Study of Paid Feeding Assistant Programs

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Final Report
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Abt Associates Inc.

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Prepared for
Susan Joslin, Ph.D.
S2-12-25
CMSO/CMS
7500 Security Boulevard
Baltimore, MD 21244

Judith Sangl, Sc.D
Health Scientist Administrator
AHRQ
Center for Patient Safety and Quality Improvement
540 Gaither Road, 3rd Floor
Rockville, MD 20850

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Prepared by
Rosanna Bertrand
Donna Hurd
Terry Moore
John Schnelle
Victoria Shier
Sandra Simmons
Rebecca Sweetland

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Origins of the PFA Legislation and This Study

Multiple studies have shown that in many U.S. nursing homes, feeding assistance is inadequate and of poor quality (Blaum *et al.* 1995, Kayser-Jones *et al.* 1999, Simmons *et al.* 2002, Simmons *et al.* 2003). Nurses' aides report that they lack sufficient time to adequately help all of the eating-dependent residents for whom they are responsible (Kayser-Jones J. 1996; Kayser-Jones J. and Schell E. 1997). Most nursing home residents in need of mealtime assistance do not receive enough feeding assistance to ensure adequate nutrition and hydration (Simmons *et al.* 2002).

Concerns about the adequacy and quality of feeding assistance care and staffing shortages of certified nurse aides (CNAs), led to action by the Centers for Medicare & Medicaid Services (CMS). On September 26, 2003, CMS published a Federal Register notice enabling long-term care facilities to use paid feeding assistants (PFAs) to supplement the services of CNAs during mealtimes. PFAs, as defined by the federal rule, were to be used only with residents who did not have complicated feeding problems. The legislation, "Requirements for Paid Feeding Assistants in Long-term Care Facilities" (68 FR 55528), had two immediate goals: to increase the availability of staff during mealtimes, and to mandate minimum training and supervision standards for paid feeding assistant programs. However, various stakeholder groups—for example, the National Citizen's Coalition for Nursing Home Reform, Service Employees International Union, and Alzheimer's Association—raised concerns about the new law's implications for resident care and safety, and for staffing configurations (Federal Register 2003; Remsburg 2004).

Therefore, in June 2004 CMS and the Agency for Healthcare Research and Quality (AHRQ) sponsored a nationwide two-phase study to gain an understanding of the characteristics of paid feeding assistant programs (CMS, 2004). Phase I included three specific goals: 1) determine the degree of implementation of PFA programs nationally, 2) understand the characteristics and design of these programs; and 3) examine whether the use of PFAs increases the quality of care in nursing homes. Phase II was proposed to expand on the Phase I study by including a larger sample of feeding programs for direct observation as well as additional interviews with facility staff and residents. In addition, Phase II would analyze the relationship between feeding assistant programs and measures of resident quality of care. Through a competitive procurement process, in September 2004 Abt Associates Inc. and its partner, the University of California at Los Angeles Borun Center for Gerontological Research (UCLA-Borun Center), were awarded the opportunity to design and implement a study to address the goals of Phase I of the CMS/ARHQ project, "The Study of Paid Feeding Assistant Programs."

Purpose of Report

This report presents Phase I findings, which were obtained through an all-state telephone inventory of state- and facility-level implementation of PFA programs, a web-based survey of facility-level implementation, site visit dining observations and staff interviews at a small sample of nursing facilities that use PFAs, and telephone interviews with PFA "stakeholders," such as nursing home trade association representatives and long-term care facility ombudsmen. Trained research staff used standardized protocols to gather data on PFA training programs, state- and facility-level program implementation, state oversight and monitoring, and **the quality of the dining experience (Appendix 2.1).** The data directly address the following four major concerns of those opposed to the Federal Regulation:

- Inadequate training and supervision of staff responsible for providing feeding assistance will result in poor-quality assistance.
- Allowing inadequately trained staff to assist residents with complicated feeding assistance needs, for example, those with swallowing difficulties, will jeopardize resident safety.
- PFAs will be used to provide other aspects of daily care for which they have not received proper training—such as, transferring residents in or out of bed, toileting, dressing, and/or walking assistance.
- PFAs will be used to replace existing nurse aide staff who require more training and supervision and higher pay, resulting in lower overall staffing, and complaints among existing nurse aide and licensed nurse staff within PFA programs.

