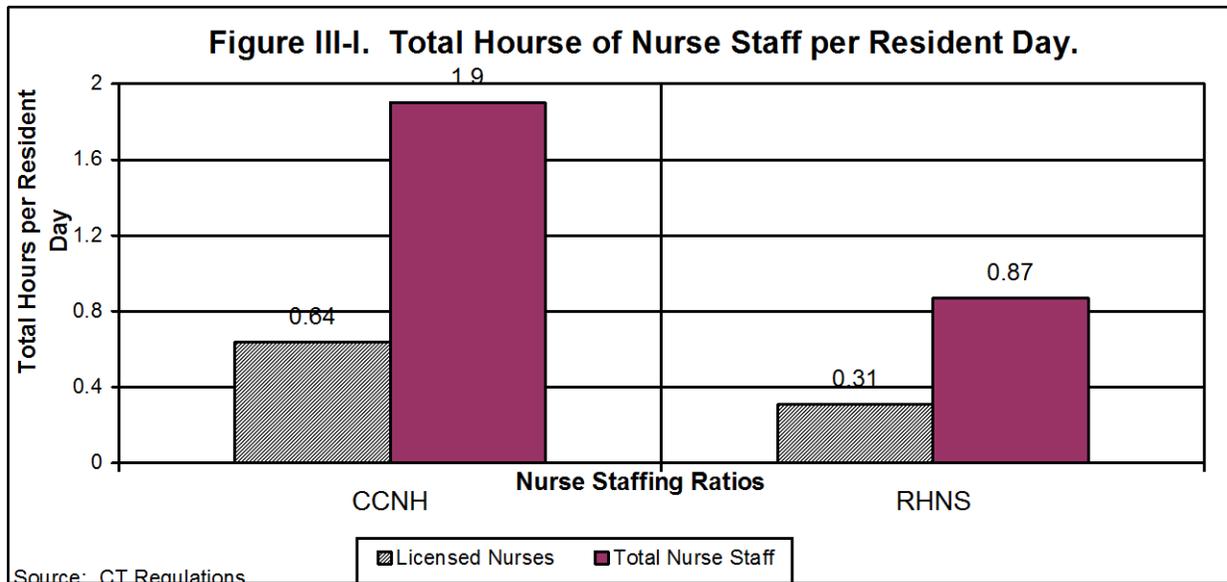
The Public Health Code has a stricter standard than HCFA by requiring each type of nursing home have at least one registered nurse on duty 24 hours per day, seven days a week. In a CCNH, there must be at least one licensed nurse on duty at all times on each resident-occupied floor. In a RHNS, the health code requires at least one nurse aide be on duty at all times on each resident-occupied floor, and intercom communication must be available with a licensed nurse. The facility's administrator and director of nursing are required to meet at least once every 30 days to determine the number, experience, and qualifications of staff necessary to comply with the regulations.

Table III-I describes the minimum nurse and nurse aide staffing requirements for CCNH and RHNS beds in Connecticut. The regulations establish minimum standards for nursing-staff-to-resident ratios during two segments of a 24-hour day and are expressed in terms of staff hours per patient (hpp). For example, on average the regulations require each resident receives 84 minutes of total nurse and nurse aide care during the 7 a.m. to 9 p.m. shift – which equals six minutes for each hour. It is important to note, nurse aide hours per patient are not specifically mandated -- a facility can have any combination of licensed nurses and nurse aides to meet the total nursing personnel category -- as long as the total hours of nursing meets the minimum standards.

Direct Care Personnel	CCHN		RHNS	
	<i>7 a.m. to 9 p.m.</i>	<i>9 p.m. to 7 a.m.</i>	<i>7 a.m. to 9 p.m.</i>	<i>9 p.m. to 7 a.m.</i>
Licensed Nursing Personnel	.47 hpp* (28 min.)	.17 hpp (10 min.)	.23 hpp (14 min.)	.08 hpp (5 min.)
Total Nurses and Nurse Aide Personnel	1.40 hpp (1 hr. 24 min.)	.50 hpp (30 min.)	.70 hpp (42 min.)	.17 hpp (10 min.)

*hpp: hours per patient
Source: CT Regulations Section 19-13D8t.

The current minimum total nursing staff hours per resident in a CCNH bed is 694 hours annually. This means each resident can expect to receive 13.31 hours of direct care each week. Figure III-1 shows the minimum number of nurse and nurse aide hours required per-resident-day is 1.9 hours (one hour and 54 minutes) - an average of less than five minutes of care per resident, per hour. In terms of licensed nursing personnel for a CCNH, the minimum requirement is .64 hours (38 minutes) per day. Licensed nurses or nurse aides may make up the remaining staff per hour. If nurse aides provide all of the non-licensed care that is allowed, they will provide a total of one hour and 16 minutes of care per resident each day.

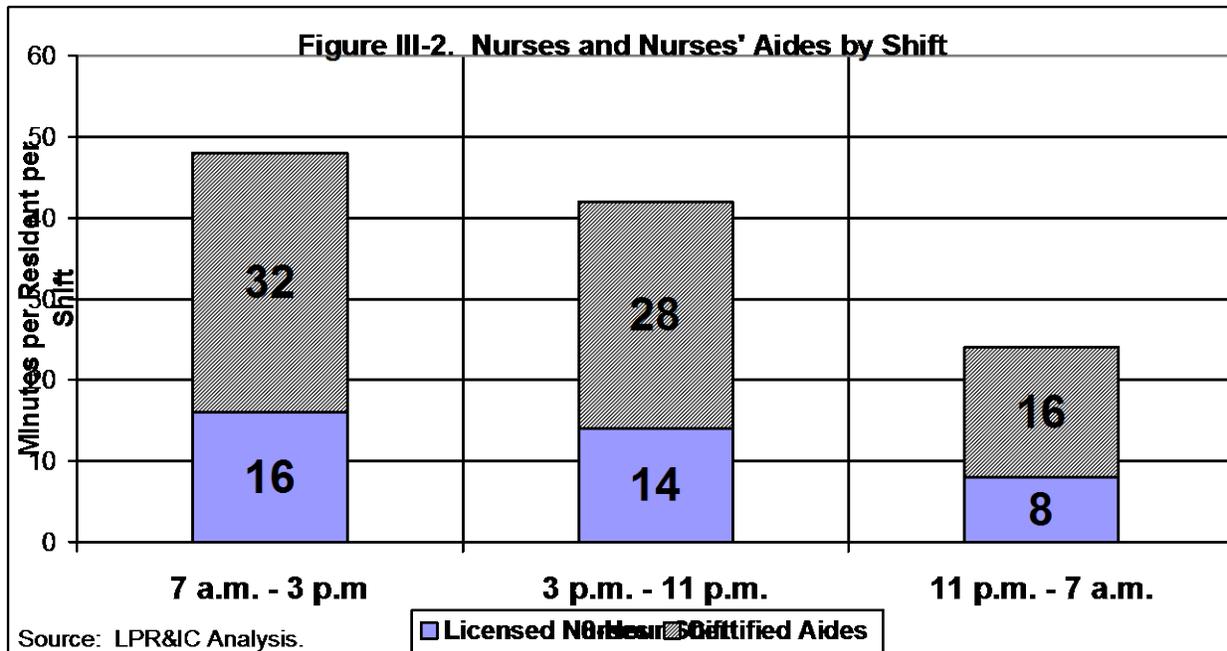


The requirements for RHNS are also presented in the figure. The nurse-to-resident hours per day are much less for rest homes with nursing supervision because those residents do not require the level of care provided to residents of CCNHs. Since these types of beds account for only 7 percent of all licensed beds in nursing homes, the analysis below focuses only on CCNH beds.

Supervisory nurses. Also, it is important to note, depending on the number of licensed beds in a facility, the regulations allow certain supervisory licensed nurses to be counted toward meeting the minimum direct-care nursing staff requirements. In facilities with 60 beds or less, the director of nursing may or may not be included in meeting the direct-care-staff-to-resident ratios. In facilities with 61 beds or more, the director of nurses must not be included in meeting the above requirements. Also, in facilities of 121 beds or more, the assistant director of nurses must not be included in meeting the above requirements.

Breakdown of staff by shifts. The nursing staff coverage mandated under the regulations divides a 24-hour day into two segments. These segments do not match the three-shift coverage (7 a.m. to 3 p.m.; 3 p.m. to 11 p.m.; and 11 p.m. to 7 a.m.) that is typical in nursing homes. For the purpose of analysis, Figure III-2 configures the nursing staff minimums based on a typical home's nurse staffing pattern – three eight-hour shifts. In addition, nurse aides are listed separately, although beyond the minimum licensed nursing staff requirement, any combination of nurses and aides may be used as long as total nursing staff meets the minimum standards.

For the day shift, 48 minutes of total nursing care per resident is required – an average of six minutes of care per hour per resident. The regulations only require half that number of nursing staff at night, with 24 minutes of nursing care per patient per shift – an average of three minutes per resident per hour. The reason for lower nursing staff at night is because residents are asleep and require less direct care than during the day and evening shift.



