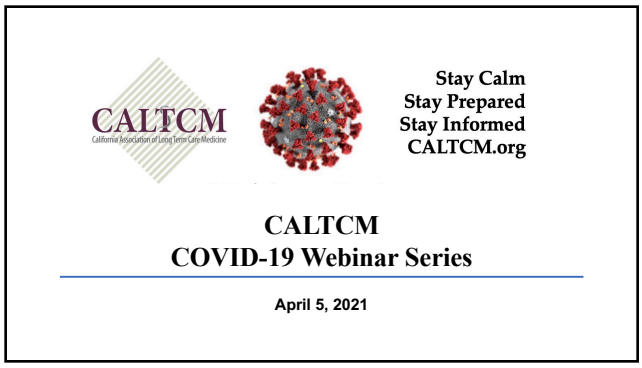
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Webinar Faculty

Deb Bakerjian PhD, APRN, FAAN, FAANP, FGSA

Clinical Professor, Betty Irene Moore School of Nursing at UC Davis

Co-Editor-in-Chief, AHRQ PSNet (PSNet and WebM&M)

Director, SPLICE Project; Director, Advanced NP PRACTICE- NP Residency Project; Director, PA PROMISE

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Webinar Faculty

Elizabeth Halifax, PhD, RN

Assistant Clinical Professor
Department of Physiological Nursing
University of California, San Francisco

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Jay Luxenberg, MD

Chief Medical Officer, On Lok
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Michael Wasserman, MD, CMD
Geriatrician
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Long Overdue
Transforming the Nursing Home Staffing Paradigm

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Presenters:

Deb Bakerjian, PhD, APRN, FAAN
Elizabeth Halifax, PhD, RN

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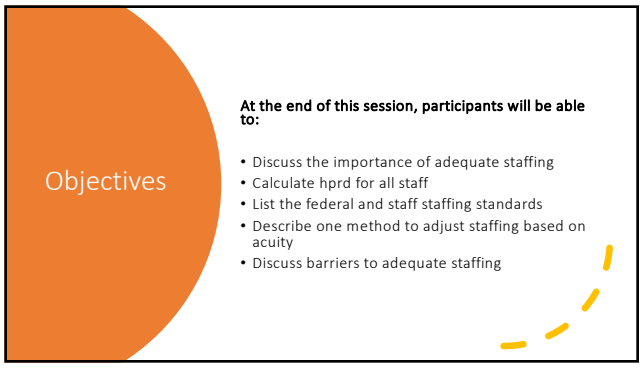
Objectives
At the end of this session, participants will be able to:
• Discuss the importance of adequate staffing
• Calculate hprd for all staff
• List the federal and staff staffing standards
• Describe one method to adjust staffing based on acuity
• Discuss barriers to adequate staffing

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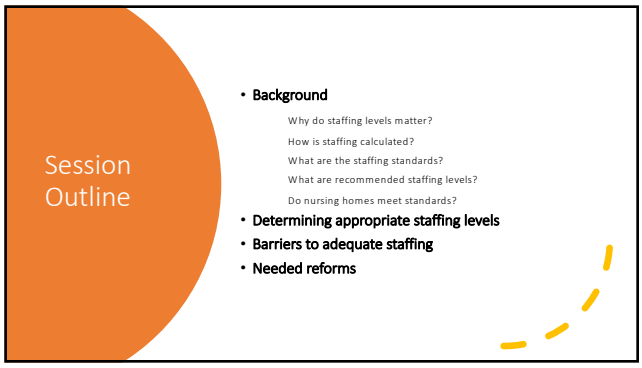
Session Outline
• Background
Why do staffing levels matter?
How is staffing calculated?
What are the staffing standards?
What are recommended staffing levels?
Do nursing homes meet standards?
• Determining appropriate staffing levels
• Barriers to adequate staffing
• Needed reforms

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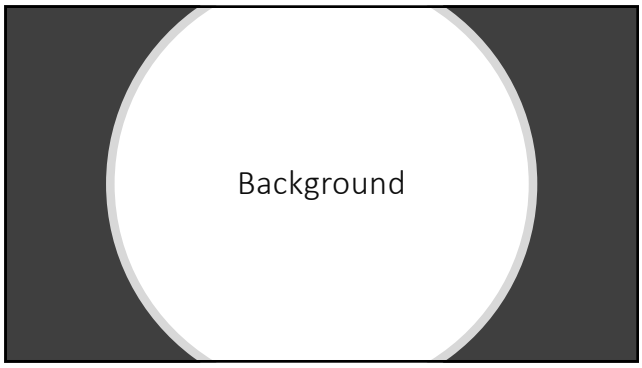
Background