Research Questions

Should the federal government be concerned about the quality of care provided by PFAs?

CMS and AHRQ sought information on the extent to which paid feeding assistants are used, and the degree to which it should be concerned (if at all) about the quality of care for nursing home residents in facilities that use them. Multiple research questions were addressed in this study. This report focuses on the following:

1. To what extent has the PFA rule been implemented nationally? That is, how far along, or at what stage of development, are states in implementing the rule?
2. To what extent do state regulations vary from the federal rule?
3. To what extent are quality assurance mechanisms, such as survey procedures, in place in states regarding the use of PFAs?

4. Is there concern among states/facilities regarding quality of care for residents served by PFAs? Are concrete data or evidence available regarding quality?

In addition, questions directly related to facility-level implementation were addressed.

1. To what extent do facilities utilize other paid workers (e.g., social service or activities personnel) to help provide foods and fluids to residents?
2. What nutritional care tasks are other paid staff allowed to perform, and what is the training and/or supervision of these staff?
3. Within facilities that use paid feeding assistants, do direct observational measures in a small sample of facilities show a difference in quality of feeding assistance care between paid assistants and traditional nurse aides?

Methods

Data were collected from multiple target populations using a variety of research methods:

- An all-state telephone inventory with state regulatory agencies, or other state agencies responsible for the PFA program, was conducted to assess state-level responses to the federal rule, and to generate lists of facilities that had received approval to implement the PFA program. **(Discussion Guide: State Agencies and State Provider Association Affiliates, Appendix 1.31.)**
- In cooperation with the American Health Care Association (AHCA), data on PFA program implementation were collected from member facilities through a **web-based survey (Appendix 3.1)**.
- Site visits were made to seven facilities in three states—Colorado, New Hampshire, and Wisconsin—to obtain facility-level **dining observations (Appendix 2.1)** and **individual interviews (Nurse Educator, Appendix 2.7; Charge Nurse, Appendix 2.15; Director of Nursing, Appendix 2.18; Administrator, Appendix 2.25; and Feeding Assistant, Appendix 2.30)** with staff. Types of staff interviewed included nurse aides, dieticians, administrators, nurse educators, charge nurses, directors of nursing, and the PFAs themselves. Data were used to assess the response to the PFA program from various types of staff, and to evaluate the process of program implementation including training, deployment of PFAs, and supervision.
- **Telephone interviews (Surveyors, Appendix 2.32, Ombudsman, Appendix 2.36, and Provider Association Affiliate, Appendix 2.40)** were conducted with ombudsmen, state surveyors, and representatives of AHCA and the American Association of Homes and Services for the Aging

(AAHSA), in each of the three target states. These interviews assessed stakeholders' responses to the PFA program and their perspectives on program implementation and oversight.

Institutional Review Board approval was obtained by Abt Associates and the UCLA-Borun Center to conduct these studies. Verbal **informed consent (Appendix 5.1)** was obtained either in person or by telephone from all respondents prior to conducting interviews.

Major Findings

This section summarizes findings from the various investigative activities of this study—i.e., the all-state telephone inventory, web-based survey, facility observations and interviews, and stakeholder interviews. Findings are organized around eight general patterns that have emerged in the data, related to program characteristics, facility operations, and program endorsement at the state and facility level. Each major finding is briefly described and accompanied by specific data that support it. Where relevant, recommendations are identified for program implementation, monitoring, or oversight. Additional detail, descriptive tables, and methods are available in the appendices.

"The program has had a very positive impact on residents. It allows more individualized attention, and less wait time. There's no rushing through the meal."
(Director of Nursing)

PFA programs are generally regarded as an improvement in resident dining, with no significant concerns noted.