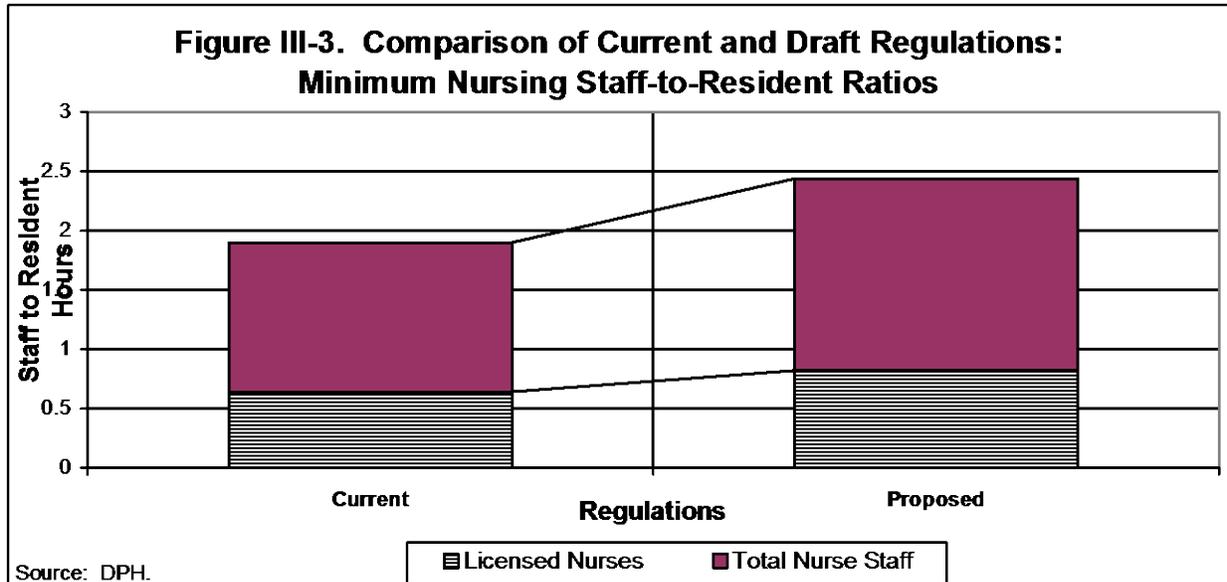
Monitoring nursing staff ratios. A facility’s compliance with nursing-staff-to-resident ratios is measured through the federal survey and state licensure process. As described in detail in Chapter Two, nursing staff schedules are examined by DPH inspectors to ensure minimum ratios are met. If, during the course of an inspection, serious quality-of-care problems are identified, an in-depth review of staffing will occur. Since 1998, DPH has issued twelve deficiencies to ten nursing facilities for insufficient nursing staff. Plans of correction are monitored by DPH to ensure staffing problems are corrected.

DPH Draft Proposed Regulations

The Department of Public Health is in the process of revising the current minimum ratios of nurses and nurse aides to residents that were adopted in 1980. Although draft regulations have been written, they have not yet been submitted to the attorney general’s office for approval.

The draft regulations increase the annual number of nursing-staff-to-resident ratios from 694 to 905 hours – an increase of 211 hours or 30 percent. The proposal also provides more flexibility for nursing facility providers to determine overall nurse staffing patterns by establishing a 24-hour total nursing-staff-to-resident ratio, and only requires set minimums between the hours of 11 p.m. and 7 a.m. Like the current regulations, the draft regulations also require that staffing levels be sufficient to provide necessary care and services to meet the needs of the residents on a continuous basis.

Figure III-3 compares total nurse and nurse aide hours per resident day required under the current and draft regulations. Under the proposed regulations, there must be a total of 2.48 hours of care provided per day, rather than the current 1.9 hours -- an increase of 35 minutes each day.



National Efforts

National Citizens' Coalition for Nursing Home Reform. Beyond the proposals for changes here in Connecticut, efforts have been underway nationwide to examine nursing staff levels and determine whether new federally mandated nursing staff ratios should be adopted. The National Citizens' Coalition for Nursing Home Reform has lobbied for an increase in nursing staff ratios for several years. The nursing staff recommendations proposed by NCCNHR are based on recommendations issued by a panel of experts convened at the John A. Hartford Institute for Geriatric Nursing, New York University, for a conference on "Staffing, Case Mix and Quality" in April 1998. The panel attendees included national experts, consisting of leading nurse researchers, educators and administrators in long-term care, consumer advocates, health economists, and health services researchers.

The panel reviewed current staffing ratios of registered nurses, licensed practical nurses, and nursing assistants, and concluded the current levels are inadequate. Seventeen out of the 30 conference participants endorsed a final staffing recommendation that established 4.55 total nursing hours per resident day as a minimum threshold. Noting that nursing management and leadership are central to providing a high quality of care in nursing facilities, the panel also recommended the director of nursing in nursing facilities have a minimum of a bachelor's degree.

The panel identified cost as a key barrier to adding more nursing personnel. They noted an increase in Medicare and Medicaid spending is needed to increase the number of nursing staff and education and training of staff.

According to NCCNHR, the greatest weakness in the 1987 Nursing Home Reform Act was the failure to establish minimum nursing-staff-to-residents standards. NCCNHR's "Consumer Minimum Staffing Standard" requires a minimum total number of direct nursing care staff of 4.13 hours per resident day, slightly lower than that recommended by the Hartford

Institute panel. These standards take into account the time required to assist residents with their activities of daily living, provide treatments and medications, and plan coordination and supervision at the unit level. In addition to the minimum direct-care-staff standard described below, the threshold protocol also requires every nursing facility to have a:

- full-time director of nurses (DoN) who is an RN with a bachelor’s degree;
- part-time Assistant RN DoN (full time in facilities with 100 or more beds);
- part-time RN director of in-service education (full time in facilities with 100 or more beds); and
- full-time RN nursing supervisor on duty at all times (24 hours, 7 days per week).

Disclosure. The coalition also recommends that each facility post its current number of licensed and unlicensed nursing staff directly responsible for resident care. As part of the disclosure requirement, current ratios of licensed nurses and nurse aides per resident for each wing or floor of the facility should also be posted.

Department of Health and Human Services study. As noted earlier, in July 2000, HCFA issued phase one of a report to Congress, after studying the relationship between nursing staff levels and resident quality of care for almost 10 years. The study found a strong association between nursing staff levels and quality of resident care, with residents of facilities staffing below certain levels at increased risk of bedsores, malnutrition, abnormal weight loss, and preventable hospitalizations. The study methodology included a review of prior literature, a multivariate analysis of the relationship between staffing and quality in three states (New York, Ohio, and Texas), and a time-motion approach to setting nursing staff standards. Preliminary study findings contained in phase one of the report show a strong association between nursing staff levels and the quality of resident cares.

The HCFA study also examines the nursing staff standards put forth by the Hartford Institute panel and adopted by NCCNHR. It notes that “although expert panels are normally established to follow highly structured protocols in reviewing published research for the purpose of making recommendations, [HCFA] cannot determine how the panel arrived at their recommendations, and found it difficult to reconcile our review of selected research on the relationship between nurse staffing and resident outcomes with the Hartford panel.”⁸ As part of the review, however, the study compared nursing staff levels among states and estimated the number of facilities that would need to increase staffing to meet the levels proposed by the Hartford panel. In Connecticut, 97 percent of nursing facilities would need to increase staffing, if the Hartford panel recommendations were adopted.⁹

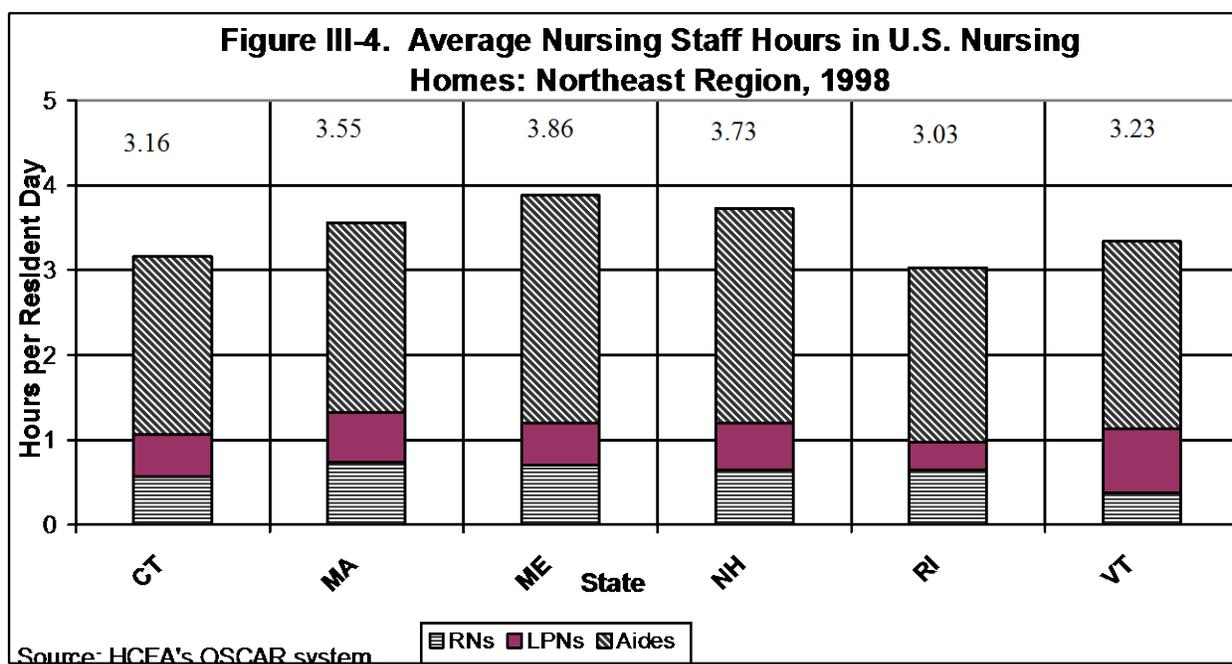
In its comparison of nursing staff hours per resident day among states, data were obtained from HCFA’s computerized reports system (OSCAR). At the beginning of a facility’s survey to receive certification under the Medicare and Medicaid programs, facilities are required to complete a standardized HCFA form on nursing staff hours (by type of staff and function) and

⁸ HCFA, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report to Congress, July 2000, pp. 6-17 and 6-33.