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Why Staffing Levels Matter

The provision of quality care to NH residents depends on adequate and appropriate staffing

- Research has shown a positive relationship between staffing and quality care
  - Particularly for RNs, but also for total licensed nurse and CNA staffing
- Higher staffing improves the quality of care in many areas.
  - Including: fewer pressure ulcers, less restraint use, decreased infections, less pain, improved independence with ADLs, reduced weight loss and dehydration, less inappropriate and overuse of antipsychotics, reduced emergency department use and hospitalizations, Infectious disease outbreaks

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Why Staffing Levels Matter

BOTTOM LINE:

Low nurse staffing levels result in:

- Lower quality outcomes
- Increased medication/treatment errors and adverse events
- Increased risk for abuse and neglect

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Nurse Staffing and COVID-19

2020/2021: During the coronavirus pandemic, adequate staffing has become even more critical

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Nurse Staffing and COVID-19

- NHs with low RN staffing were 2X more likely to have residents with COVID infections
- Higher total staffing hours were protective, reducing the NH COVID infection rates by half
- Higher RN staffing reduced NH COVID death rates by half

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How do we calculate and compare staffing?

Hours per resident day (hprd)

How much time each type of nursing staff (RN, LVN, and CNA) has on average for each resident in one day

Resident Acuity

Resident care needs are determined by acuity - the measurement of the intensity (time and skill) of nursing care that is required by a resident

Staffing Skill Mix

Education, skills and experience of different nursing staff

For example, LVNs are not equivalent to RNs

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Hours Per Resident Day (hprd)

Calculating Hours per resident day (hprd)

Hprd should be determined for each type of nursing staff (RNs, LVNs and CNAs) and for total nursing staff

(1) Calculate the total number of hours worked by relevant staff in a 24-hour day

(2) Divide (1) by the number of residents in the facility that day. This average = hprd

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Example: Calculating hprd

On December 3rd, Happy Campers Nursing Home had a census of 84 residents, and we need to calculate CNA hours per resident for that day.

On that day there were:

- 13 CNAs on the morning shift (07:00-15:00)
- 11 CNAs on the afternoon shift (15:00-23:00)
- 6 CNAs on the night shift (23:00-07:00)

A total of 30 CNAs

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Calculating hprd, example:

A total of 30 CNAs each working 8 hours to provide care to 84 residents

Q. How many total hours did CNAs work?

A. 30 CNAs x 8 hours **= 240 hours**

Q. What were the CNA hours per resident day (hrpd)?

A. 240 CNA hours divided by 84 residents = **2.82 CNA hprd**

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What are the staffing standards?

- Federal standards
- State standards
- Expert recommendations

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What are the federal requirements for staffing NHs?

The Nursing Home Reform Act (NHRA) (Omnibus Budget Reconciliation Act [OBRA], 1987)

- Does not specify exact staffing levels for nursing staff

CMS regulations require staffing to be adjusted upward for higher acuity residents, stating the facility must have:

Sufficient nursing staff to:

- Assure resident safety
- Attain/maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident (from §483.35, OBRA 1987)

Staffing levels determined by:

- Resident assessments and individual plans of care
- Considering the number, acuity and diagnoses of residents (See 42 C.F.R. §483.70(e).

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What are the federal requirements for staffing NHs?

The NHRA also stipulates that:

- The Director of Nursing (DON), Assistant DON in larger facilities must be RNs
- Facilities have at least one RN on duty for no fewer than 8 hours per day, 7 days per week. The DON may serve as the one RN on duty in facilities <60 beds
- A licensed nurse (RN or LVN) be on duty for the evening and night shifts.
- The facility employ sufficient levels of ancillary staff, including certified nursing assistants (CNAs)

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What are California's minimum staffing standards?

California's minimum standard is 3.5 nursing hprd

- 3.5 hprd is insufficient to provide acceptable levels of care and quality of life and indeed, protect residents from harm and jeopardy
- Minimum staffing at 3.5 hprd does not account for resident acuity and the complex needs of a population that is living longer with multiple comorbidities

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What staffing levels are recommended by research studies and experts?