⁹ *Ibid.*, p. 3-40.

certify the information is accurate. This information is entered into the OSCAR system by state surveyors. It is important to note however, that staffing data contained in the OSCAR database are self-reported, and not audited by an independent party.

Figure III-4 compares Connecticut's nursing home staff to other homes in the Northeast Region for 1998. According to the OSCAR database, Connecticut's average nursing-staff-hours-to-resident-day is the second lowest in New England – 3.2 hours per resident day. Maine had the highest average staffing ratio at 3.86, followed by New Hampshire at 3.73. Appendix H shows the average nursing hours per resident for each state in the U.S. The report notes that reasons for variation in staffing levels among states could be due to a variety of factors. These include: the reliability of OSCAR data, acuity level of residents, Medicaid reimbursement rates, labor market conditions, differences in practice patterns, or differences in the quality of care.



Preliminary study findings. HCFA's preliminary study findings identify two possible nursing-staff-to-resident-day standards, both lower than those put forth by the Hartford Institute panel or NCCNR. The ratios include a:

- minimum ratio that may reduce the likelihood of quality-of-care problems; and
- higher "preferred minimum" ratio, which the study indicated would contribute to improvements in quality of care.

It is important to note, neither of these standards has been adopted by HCFA. The second phase of HCFA's study is expected to be completed in the Fall of 2001. This phase will: refine ways to adjust minimum staffing requirements for the case mix, or severity of illness, and the amount of care required by residents in a given facility; expand the study beyond the three states

included in the research thus far; and determine the costs and feasibility of adopting a federal minimum nursing staff standard.

The two staffing ratios contained in phase one of HCFA's study are shown in Table III-2. The preliminary study findings indicate the minimum staffing level associated with reducing the likelihood of quality problems is approximately 2.75 hours per resident day, regardless of a facility's case mix. The preferred minimum total staffing levels at which quality was improved across the board was 3.00 hours per resident day.¹⁰

Table III-2. Department of Health and Human Services Nursing Staff Study.		
Staff	Minimum Staffing Level	Preferred Minimum Level
Aide	2.00 hrs/resident day	2.00 hrs/resident day
RN and LPN	.75 hrs/resident day ¹¹	1.00 hrs/resident day ¹²
Total	2.75 hrs/resident day	3.00 hrs/resident day
Source: Department of Health and Human Services, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000.		

In addition, the study emphasized that ideally nursing staff minimum ratios should be based on the acuity (health and care needs) of residents within a facility. The report notes, however, that no models currently exist to group facilities by resident acuity and thereby establish different nursing staff ratios. Finally, the study also noted that even if cost increases could be absorbed that alone may not be enough to obtain nursing staff at realistic wage levels.

Specifically, HCFA's study findings indicate:

- *levels or thresholds for nursing staff exist, below which facilities are at substantially greater risk for quality problems;*
- *thresholds can be identified for all types of nursing staff;*
- *these thresholds are dependent on a facility's case mix (characteristics of residents in a facility);*
- *nursing staff levels will need to be increased in a substantial portion of facilities across the U.S. to improve quality of care; and*
- *facilities have more quality problems if they have less than 12 minutes of registered nursing care, 45 minutes of total licensed staff care, and 2 hours of nursing aide care per resident per day.*

Comparisons among Connecticut Regulations and Other Staffing Minimums

Table III-2 compares Connecticut's current and proposed nursing-staff-to-resident ratios with those recommended by NCCNHR, and contained in HCFA's nursing staff study. For the purposes of analysis, Connecticut's and NCCNR's ratios are separated into two categories -- nurse aides and licensed nurses; even though any combination of nurse aides and licensed nurses

¹⁰ Ibid., E.S.-6.

¹¹ Of the 0.75 hours per resident day, 0.2 must be provided by an RN.

¹² Of the 1.00 hours per resident day, 0.45 must be provided by an RN.

can be used beyond the minimum licensed nurse requirements. Although NCCNR has the highest total hours, HCFA's preferred minimums exceed all of the other proposals for licensed nurse hours per day.

Proposals	NA	Licensed Nurse	Total Hours
CT Regulations	1.26	.64	1.9
CT Proposed Draft Regulations	1.66	.82	2.48
HCFA Preliminary Minimums	2.00	.75	2.75
HCFA Preliminary Preferred Minimums	2.00	1.00	3.00
NCCNR's Consumer Standard	2.93	1.20	4.13

Source: LPR&IC Analysis.

The program review committee converted the various minimum-staffing ratios from hours-per-resident-day to the number of nursing staff that would be required based on a hypothetical 8-hour a day shift. The results are shown in Table III-4.

8-Hour Shift	CT Current Regulations	CT Proposed Regulations	HCFA Preliminary Findings of Nursing Ratios		National Citizens Coalition for Nursing Home Reform
			<i>Minimum</i>	<i>Preferred</i>	
Day					
-NA	1:14	1:9	1:8	1:8	1:5
-Licensed	1:30	1:18	1:21	1:16	1:15
Evenings					
-NA	1:16	1:18	1:12	1:12	1:10
- Licensed	1:33	1:37	1:32	1:24	1:25
Night					
-NA	1:31	1:25	1:24	1:24	1:15
- Licensed	1:57	1:50	1:64	1:47	1:35

Source: LPR&IC Analysis.

Selected Other States

Although the majority of states (35) have established some type of nursing staff requirements that go beyond the federal law (i.e., licensed nursing services 24 hours per day, seven days a week, with a registered nurse on duty for at least eight of those hours), the requirements vary considerably from state to state. In addition, there has been a flurry of proposed state legislation to establish (for states without requirements) or increase nursing-staff-to-resident ratios as the way to improve quality of nursing home care. Indeed, at least 14 states, including Connecticut, raised legislation during the 2000 session concerning nursing staff ratios. States that recently increased their nursing staff standards include California, Delaware,

Kentucky, Maine, Maryland, and Minnesota, and all vary in terms of the minimum number of nursing hours per resident-day required. (See Appendix I for Office of Legislative Research Report describing legislation.)

Most of the proposed legislation has been based on the standards put forth by NCCNHR. The reason for this, in the opinion of the committee, is the NCCNHR standards received national exposure and been extensively lobbied. In addition, until HCFA released its study in July 2000, there were no other national proposals existing; thus, NCCNHR's were the *only* standards. However, it appears the NCCNHR standards were arrived at by a consensus based on expert opinion, rather than any empirical study findings.

Other New England states. The committee also conducted a telephone survey of the other five New England states to determine if they have nursing staff standards and how they monitor staffing in homes. Four of the states do not have standards, but follow federal requirements. Maine and Connecticut are the only two states that have minimum nursing staff ratios in statute or regulation. Rhode Island proposed legislation during its last legislation session, but it was not adopted.

In its last legislative session, the state of Maine adopted legislation increasing nursing staff levels. It defines direct care providers and requires, by October 1, 2000, minimum ratios of one direct care provider for every five residents for the day shift, one to 10 residents for the evening shift, and one to 18 for the night shift. These standards equate to a ratio of 2.84 hours of direct care per resident-day.

According to Maine's Nursing Home Ombudsman's Office, the majority of Maine's 113 nursing facilities already meet the newly adopted standard with only 11 facilities needing to increase their nursing staff levels. In addition, the legislation requires Maine's Department of Human Services to begin developing staffing ratios based on resident acuity levels and report its progress to the legislature by May 2001. However, the program review committee contacted a spokesperson within the Bureau of Elder and Adult Services in December 2000, and was told that work on developing acuity based staffing ratios has been postponed indefinitely, primarily because no accepted model exists, and the state first needs to implement the nursing staff ratios adopted in the legislation.

Committee Analysis of Nursing-Staff-to-Resident Ratios in Connecticut Nursing Facilities

There are no standardized data collected on a routine basis to monitor nursing staff levels in nursing homes so information on nursing-staff-to-resident levels per shift is not readily available. The OSCAR database and the Annual Report of Long-Term Care Facility (known as the Medicaid cost reports) are the only two aggregated sources of staffing data available in Connecticut. Staffing data contained in both the OSCAR database and the 1999 Medicaid cost reports are self-reported, not audited by an independent party, and are not validated against another source.

Nursing facilities report their costs annually to DSS. The Medicaid cost reports provide a comprehensive listing of facility staffing by total costs and hours, including nursing pool (i.e.,

temporary nursing) staff. The cost reports are used by the state to set a facility's Medicaid reimbursement rate.

Staffing and quality of care. A relationship between staffing and quality of care in nursing homes is inherently logical. However, the correlation is difficult to demonstrate because of the complexities in defining and measuring quality, the lack of valid nursing staff data, and the differences in residents' acuity levels among facilities. The committee obtained inspection data for each facility from the Department of Public Health to determine if the number of deficiencies issued to a facility correlated with the annual number of nursing staff hours each facility reported on its 1999 Medicaid cost report. The purpose of the analysis was to determine if facilities that received a high number of deficiencies reported less staff per resident day than those with zero or only one deficiency.

Analysis of deficiencies issued and staffing levels. The committee found no correlation between the number of deficiencies issued to a facility during its last inspection and the ratio of nursing and aide staff hours per resident day. A primary limitation of the analysis was resident case mix for each facility was unknown. As noted in the HCFA study, "controlling for case mix is essential in explaining the association between staffing and quality. Without adequate control for resident case mix, facilities that staff more heavily could score worse on quality measures merely because their residents have the greatest care needs and are at greatest risk for poor outcomes."¹³

Nursing homes meeting or exceeding nursing staff minimum ratios. The program review committee compared the minimum regulatory nursing staff requirements to actual hours of nursing staff reported by facilities in its Medicaid cost reports. There are several caveats attached to the data used for an analysis of the distribution of nursing staff among Connecticut's nursing facilities. First, the number of hours reported for RNs, LPNs, and nurse aides by facilities is self-reported and not audited by DSS. In addition, there are no uniform definitions for reporting on nursing staff hours. Thus, while some facilities may report paid hours, which include any vacation, sick, and personal time accrued, others might report actual hours worked. Third, nursing staff hours are reported on an annualized basis, but daily, weekly, and monthly nursing staff fluctuations may vary considerably. Finally, data were available for only 226 facilities out of the 253 licensed CCNHs, and estimates are based on an average 95 percent occupancy rate, rather than a facility's actual occupancy.

Based on an analysis of 1999 cost report filings, all of Connecticut's nursing facilities licensed as CCNHs exceed the minimum nursing-staff-to-resident-day ratios established under the regulations. Although the regulations require 694 annual minimum nursing staff hours for CCNHs, all nursing homes licensed under the CCNH category had 754 annual hours or more per bed in direct care staffing. Based upon the data contained in the cost reports, there was an average of 1,435 direct care hours per resident per year; more than double that required under the regulations.

¹³ HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, p. 10-2.

Table III-5 shows the distribution of nursing staff hours in relation to the minimum standard of 694 nursing staff hours per resident day. One hundred and ten homes (49 percent) of those in the database reported nursing staff hours at one-and-one-half to two times the hours required under the regulations. The majority of homes provide nursing staff between one-and-one-half to two-and-one-half times the threshold -- well above the minimum.

The table shows that nursing homes have clearly staffed at levels above the minimum standards set by the state. The reasons for doing so relate to meeting residents' needs and providing a quality of care consistent with the level of funding provided by the state.

Table III-5. Facility Distribution of Total Nursing Staff Hours per Bed.	
Total Nursing Staff	CCNH Total Facilities=226
<i>Hours</i>	<i>Number of Facilities in Each Category</i>
Minimum Hours Required = 694 hours	226 (100 %)
Category 1: 695 – 1,041 hours (exceeds minimum hours by up to 1.5 times)	3 (1 %)
Category 2: 1,042-1,388 hours (exceeds minimum hours by 1.5 – 2 times)	110 (49%)
Category 3: 1,381-1,735 (exceeds minimum hours by 2 – 2.5 times)	96 (42%)
Category 4: 1,736 – 2,082 hours (exceeds minimum hours by 2.5 – 3 times)	12 (2 %)
Category 5: 2,083+ hours (exceeds minimum hours by 3+ times)	5 (1%)
Total Exceeding Minimum Standards	226 (100%)

Source: LPR&IC staff analysis of 1999 Medicaid cost reports, DSS.

Although Connecticut established minimum nursing staff standards in 1980, almost all nursing facilities have staffing patterns that exceed those minimums according to Medicaid cost report data. In addition, since 97 percent of the facilities go beyond the minimum-staffing ratio, the threshold may be meaningless as a measure for regulators to use in determining the adequacy of nursing staff. Finally, although most facilities have higher levels than required, there is still wide variation among nursing facilities. Although the severity of residents' illnesses should account for much of this variation, there has been no analysis done at the state level that links higher nursing staff to facilities that serve sicker residents.

Medicaid Cost Estimates for Increasing Nursing Staff

A key barrier to adding more nursing staff is the cost, especially to the government, which pays a majority of all nursing home expenditures. The amount of increased funding would be dependent upon the number of additional staff needed to meet new minimums, and the cost of that added nursing staff on nursing home operations.

Current per diem rates set by the social services department account for each facility's present staffing levels. If minimum nursing staff standards are raised, per-diem rates would also have to be increased by the state. Connecticut General Statutes Section 17b-340 provides that nursing homes are eligible for direct reimbursement of costs added to comply with changes in the Public Health Code (PHC). Therefore, any increases in nursing-staff-to-resident ratios would require additional funding, most likely through the Medicaid program.

Table III-6 provides cost estimates for increasing the nursing-staff-to-resident ratios, based on the four nursing staff proposals presented earlier in this chapter. The estimates are derived from 1999 Medicaid cost report information submitted annually to DSS by all nursing facilities. The database contained complete information for 243 facilities. This included 234 CCNH facilities, of which 55 also were licensed as RHNS, and nine freestanding RNHS facilities.

The estimates show the total cost to increase nursing staff levels would range from \$12.7 million to \$111.1 million, depending on the standard adopted. The state is only responsible to reimburse facilities for residents who receive Medicaid -- about 70 percent of all nursing home residents. The third column of the table shows the increased Medicaid cost. Any Medicaid costs incurred as a result of increasing staffing would be eligible for 50 percent reimbursement from the federal government. The state share (half of the Medicaid cost) is shown in the last column of the table. The extent to which homes staff at higher levels than those mandated -- either in order to provide for nursing staff absenteeism or because of greater resident needs -- determines if additional costs will be incurred.

Table III-6. Implementation of Nursing Staff Ratios: Increased Cost Estimates.					
<i>Proposal</i>	<i>Number of Additional Hours Needed</i>		<i>Total Cost</i>	<i>Medicaid Cost</i>	<i>State Share</i>
	<i>Aides</i>	<i>Nurses</i>			
CT Proposed Reg.	557,113	119,375	\$12,714,509	\$8,900,156	\$4,450,078
HCFA Minimum	1,038,930	91,776	\$19,538,767	\$13,677,136	\$6,838,568
HCFA Preferred Minimum	1,038,930	295,757	\$26,042,719	\$18,229,903	\$9,114,952
NCCNHR's Consumer Standard	6,840,727	353,896	\$111,126,134	\$77,788,294	\$38,894,147

Source: LPR&IC Analysis.

It should be noted, under the DPH proposed and the HCFA minimum ratios, no new licensed nurses would be needed by CCNHs. Thirty-one facilities licensed as RHNS would need additional licensed nurse hours, if either of these standards were adopted. Adoption of the NCCNHR standard would impact the most facilities, with 215 CCNHs needing to increase aide hours, and 94 CCNHs needing to increase nurse hours. Almost all of the RHNS would need to hire additional nurses and aides to meet the NCCNHR proposal.

Methodology for estimates. The methodology used to calculate estimated costs is predicated on a number of assumptions. First, all hours reported for licensed nurses are included

in the calculation.¹⁴ Next, it was assumed all of the nursing facility staff hours reported included paid vacation, sick, holiday, and personnel time, not only hours worked. Therefore, the annual number of nurse and nurse aide hours reported were reduced by 12 percent (six weeks of paid time off) to estimate actual hours worked.

To account for the use of nurses and aides supplied by temporary agencies, half of the total licensed nurses hours needed were calculated at an average pool nurse wage rate of \$36.23, and half at an average facility-based hourly wage rate of \$27.54 (includes 23 percent fringe). For nurse aides, one-quarter of the total number of hours needed were calculated at an average pool aide wage rate of \$19.50, and three-quarters at an average facility-based rate of \$14.82 (includes 23 percent fringe). Finally, an inflation factor of 6 percent was added to the total estimated cost to account for the time lag between the cost information contained in the 1999 Medicaid reports (based on reported expenditures and hours from October 1, 1998, through September 30, 1999) and likely costs at the end of the 2002 state biennium budget year.

Summary of Committee Findings:

- *Connecticut's current nursing staff ratio requirements are confusing, administratively complicated, and limit a facility's flexibility - currently, there are eight separate nursing-staff-to-resident ratios depending on:*
 - *a facility's licensure category, and*
 - *the time of day;*
- *the current ratios were established in 1981, almost 20 years ago while from all accounts in the literature, the health care needs of residents have increased;*
- *with the percent of total nursing home residents aged 85 and older increasing in Connecticut's facilities, other assisted living housing options available for individuals who do not need the level of care provided for in a nursing home, and a trend of shorter hospital stays so that sub-acute care is being provided in nursing homes, homes increasingly care for the most frail and needy population;*
- *DPH began revising the current regulations in 1995 and almost six years later they still have not been submitted to the Regulation Review Committee; and*
- *the only nursing staff ratios based on analysis of resident outcomes are those put forth by HCFA.*

¹⁴ All nursing hours except those of the director of nursing had to be included in the calculation because they are reported together for the Medicaid cost reports. Thus, there is no way currently to separate direct care nursing hours from those spent performing administrative or other indirect care.

Based on the committee findings that current ratios are outdated, inflexible, and that attempts to approve regulations since 1995 have yet to produce results, **the program review committee makes the following recommendations:**

The state Department of Public Health shall not issue or renew the license of a nursing facility unless that facility employs the nursing personnel needed to provide continuous 24-hour nursing care and services to meet the needs of each resident in the nursing facility.

By October 1, 2001, aggregate licensed nursing and nurse aides staffing levels shall be maintained at or above the following standards for nursing facilities licensed by the Department of Public Health as chronic and convalescent nursing homes and rest homes with nursing supervision:

- **Over a 24-hour period, each facility shall provide:**
 - **At least 1.66 hours of direct care and services given by nurse aides per resident; and**
 - **at least 0.7 hours of care and services given by licensed nurses per resident, of which 0.1 hours shall be provided by a registered nurse.**

By October 1, 2002, aggregate licensed nursing and nurse aides staffing levels shall be maintained at or above the following standards for nursing facilities licensed by the Department of Public Health as chronic and convalescent nursing homes and rest homes with nursing supervision:

- **Over a 24-hour period, each facility shall provide:**
 - **at least 2.0 hours of direct care and services given by nurse aides per resident; and**
 - **at least 0.75 hours of care and services given by licensed nurses, of which 0.2 hours shall be provided by a registered nurse.**

The director of nurses shall not be included in satisfying the licensed nursing staff requirement for facilities with a licensed bed capacity of 61 or greater.

Facilities with a capacity of 121 licensed beds or greater shall employ a full-time assistant director of nurses who shall not be included in satisfying the licensed nursing staffing requirement.