CMS study **2001** recommended staffing (hprd)

RN	0.75
LVN	0.55
CNA	2.80
RN + LVN	1.30
Total staffing	**4.10**

Note: these are ***minimum standards*** and do not take resident acuity into account

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CMS Expected Staffing Levels

CMS calculates **expected staffing** based on residents' aggregate acuity

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Are nursing homes meeting staffing standards?

>50% nursing homes did not meet CMS expected staffing levels for RNs, CNAs and total nurse staffing (2014)[1]

25% had <3.53 total nursing staff hprd - dangerously low staffing (2014)[1]

2017-2018: 75% of nursing homes almost never met CMS expected RN staffing based on resident acuity[2]

1. Harrington C, Schnelle JF, McGregor M, Simmons SF. The need for minimum staffing standards in nursing homes. *Health Serv Insights*. 2016;9:13-19.
2. Geng F, Stevenson DG, Grabowski DC. Daily nursing home staffing levels highly variable, often below CMS expectations. *Health Aff (Millwood)*. 2019;38: 1095-1100.

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Determining Appropriate Nurse Staffing Levels

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5 Steps in the Process

1. Determine the Collective Resident Acuity and Care Needs
2. Determine the Facility's Actual Per Resident Per Day Staffing Levels
3. Determine Appropriate Nurse Staffing Levels Based on Resident Acuity
4. Identify Evidence Regarding the Adequacy of Staffing
5. Identify the gaps between appropriate and actual staffing

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Step 1: Collective Resident Acuity

Adequate and appropriate staffing is based on the census and the aggregate needs of residents in a facility

Calculating collective resident acuity and care needs is a federally required component of the facility self-assessment (since 2016) and must consider:

"…the number, acuity and diagnoses of the facility's resident population" and must be updated at least annually (42 C.F.R. §483.70(e)).

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Step 1: Collective Resident Acuity

- Since 2019, CMS Medicare prospective payment system requires that Minimum Data Set (MDS) assessments use the Patient Driven Payment Model (PDPM)
- PDPM uses the same nursing classifications as RUG IV with the following modifications:
  - Function is assessed using MDS section GG (not G)
  - Functional groups collapsed from 43 to 25 groups
  - The nursing classification is represented by the third letter in the HIPPS codes
  - Each of the 25 classifications is designated a letter from A-Y

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Step 1: Collective Resident Acuity

Average resident acuity can be calculated by:

1. Aggregating the PDPM nursing acuity needs of residents
2. Dividing it by the average census.

These scores should identify both the licensed nursing and CNA care needs

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Step 2: Actual Staffing Levels

Actual staffing levels can be determined using Payroll based journal data

Should not include:

- Nursing staff not based at the NH (for example, nursing corporate consultants)
- Nursing staff who are being paid, but not working (for example, on vacation/leave)

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Step 3. Determine Appropriate Nurse Staffing Levels Based on Resident Acuity

Recommended staffing hours and ratios have been developed to guide NHs in addressing the average resident acuity

- Acuity levels have been defined

Harrington, C., Dellefield, M. E., Halifax, E., Fleming M.L., Bakerjian, D. (2020). Appropriate nurse staffing levels for United States nursing homes. *Health Service Insights*, (13), 1-14 DOI: 10.1177/1178632920934785 https://pubmed.ncbi.nlm.nih.gov/32655278/

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Average Recommended Nurse Staffing (Hours per Resident Day)

Acuity	RN	LVN	CNA	Total
Extensive services	1.85	1.36	3.60	6.81
Special care high	1.36	0.84	3.40	5.61
Special care low	1.36	0.84	3.40	5.61
Clinically complex	1.03	0.67	3.20	4.90
Behavioral symptoms	0.75	0.55	3.00	4.30
Reduced physical function	0.75	0.56	3.20	4.51

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Step 4. Identify Evidence Regarding the Adequacy of Staffing

- Federal and state deficiencies and complaints
- Quality measures
- Missed or omitted care
- Staff turnover
- Adverse/sentinel events
- Care problems

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Step 5. Risk Adjustment

Having completed steps 1-4, each facility should then adjust its staffing to a level commensurate with the resident needs as recommended.