“Direct care” means hands-on care provided to residents, including, but not limited to, feeding, bathing, toileting, dressing, lifting, and moving residents. Direct care does not include food preparation, housekeeping, or laundry services, except when such services are required to meet the needs of an individual resident on any given occasion.

Each nursing facility licensed by the Department of Public Health as a chronic and convalescent nursing home or a rest home with nursing supervision that fails to meet the minimum nursing staff-per-resident ratios on any day shall submit a quarterly report to the Department of Public Health. The report shall identify the day(s) and shift(s) the minimum nursing staff ratios were not met, how they were not met, and the reason(s) they were not met.

Upon determination by DPH that evidence exists of a pattern of failure to comply with mandated staff ratios, the Department of Public Health shall have grounds to take enforcement action in accordance with C.G.S. Sec. 19a-524.

The program review committee believes the minimum nursing staff ratio suggested in HCFA's study is based on the most comprehensive and defensible research to date. Furthermore, the establishment of minimum nursing staff standards does not negate the federal and state requirements that nursing facilities provide adequate nursing staff to meet residents' needs. Minimum staffing thresholds merely establish a floor below which a facility cannot drop. In addition, the requirements under the Department of Public Health's current regulations (i.e., full-time director of nurses, 24 hour RN coverage seven days a week, and designated RN supervision per shift, etc.) would still be in effect beyond the statutorily increased minimum nursing-staff-to-resident ratios.

When minimum standards are set, the goal is to ensure those standards are adequate for residents with the lowest acuity or fewest needs. Facilities, however, should base nursing staff decisions on the acuity level of residents in their care. The committee believes many facilities already do this. In fact, the average number of nurse and aide hours per resident per year (1,435) for 1999 was more than double the required number under Connecticut's current minimum thresholds.

Minimum staffing ratios are only one tool in ensuring quality of care in nursing homes, but an extremely important one. Therefore, it is imperative the staffing ratios accurately reflect the requirements necessary to meet the needs of residents currently in nursing facilities. The program review committee believes the HCFA minimum standards are the most accurate and appropriate to meet these needs.

To be effective, staffing ratios need to be checked and verified. The program review committee believes the new ratios, along with the improved method to assess staffing during inspections as recommended in Chapter Two, should improve oversight of quality of care. In addition, the recommendation includes another oversight mechanism of staffing ratios – a requirement that facilities report when they cannot meet the minimum standards. While this is a self-reporting requirement, it should provide regulators with additional information in preparing for individual facility inspections, as well as serve as an indicator if staffing problems are occurring in certain geographic locations or within the nursing home industry overall.

The recommendation also provides flexibility in a number of ways. It moves to a single 24-hour ratio for both nursing facility licensure levels (CCNH and RHNS) and eliminates the

separate requirements for different ratios for two segments of a 24-hour day. Most of the RHNS are a separate wing of a CCNH facility; thus, facility administrators need greater flexibility in allocating staff resources. Elimination of the segmented shift requirements allows administrators to place staff resources where residents most need them.

Finally, the recommendation has a two-year phase-in for the mandated higher nursing staff levels. The reason for this is three-fold. First, facilities are having difficulty recruiting and retaining licensed nurses and, to a lesser extent, nurse aides. A study currently being conducted by DPH will contain recommendations to address the shortage. Phasing in the nursing staff ratios will allow some time for those DPH recommendations to be adopted and implemented, before the full impact of the increased mandates will take effect. Second, adoption of the HCFA minimum standard will cost the state an additional \$6.8 million per year. A phase-in allows those costs to be spread over a two-year period. Lastly, recommendations will most likely be proposed once HCFA completes its study. If funding incentives to increase staff ratios are part of the HCFA proposal, Connecticut should still have an opportunity to access them.

Nursing Home Wage, Benefit, and Staffing Enhancement Program

The Nursing Home Wage, Benefit, and Staffing Enhancement Program was established under Public Act 99-279 to enable nursing facilities to increase current employees' wages and benefits and/or add direct and indirect care staffing. The wage enhancement program was allocated \$75 million in the FY 00 budget year, retroactive to April 1, 1999. The act also increased each home's per diem rate, resulting in additional funding of \$10 million in FY 00 and \$22.8 million in FY 01.

Allocation Formula

The act required the commissioner of DSS to adjust nursing home Medicaid rates for the period April 1, 1999, through June 30, 1999, by a per diem amount representing each home's allocation of funds appropriated under the enhancement program. A facility's share of the enhancement initiatives funds was based upon its percentage of total direct (e.g., nurses and nurse aides) and indirect (e.g., dietary, housekeeping, and social work) costs, during the 1998 cost reporting year, in relation to the costs of all facilities, adjusted for Medicaid days. Nursing pool costs were included in the calculation. The per diem increase was then built into a facility's 2000 Medicaid rate issued by DSS.

Program funds. The Medicaid cost reports are filed by each facility based on annual expenditures from October 1 through September 30. Since the act provided for per diem increases as of April 1, 1999, and program funding of \$75 million was allocated on an annualized basis, \$37.5 million was available for the first six months of the program (April 1, 1999 – September 30, 1999).

There were 252 facilities that received enhancement funds. The per diem add-on ranged from \$3.47 to \$17.69 per Medicaid resident. The average per diem received was \$9.92 per facility.

Allowable Increases

Although a facility's enhancement allocation is based on direct and indirect employee costs, funds could also be applied toward salary, wage, and benefit increases for employees categorized in certain administrative areas such as office support and maintenance workers. The funds could also be applied to increases in costs related to nursing pool services, if the DSS commissioner deemed them reasonable and necessary. The act prohibited the use of funds for wage and salary increases for nursing facility administrators, assistant administrators, owners, or related-party employees. There are four areas of allowable expenditures:

-
- **salary and wage** - all payroll expense increases, such as hourly wage adjustments, overtime, and bonuses (but payments to employees made in the form of a gift or service award are not recognized under the program);
 - **fringe benefits** - workers' compensation, social security (FICA), insurance (e.g., health, disability, unemployment, life), pension, uniform allowance, child daycare, and employee physicals (but costs associated with employee recruitment, staff parties, training, seminars, and conferences are not recognized under the program);
 - **additional direct and indirect staff** - increases in Medicaid allowable direct and indirect employee costs related to added staffing and/or hours:
 - direct care component staff includes nurses and nurse aides; and
 - indirect component staff includes dietary, housekeeping, laundry, social work, recreation workers, physicians, pharmacists, and therapists (Medicaid-allowable therapy costs are determined based upon a payer-type utilization formula. and professional fees are subject to per-hour limits under Medicaid reimbursement regulation); and
 - **necessary and reasonable increases in nursing pool/temporary staffing costs** - although the intent of the wage enhancement program is to provide permanent nursing facility employees with higher wages and benefits and to increase direct and indirect care staffing, the law permits the DSS commissioner to allow reasonable and necessary increases in outside temporary staffing services. As a guideline, facilities must notify the department of increases in outside service costs projected to be in excess of 30 percent from the prior year. The department then conducts a review for reasonableness and necessity. Enhancement payments may not be applied to cost increases associated with contracts for services such as therapy, dietary, housekeeping, and laundry.

Verification of the Proper Use of Payments

Auditing of cost reports. Through its annual review of Medicaid cost report filings, the social services department compares each home's entire 1998 expenditures for wages, benefits, and staffing to such expenditures in the 1999, 2000, and 2001 cost reports to determine whether a home has applied payments to the allowable enhancements. Facilities must demonstrate spending for wages, benefits, and direct/indirect staffing increased over 1998 costs by an amount equal to or exceeding payments received under the enhancement program.

It is important to note under P.A. 99-279 facilities are credited with wage, benefit, and staffing enhancements made during the entire 1999 cost-reporting period (10/1/98 – 9/30/99), not just after April 1, 1999, which was the date the Medicaid rate increases related to the enhancement program took effect. A facility that gave a wage and/or benefit increase or

increased staffing between October 1, 1998, and March 31, 1999, would also be eligible for enhancement funds. Thus, those facilities' entire 1998 allowable expenditures are compared to 1999, 2000, and 2001 to determine whether a home has applied additional payments to those allowed under the law.

Program Impact to Date

As required by the act, the Department of Social Services completed a compliance review for all of the nursing facilities that received enhancement payments. The review compared 1998 and 1999 expenditures. Data provided by the department to the program review committee showed 252 facilities received enhancement payments. Of these:

- 180 nursing facilities passed the spending test;
- 72 nursing facilities required additional review after not meeting the initial spending test, of which:
 - 27 homes passed after a more thorough review;
 - 6 homes had partial rate reductions;
 - 3 homes failed and had a complete rate reduction;
 - 6 homes remain under review; and
 - 30 homes have missing data because required cost reports were not filed or there was poor or missing data.

One factor that triggered a more careful review by DSS was if expenditures for nursing pool personnel were greater than 30 percent between 1998 and 1999. According to DSS, facilities with those expenditures were ultimately approved. In addition, under C.G.S. Section 17b-238(b), nursing facilities have the right to appeal revisions to their rates as a result of enhancement program verification reviews and field audits.

The vast majority (82 percent) of nursing facilities passed the DSS spending test for 1999 by using enhancement funds in one or more of the four allowable expenditure categories. Table IV-1 compares total facilities' expenditures by specific categories for 1998 and 1999. As noted above, the aggregate amount that needed to be expended by facilities in order to pass the 1999 spending test was \$37.5 million (one-half of the \$75 million allocated for the program for the six-month period from April 1, 1999, to September 30, 1999).

As the table shows, total expenditures increased by \$72 million from 1998 to 1999. Increases in expenditures for nursing personnel (combined nurse, aide, and pool) accounted for \$44 million (61 percent) of the \$72 million. The greatest dollar increase was for nurse aides, while expenditures for temporary pool services, the bulk of which is used to obtain nurses and aides, grew a full 50 percent from 1998 and 1999. Such large increases in this category is one indication of the problems nursing facilities are experiencing in recruiting nursing personnel.