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Barriers to Adequate and Appropriate Staffing

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Barriers to Adequate Staffing

Include:

- The drive for profits in the NH industry
- Poor job quality/Low wages and benefits
- High turnover rates
- Shortages of nursing staff that want to work in NHs

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Profits in the Nursing Home Industry

- There are over 1,200 nursing homes in California
- The majority, 83.6%, were for-profit in 2014
- For those driven by profits, staffing is the most expensive outlay and presents best opportunities for savings

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Profits in the Nursing Home Industry

- NHs participate in Medicare and Medicaid programs on a voluntary basis
- PDPM reimbursement designed to meet the needs of residents (determined by resident acuity through RUG scores)

However…

There is no accountability regarding how $ are used, for example:

- No limit on what share of income goes towards administration and profits
- No transparency regarding payments to related-party entities

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Poor Job Quality for Nursing Home Staff

Poor job quality for nursing staff in nursing homes results in poor recruitment and retention due to factors that include:

- Low compensation
- Poor benefits- vacation, sick leave, health care
- Inadequate training and limited career paths
- Limited support, respect and recognition
- High turnover
- Gender and racial inequalities
- A challenging culture

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Poor Job Quality for Nursing Home Staff

Low Compensation/benefits

For CNAs, entry level wages/benefits fall near or below jobs with similar entry-level requirements (for example janitor, food prep workers)

- 13% of CNAs live under the federal poverty line
- 36% rely on some form of public assistance
- 44% live in low-income households
- 75.3% of CNAs not receiving living wage

A raise of 15.5% would provide a living wage for all

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Poor Job Quality for Nursing Home Staff

Low Compensation/poor benefits

For RNs and LVNs salaries/benefits are well below other healthcare settings such as acute care

Nursing home RN salaries average 15% below acute care hospitals nationally.

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High Nursing Home Staff Turnover

Using Payroll based journal (PBJ) data, research found an average annual turnover rate (2017-18) of:

100% (all nursing staff)

141% (RNs)

Gandhi, A., Yu, H. & Grabowski D.C. (2021). High nursing staffing turnover in nursing homes offers important quality information. *Health Affairs*, 40(3):384

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Poor Job Quality for Nursing Home Staff

Inadequate training and limited career paths

Failure to provide skills, build knowledge and confidence leads to poor job satisfaction; little or no career advancement opportunities

Limited support, respect and recognition

Limited training and support (for example, shortages of PPE during COVID-19)

Gender and racial inequalities

As a low wage sector, NHs staffed with a concentration of people of color who have experienced systemic racism and discrimination across their lives leading to inequality and disparities

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Nursing Homes: An Unattractive Workplace

Few aspire to a career as a NH licensed nurse or CNA

- Poor job quality described above
- Onerous workloads that create moral distress
- Dangerous work – especially during a pandemic

Results in difficulty recruiting skilled and experienced staff and high nursing staff turnover

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A Challenging Culture

- Poor patient safety culture
- Low psychological safety

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Staffing and Wages

Recommendations

- Increase minimum staffing to 4.1 hprd
- Eliminate all staffing waivers
- 15% wage increase for all CNAs

Note: In California, Senators Gabriel and Stern are taking up the staffing issue.

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Ownership and Financial Transparency

Audits would reveal where money meant for direct resident care/nurse staffing is being spent

Recommendation

Require that nursing homes submit an annual consolidated financial report by a certified auditor for all-related party organizations and entities

SB 650 (Stern): Skilled Nursing Facility Transparency and Accountability

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Ownership and Financial Transparency

Recommendation

Establish financial limits on administrative costs and profits on the entire nursing home company so that the remaining funds are used to pay for direct care services.

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References and Sources

- Paek, SC., Zhang NJ, Wan, TTH, Unruh, LY, and Meemon, N. (2016). The impact of state nursing home staffing standards on nurse staffing levels. *Medical Care Research & Review,* 73(1):41-61
- Harrington, C., Dellefield, M. E., Halifax, E., Fleming M.L., Bakerjian, D. (2020). Appropriate nurse staffing levels for United States nursing homes. *Health Service Insights,* (13), 1-14 DOI: 10.1177/1178632920934785 https://pubmed.ncbi.nlm.nih.gov/32655278/
- US Nursing Assistants Employed in Nursing Homes, Key Facts PHI Report. https://phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-2018
- Leading Age, Making Care Work Pay Report https://www.leadingage.org/making-care-work-pay
- U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. 2019. Medicare Program; Prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2020. *Federal Register.* Proposed Rule 4/25/2019. https://www.federalregister.gov/documents/2019/04/25/2019-08108/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

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Q & A

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