Table IV-2 shows, by type of nursing staff, the increase in 1999 expenditures and whether the expenditure was a result of additional hours or higher wages. For example, \$16 million more was spent for licensed nurses in 1999, with \$7.2 expended because of additional hours and \$8.8 million because of increased wages. It is not possible to discern if the increase in

nursing hours are as a result of newly hired nursing staff or if existing nursing staff worked more hours. Overall, the table shows, almost half of the total growth in expenditures can be attributed to increased hours, and half can be attributed to increased wages.

<i>Category</i>	<i>Total 1998 Expenditures</i>	<i>Total 1999 Expenditures</i>	<i>\$ Increase</i>	<i>% Increase</i>
Licensed Nurses (RNs, LPNs)	\$285	\$301	\$16	5.6%
Nurse Aides	\$262	\$282	\$20	7.6%
Temp. Agency Services (i.e., pool nursing staff)	\$16	\$24	\$8	50.0%
Indirect	\$175	\$188	\$13	7.4%
Administration	\$65	\$70	\$5	7.6%
Fringe Benefits	\$187	\$197	\$10	5.3%
Total	\$990	\$1,062	\$72	7.3%

Based on 222 facilities (30 homes missing because required cost reports not filed, or poor or missing data)
 Increase of \$37.5 million needed for 1999 (1/2 year of program)
 Source: Department of Social Services

<i>Type of Personnel</i>	<i>Due to Hours</i>	<i>Due to Wages</i>	<i>Total</i>
Licensed Nurses	\$7.2	\$8.8	\$16
Nurse Aides	\$9.6	\$10.4	\$20
Pool	\$4.5	\$3.5	\$8
Total	\$21.3	\$22.7	\$44

Source: Department of Social Services.

Table IV-3 compares the reported number of nursing hours in 1998 and 1999, the increase for 1999, and the number of full-time equivalent (FTE) positions resulting from the increase. One caveat associated with the increase in reported annual hours, however is that no uniform definition exists in the cost report on what facilities should include in the number of hours reported. While some facilities may report paid hours, which include any vacation, sick, and personal time accrued, others might report actual hours worked. As a result, the increase in hours reported for 1999 may include more employee paid days off and not additional hours actually worked. However, if the entire increase in hours were in fact worked, it would equal a total of 461 additional FTE positions.

Medicaid Cost Reporting

The Medicaid cost reports submitted to DSS by each nursing facility contain total salaries and wages paid for specific employee categories for all staff of the nursing homes. Aggregated annual hours by employee category must also be reported. The same information is also reported

for consultants, paid on a fee-for-service basis, including nurses and aides obtained through temporary agencies. As noted above, the committee found a major limitation of using the Medicaid cost reports for policy analysis is the lack of uniform definitions for reported hours. The department also recognized this problem and provided a uniform definition (hours reported should be based on actual employee hours paid for the year including paid time off) for facilities to report beginning with the 2000 Medicaid cost report filings.

Table IV-3. Comparison of Aggregate Nursing Staff Hours Reported: 1998 and 1999.

<i>Type of Nursing Staff</i>	<i>1998 Hours</i>	<i>1999 Hours</i>	<i>Increase</i>	<i>FTE Positions</i>
Licensed	13,148,769	13,431,555	282,786	136
Aide	23,147,187	23,668,780	521,593	251
Pool	645,037	799,119	154,082	74
Total	36,940,993	37,899,454	958,461	461
Source: DSS and 1999 Medicaid Cost Reports.				

Another limitation of the Medicaid cost report is that the wages and hours for registered and licensed practical nurses, both for employees and nursing pools, do not distinguish between nurses who are responsible for providing direct resident care and those who perform administrative tasks. *The committee finds since the information in the cost report is increasingly being used for staff and wage analysis among nursing facilities, there is a need to refine the categories to more accurately distinguish nursing staff that provide direct resident care from those performing administrative tasks.*

Committee Recommendation

The Department of Social Services should amend pages 10 and 13 of the Medicaid cost report, beginning with the 2001 submission, so that salaries and wages, and hours for RN and LPNs involved in providing direct care to residents shall be reported separately from RNs and LPNs involved in administrative functions.

“Direct care” shall mean the provision of direct care and services to the resident, commonly referred to as hands on care services, including, but not limited to, the administration of medication and treatment, feeding, bathing, toileting, dressing, lifting, and moving residents. Administrative nurse functions shall include, but not be limited to, infection control, in-service training, and maintaining the federally required minimum data set.

While required as a submission to verify costs for Medicaid reimbursement, the Medicaid cost report data offers the most comprehensive data on staffing and costs in the industry. Hence, it has become a valuable tool for policymakers and researchers, as well as cost regulators.

If Medicaid cost report data are to continue being used to make policy decisions, the reporting needs to be accurate and provide a fair representation of what is actually occurring in the industry. Since the cost report contains the most complete information, with salaries and hours worked by employee category and temporary agencies, this is the most logical place to

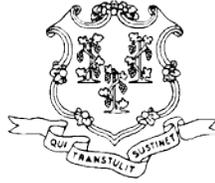
require a refinement of the definition of type of work. The committee believes this recommendation will allow analysis based on cost report data to be more accurate, and thus, of better use to policymakers.

APPENDIX A

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Joxel Garcia, M.D., M.B.A.
Commissioner



John G. Rowland
Governor

February 5, 2001

Michael L. Nauer, Director
Legislative Program Review and
Investigations Committee
State Capital, Room 506
Hartford, CT 06106

Dear Mr. Nauer:

Thank you for providing the Department of Public Health (DPH) the opportunity to comment on the Legislative Program Review and Investigations Committees (LPRIC) findings and recommendations on Staffing in Nursing Homes.

I would like to express the Department's appreciation for the effort and time Maryellen Duffy, Principal Analyst, invested in this study. The report contains a comprehensive overview of several issues impacting Connecticut's nursing home industry. However, the Department would submit the following factual information for your review and consideration.

The Department of Public Health as well as The Health Care Financing Administration (HCFA) has long felt that the unpredictability of nursing home inspections, including their unannounced nature, is an effective regulatory tool in and of itself. HCFA has consistently found DPH's scheduling methodology and implementation to be in accordance with Federal mandates and effective in maintaining the surprise nature of nursing home inspections (see attached letter from Alan A. Tavares, HCFA). Federal law requires that surveys be conducted no earlier than nine months and no later than 15 months after the prior survey and that the statewide average survey interval must not exceed twelve months.

In addition, HCFA only budgets funding to states to conduct an average of one survey per facility per Federal fiscal year; more frequent surveys will not be reimbursed. Further, HCFA's directives encourage states to schedule those facilities found to have substandard quality of care, or a history of frequent deficiencies resulting in "actual harm" to residents, more frequently (i.e., 9 - 11 months after the previous survey). In complying with these multiple directives, DPH must occasionally schedule some surveys approximately 12 months after the previous survey.



The report considers only the routine inspections performed by DPH. In addition to these standard surveys DPH also conducts complaint investigations and follow-up visits for both surveys and complaint investigations. These visits are also unannounced and are scheduled on all days of the week and all shifts in response to the nature of the allegations or previous findings. Complaint investigations are scheduled based on the seriousness of the allegations and are completely unpredictable from the provider's perspective. Follow-up visits must occur within 90 days of the survey or complaint being reviewed. Enforcement sanctions may be imposed on facilities following any of these types of inspection visits. Thus, an evaluation of a survey agency's "scheduling unpredictability" needs to include all types of visits, not just routine surveys and licensure inspections. Further, the report speaks only to the standard surveys, noting that "most facilities are inspected only annually" when in fact most facilities receive approximately six visits annually (standard survey, follow-up visit, two or three complaint investigations and two associated follow-up visits).

HCFA mandated in 1998 that states begin 10% of standard surveys on weekends or the evening or night shift. Connecticut has complied with this directive for standard surveys and also conducts complaint investigations and follow-up visits during "off-hours." The report states in error that facilities are selected for "off-hour" surveys depending on "whether DPH staff have volunteered for this off-time schedule." In fact, the facilities are selected based on compliance history and any complaints concerning the off-shifts; volunteers are then secured in compliance with union contracts for these scheduled surveys. DPH has experienced no difficulty in staffing "off-hour surveys", complaint investigations or follow-up visits.

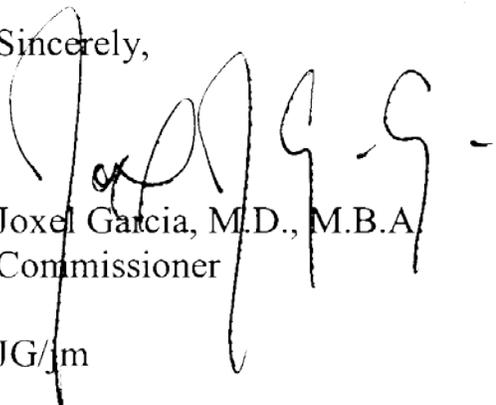
While DPH projects a variable survey schedule each year, which is approved by HCFA, other factors may take precedence and cause changes to the schedule, which may then affect some facilities' survey interval. For example, if serious complaints are received, a full survey may be conducted in conjunction with the complaint investigations. This strategy complies with Federal directives, but causes the projected survey interval of the facility to change. Another facility's projected date must then also be changed to accommodate the requirement of the "statewide average interval of 12 months". Another example that may alter DPH's projected survey schedule is labor actions in nursing homes. During a period of widespread strikes, all survey staff are assigned to the critical task of monitoring care in striking facilities. While this is clearly an agency priority, it causes multiple changes in the projected schedule.

DPH has tracked the dates of surveys for several years and will continue to do so. Each year the goal has been to increase the unpredictability of surveys so they will present a true picture of a facility's day-to-day resident care and operations. In FFY 2001, the goal is to schedule as few surveys as possible within 15 days of the prior survey. However, critical occurrences such as those noted above may take precedence over the full achievement of this goal. As an additional quality improvement measure, DPH will institute a monthly management level review of each scheduled survey's interval from the previous year's survey.

The report also recommends use of the Medicaid cost report and individual nursing home resident "RUG" scores to evaluate the adequacy of staffing. Cost reports are submitted annually based on data from the prior Federal fiscal year so they may or may not reflect current staffing or current resident case mix at the time DPH conducts its survey. For example, as of January, 2001 most facilities had cost reports on file for the period of October 1, 1999 to September 30, 2000. "RUG" (Resource Utilization Groups) scores are calculations of amounts of nursing time needed by an individual based on their medical conditions and functional abilities. These scores are obtained from the data collected in the HCFA required assessments (MDS or Minimum Data Set) of each nursing home resident. DPH would need to assess the availability of RUG scores and amount of staff time necessary to calculate and analyze care hours actually provided in relation to care hours required according to the MDS assessment. It is important to note that the RUG score for a resident is calculated based on the last full MDS, which may be up to a year old. The usefulness of such aged data at the time of the survey is certainly questionable. This analysis will result in increasing the amount of time inspectors spend reviewing documents instead of observing the actual care and services provided to residents.

Thank you for providing the Department with the opportunity to comment on the LPRIC's final report.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read 'Joxel Garcia'.

Joxel Garcia, M.D., M.B.A.
Commissioner

JG/jm



DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING
ADMINISTRATION

Division of Medicaid and State Operations

Region I
JFK Federal Building
Government Center
Boston, MA 02203

January 8, 2001

Ms. Wendy Furniss
Public Health Services Manger
Division of Health Systems Regulation
Department of Public Health
410 Capitol Avenue, M.S. #12HSR
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Furniss:

I understand that you have to respond to a Legislative study that dealt in part with the annual scheduling of nursing home surveys. HCFA has required States, for a number of years now, to adjust their Long Term Care (LTC) survey schedule to assure that providers are not tipped off as to when their next survey may be. To accomplish this, HCFA allowed States the flexibility to schedule surveys up to 15 months after the preceding survey as long as the State maintained an average survey cycle of 12 months for all LTC surveys.

The Boston Regional Office has been tracking the performance of our six New England States for the past 6 years. During this period, your office has done an effective job of conducting surveys in an unannounced manner as evidenced by the following statistics that we have compiled:

Survey Interval	FY 1998	FY 1999	FY 2000
Under 9 months	.8%	2.4%	1.2%
9.0 - 9.9 months	15.3%	10.1%	6.1%
10.0 - 10.9 months	19.4%	16.1%	17.6%
11.0 - 11.9 months	20.7%	12.9%	20.2%
12.0 - 12.9 months	16.9%	17.7%	23.3%
13.0 - 13.9 months	17.4%	18.2%	15.7%
14.0 - 14.9 months	8.3%	18.6%	14.1%
15.0 - 15.9 months	1.2%	4.0%	1.9%
Total Surveys Conducted	242	245	262
Avg. Survey Days - Total	358.2	374.6	369.8

Please let me know if you would like any additional information regarding the above statistics.

Sincerely yours,

Alan A. Tavares
Health Insurance Specialist
Financial Management Branch



APPENDIX B
STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

February 6, 2001

Michael L. Nauer, Director
Legislative Program Review and
Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Mr. Nauer:

Thank you for the opportunity to comment on the Committee's Staffing in Nursing Homes Report. I congratulate Ms. Duffy and the Committee for developing a valuable report on the staffing requirements for the care of some of our state's most vulnerable residents.

The Committee recommends that the Department revise the 2001 Medicaid cost report for nursing facilities to separate costs and hours worked by nurses into direct care and administrative functions. This recommendation has been made by the Committee to improve the data available to policymakers and researchers involved in monitoring and assessing nursing home staffing levels.

As you know, while nursing homes are required to indicate the number of hours by job category in the annual Medicaid cost report, this information is not used for Medicaid rate setting purposes. Consequently, the Department has not implemented stringent review procedures on the accuracy of this reported information. We are aware that there may be inconsistencies between facilities in reported hours. For example, some facilities may report hours on duty while others may report hours paid including time off. Due to the increased focus on the level of nursing home staffing by both federal and state agencies, the Department included a clarification with the transmittal of the 2000 cost report that reported hours should reflect all paid hours including time off and applicable accruals.

Concerning the Committee's recommendation, we will revise the 2001 cost report format to capture direct care and administrative nursing hours. We will seek input from nursing home operators and refine, if necessary, the direct care/administrative function definitions presented in the Committee's report.

My staff and I greatly appreciated the courtesy and cooperation extended by your staff in conducting this study.

Sincerely,

Patricia A. Wilson-Coker
Commissioner

Appendix C

Daily Duties of a Nurse Aide

The following are examples of resident care responsibilities a nurse aide may have on a single daily shift:

Task	Average Time to Complete Task
Shower	10-30 min.
Bed bath	10-15 min.
Personal hygiene care	5-10 min.
Partial baths (face, oral care, hands, pericare)	10 min.
Foley catheter care	5-10 min.
Empty and measure catheter bag at end of shift	5 min.
Oral care/dentures	5-10 min.
Groom/shave	5-10 min.
Dress	5-10 min.
Nail care	5-10 min.
Body/hand lotion to skin	5 min.
Toilet	10-15 min.
Vital signs (temperature, pulse, respiration, & blood pressure)	10 min.
Set up meal tray, document food/fluid intake each meal	5-10 min.
Total feed the meal to a resident	20-60 min.
Serve and feed nutritional supplements during the shift	1-10 min.
Handwashing between each resident	1 min.
Bed making – unoccupied	5 min.
Bed making – resident in bed	10-15 min.
Documentation & observations on the resident care records	3-5 min.
Passive range of motion (5-10 repeats)	15 min.
Ambulating resident to dining room or other areas	10-15 min.
Assessment of pain, depression, and behavior	5-10 min.
Source: adapted from The Nursing Service Group, Inc. (found on the National Citizens Coalition for Nursing Home Reform website).	

Appendix E

Other States Nurse Staffing Ratios

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. 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 ¹	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	

Source: HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, attachment to executive summary.

¹ The program review committee contacted the state of Massachusetts. According to the Department of Health, Division of Health Care Quality, Massachusetts does not have minimum nursing staff ratios but follows those contained in the federal law.

APPENDIX F

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION INVESTIGATIVE PROTOCOL NURSING SERVICES, SUFFICIENT STAFFING

Objectives

- To determine if the facility has sufficient nursing staff available to meet the residents needs.
- To determine if the facility has licensed registered nurses and licensed nursing staff available to provide and monitor the delivery of resident care.

Task 5C: Use:

NOTE: This protocol is not required during the standard survey, unless it is triggered in the event of care concerns/problems which may be associated with sufficiency of nursing staff. It is required to be completed for an extended survey.

This protocol is to be used when:

- Quality of care problems have been identified, such as: Residents not receiving the care and services to prevent pressure sore/ulcer(s), unintended weight loss and dehydration, and to prevent declines in their condition as described in their comprehensive plans of care, such as bathing, dressing, grooming, transferring, ambulation, toileting, and eating; and
- Complaints have been received from residents, families or other resident representatives concerning services, such as: Care not being provided, call lights not being answered in a timely fashion, and residents not being assisted to eat.

Procedures:

- Determine if the registered/licensed nursing staff are available to:
 - Supervise and monitor the delivery of care by nursing assistants according to residents care plans;
 - Assess resident condition changes;
 - Monitor dining activities to identify concerns or changes in residents needs;
 - Respond to nursing assistants requests for assistance;
 - Correct inappropriate or unsafe nursing assistants techniques; and
 - Identify training needs for the nursing assistants.

- If problems were identified with care plans/services not provided as needed by the resident, focus your discussion with supervisory staff on the situations which led to using the protocol: how do they assure that there are adequate staff to meet the needs of the residents; how do they assure that staff are knowledgeable about the needs of the residents and are capable of delivering the care as planned; how do they assure that staff are appropriately deployed to meet the needs of the residents; how do they provide orientation for new or temporary staff regarding the resident needs and the interventions to meet those needs; and how do they assure that staff are advised of changes in the care plan?

- Determine if nursing assistants and other nursing staff are knowledgeable regarding the residents care needs, such as: the provision of fluids and foods for residents who are unable to provide these services for themselves; the provision of turning, positioning and skin care for those residents identified at risk for pressure sore/ulcers; and the provision of incontinence care as needed;

- If necessary, review nursing assistant assignments in relation the care and or services the resident requires to meet his/her needs;

- In interview with resident, families and/or other resident representatives, inquire about the staffs response to requires for assistance, and the timeliness of call lights being answered; and

- Determine if the problems are facility-wide, cover all shifts or if they are limited to certain units or shifts, or days of the week. This can be based on information already gathered by the team with additional interviews of residents, families and staff, as necessary.

Task 6: Determination of Compliance:

NOTE: Meeting the State mandated staffing ratio, if any, does not preclude a deficiency of insufficient staff if the facility is not providing needed care and services to residents.

- Compliance with 42 CFR 483.30(a), F353, Sufficient Staff:

- The facility is compliant with this requirement if the facility has provided a sufficient number of licensed nurses and other nursing personnel to meet the needs of the residents on a twenty-four hour basis. If not, cite F353.

Appendix G. Total Nursing Staff Time by RUG III Number.					
RUG III	RN Min.	LPN Min.	Total Licensed Min.	Aide Min.	Total Min.
1	112.7	87.7	166.5	180.1	346.6
2	87.7	37.4	125.1	123.8	248.9
3	64.5	40.4	104.9	98.4	203.3
4	90.9	50.7	141.6	164.9	306.5
5	94.7	41.6	136.3	136.3	272.6
6	75.6	30.0	105.6	106.8	212.4
7	110.6	53.5	164.1	167.0	331.0
8	102.3	39.9	142.2	129.9	272.1
9	89.7	27.6	117.3	102.6	219.9
10	111.2	66.8	178.0	180.0	358.0
11	101.2	42.4	141.8	285.4	143.6
12	95.0	33.9	117.3	246.2	128.9
13	79.0	48.9	127.9	191.3	319.2
14	64.5	32.0	96.5	122.8	219.3
15	140.7	101.5	242.2	191.3	433.5
16	110.4	85.4	195.8	163.2	359.0
17	77.9	60.1	138.0	195.3	333.3
18	72.9	64.3	137.2	184.1	321.3
19	70.9	55.0	125.9	172.4	298.3
20	91.7	41.7	133.4	130.4	263.8
21	85.2	42.5	127.7	191.1	318.8
22	55.7	57.7	113.4	176.9	290.3
23	61.5	41.8	103.3	159.0	262.3
24	59.0	36.2	147.3	95.2	242.5
25	58.8	43.3	102.1	130.3	232.4
26	59.7	37.6	97.3	103.3	200.6
27	40.0	32.0	72.0	137.2	209.2
28	39.0	32.0	130.0	71.0	201.0
29	38.0	27.0	65.0	100.0	165.0
30	33.0	26.0	59.0	96.0	155.0
31	40.0	30.0	70.0	136.0	206.0
32	38.0	28.0	66.0	130.0	196.0
33	38.0	30.0	68.0	90.0	158.0
34	34.0	25.0	59.0	73.5	132.5
35	37.0	32.0	69.0	184.8	253.8
36	37.0	29.4	66.4	181.6	248.0
37	36.0	25.0	170.0	61.0	231.0
38	36.0	27.6	63.6	160.0	223.6
39	25.6	32.8	58.4	154.4	212.8
40	45.1	20.6	65.7	124.2	189.9
41	28.0	36.8	64.8	80.6	145.4
42	27.5	27.7	55.2	93.9	149.1
43	31.9	30.6	62.5	72.9	135.4
44	28.2	29.8	58.0	72.8	130.8

Source: Adapted from Federal Register, 5/12/98, Table 2C, pages 26262-63.

Appendix H

Staffing Levels in U.S. Nursing Homes: Total Hours per Resident Day by State 1996-1999.						
State	1997		1998		1999*	
	Number	Mean	Number	Mean	Number	Mean
AK	11	5.49	11	4.92	7	4.74
AL	166	3.56	185	3.73	91	3.59
AR	218	3.03	195	3.12	106	3.19
AZ	91	3.71	102	3.74	36	3.25
CA	1,026	3.57	938	3.52	478	3.41
CO	186	3.39	162	3.30	97	3.23
CT	211	3.10	190	3.16	121	3.15
DE	32	3.81	24	4.41	17	3.88
FL	492	3.64	481	3.59	306	3.49
GA	291	3.10	286	3.10	148	3.06
HI	34	4.13	32	4.11	19	3.83
IA	393	2.64	396	2.69	192	2.74
ID	58	4.27	55	4.05	30	4.28
IL	713	2.93	707	3.01	389	3.10
IN	458	2.83	455	2.87	248	2.94
KS	363	2.62	353	2.64	200	2.69
KY	222	3.71	246	3.59	128	3.60
LA	259	3.21	248	3.14	140	3.14
MA	461	3.46	441	3.55	278	3.45
MD	185	3.20	159	3.34	49	3.42
ME	113	3.73	103	3.88	58	3.69
MI	365	3.33	350	3.32	166	3.32
MN	361	2.86	371	2.84	187	2.82
MO	461	3.05	431	3.00	227	3.09
MS	171	3.52	153	3.46	72	3.28
MT	89	3.47	82	3.57	49	3.40
NC	343	3.64	340	3.70	161	3.58
ND	76	3.28	79	3.20	40	3.52
NE	210	2.93	197	2.97	109	3.05
NH	72	3.61	62	3.73	34	3.83
NJ	285	3.18	278	3.27	107	3.37
NM	67	3.41	55	3.23	36	3.03
NV	27	3.70	35	3.82	15	4.73
NY	516	2.99	504	3.06	279	3.06
OH	795	3.48	775	3.41	381	3.52
OK	325	2.64	256	2.61	163	2.46
OR	135	3.14	129	3.09	63	3.06
PA	691	3.58	688	3.69	364	3.58
RI	68	3.00	69	3.03	38	3.11
SC	150	3.65	126	3.67	72	3.65
SD	86	2.72	81	2.77	45	2.66
TN	277	3.02	276	3.21	128	3.06
TX	1,015	3.21	914	3.11	536	3.01
UT	77	3.28	67	3.46	35	3.83
VA	217	3.31	207	3.38	125	3.41
VT	32	3.32	29	3.33	25	3.34
WA	224	3.80	218	3.74	120	3.73
WI	362	3.18	356	3.13	199	2.99
WV	66	3.70	65	3.35	79	3.41
WY	32	3.25	31	3.27	18	3.24

*1999 data were available only for assessments completed before July 1, 1999.

Source: HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report to Congress, July 2000, p. 3-36.



OLR RESEARCH REPORT

October 23, 2000

2000-R-1006

NURSING HOME STAFFING

By: John Kasprak, Senior Attorney

You asked for information on states with laws addressing staffing levels in nursing homes.

BACKGROUND

The majority of states, 36, have established some type of staffing requirements or standards for nursing homes. The requirements are found in either statute or regulation (e.g., Public Health Code) and vary considerably. These standards generally require nursing homes to (1) provide a certain number of nursing care hours per patient day, (2) maintain a certain staff-to-patient ratio, or (3) maintain certain types of staff (e.g. registered nurses) to provide care. Table 1 following, derived from a recent Program Review and Investigations Briefing Paper on "Staffing Levels in Nursing Homes" (September 12, 2000), summarizes these state requirements by category.

TABLE 1: States' Nursing Home Staffing Requirements

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

Note: some states appear in more than one category because they have more than one type of requirement.

Source: HCFA, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, July 2000, as reported by the Program Review and Investigations Committee in its "Staffing in Nursing Homes" Briefing Paper, September 12, 2000.

RECENT STATE ACTIVITY

States have implemented a range of requirements that address minimum standards for nursing care. During 2000, five states (California, Delaware, Kentucky, Maryland, Minnesota), enacted laws addressing staffing ratios in long-term care facilities according to NCSL's Health Policy Tracking Service. California requires the state Department of Health Services to determine the need for any increase in the minimum number of nursing hours per patient day in skilled nursing facilities beyond the 3.2 minimum specified in existing law, and make recommendations by May 1, 2001.

A new Delaware law sets a new minimum staffing standard for nursing services by direct caregivers (includes certain licensed and certified nursing personnel) of 3.0 hours of direct care per resident per day. This takes effect March 1, 2001, with additional minimum ratio requirements for nursing staff distribution according to their shift. It also provides for adjusting Medicaid reimbursements to reflect the costs associated with increased staffing levels (Senate Bill 115). The law provides for an incremental increase in the new minimum staffing standard over three years from the initial 3.0 hours of direct care per resident per day when the standard takes effect in 2001 to 3.28 the next year, and up to 3.67 hours by 2003. Also, the Delaware Nursing Home Residents Quality Assurance Commission will assess and review the efficacy of each of these increases to determine their effect on quality of care.

In Minnesota, a new law prohibits including resident attendants as staff for the purpose of meeting minimum staffing requirements in nursing homes (Minn. Stat. § 144A.04).

The Kentucky and Maryland laws created task forces to examine staffing issues in the states' long-term care facilities.

Michigan is currently considering, but has not yet passed, legislation that would incrementally increase staff-to-patient ratios from at least 2.75 hours of direct patient care per day in 2001 to 3.0 hours of direct patient care per day by 2002 (H 4362).

FEDERAL GUIDELINES

The federal government established guidelines in 1987 that required nursing facilities to provide residents with licensed nursing services 24 hours per day. The law specifies that a registered nurse must be on duty for at least eight of those 24 hours, seven days per week. The 1987 guidelines derived from a National Institute of Medicine report that found a "disturbing state of patient care in nursing homes" (see *Nursing Home Staff Ratios*, Health Policy Tracking Service Issue Brief, October 3, 2000). Congress responded by folding these nursing home guidelines into its omnibus budget reconciliation act (PL 100-203). Since 1987, many states have moved beyond this federal minimum to enact their own minimum staffing laws.

FEDERAL NURSING HOME STUDY

In July of this year, the federal Health Care Financing Administration (HCFA) reported to Congress on the staffing situation in the nation's nursing homes. It found that over half of nursing homes had too few staff to ensure a minimum quality of care for patients. The report states that patients in understaffed nursing homes were at greater risk for preventable health conditions that led to hospitalization, such as pneumonia, urinary tract infections, sepsis (a life-threatening infection originating in the blood), congestive heart failure, and dehydration.

This study, which took eight years to complete, suggests staffing requirements necessary to provide a minimum quality of care, below which quality may be "seriously impaired." Suggested staff levels include two hours of nurse aide care per resident day, 45 minutes of care per resident day from a licensed practical nurse or RN, and 12 minutes of care per resident day from an RN. Another part of the study identified a minimum level for nurse aide staff needed to provide optimal care to patients-2.9 hours of care per resident day. HCFA found that over 90% of nursing homes in the United States fall below this level, and about half

of these would have to double nurse aide staff to reach this threshold (see NCSL/Health Tracking Service Issue Brief).

JK:ts