State agency respondents, facility staff, and **stakeholders (Appendix 6.1)** (e.g., trade association representatives and ombudsmen) strongly supported the PFA rule and did not express concern about the quality of care.[1] The majority of state agency contacts (60 percent) expressed the belief that the PFA program is a good idea, and more than half of all states expressed no concerns about the use of feeding assistants. Staff in the facilities visited had no concerns about their PFA programs (see comments that follow), and had plans to continue and/or expand the programs. CNAs were very enthusiastic about the program, and reported no concerns about the PFA program at their facilities. Industry representatives contacted in the three study states were positive about the use of PFAs.

[1] It is important to note that at the time of this study, six states plus the District of Columbia had not implemented the Federal rule for varying reasons. Two states adopted a 'wait and see' attitude pending resolution of a lawsuit brought against CMS by the Resident Councils of Washington.

The following comments were voiced regarding the impact of PFA programs:

- "[The program] …frees up the nursing staff to focus on residents who need more skilled assistance." (AHCA representative)
- "Anything that helps [staffing] is good. It takes a long time to get residents to eat properly. There's no reason someone with proper training can't do this." (State Agency representative)

> **Interpretation and Resulting Recommendation:** *The PFA program appeared to be well received by regulators and the majority of advocates, as well as by facility management and direct care staff.* We believe that CMS and AHRQ should continue to support the PFA program.

Most state PFA training programs exceed the federal requirements.

Nearly all (89 percent) of the active states (i.e., those that had PFA programs) adopted more stringent requirements than those articulated in the federal rule. This finding parallels that seen for nurse aide training requirements, with 56 percent of states requiring additional nurse aide training hours over the federal requirement.[2] States increased the required number of PFA training hours beyond the eight federally required hours, and mandated additional training content. They also specified instructor qualifications and mandated competency testing, while the federal rule did neither. For detailed findings regarding state training program requirements, see "Study of Paid Feeding Assistant Programs: Interim Report," **Section 4.2.1 (Appendix 1.14), Table 3 (Appendix 1.16).**

All PFAs interviewed (except those certified as nurse aides) reported having received at least eight hours of formal training specifically focused on feeding assistance, which included both written and performance-based competency evaluations.

> **Interpretation and Resulting Recommendation:**
> *Since the majority (89 percent) of active PFA states adopted PFA training requirements more stringent than the federal rule, CMS and AHRQ should further investigate variation in state-level PFA training program implementation to determine whether the federal requirements should be strengthened.*
> Early on, states identified some components of the federal PFA program as inadequate. These components may have been related to state-specific requirements, or may have represented areas of the PFA program that stakeholders simply found to be lacking. Now that these active PFA programs have been under way for more than two years, states and providers may have additional insights to share regarding PFA program

[2] Based on telephone inventory (March 2005) regarding minimum nurse aide training requirements conducted as part of report on improving nurse aide training for CMS Contract #500-95-0065 TO#3.

requirements. These individuals could be valuable informants to CMS in determining whether some components of the current program need to be changed, based upon lessons learned. This study produced a full inventory of state-level variation in training hours, content, competency testing, and instructor qualifications, but CMS may wish to obtain more detailed information about the states' rationale for adopting more stringent training requirements. This information could help CMS determine whether these additional requirements should be considered for adoption at the federal level.

Little to no variation was found in the adequacy and quality of assistance provided by PFAs versus CNAs.

Based on observations of 196 resident-meals, we found that PFAs spent significantly more time providing feeding assistance to residents, as compared to nurse aides. A significantly higher proportion of residents ate less than half the meal served, and received less than one minute of assistance when assisted by CNAs, as compared to when assisted by PFAs (see Table 1). In terms of how staff respond to residents with poor intake during the meal, our observations revealed that one-third of the time, neither PFAs nor CNAs offered the resident a substitution when he or she ate less than half of the meal. For additional information on dining observations, see **Site Visit Findings (Appendix 7.1)**.

Table 1

A Comparison of Care Process Measures Between Certified Nurse Aides (CNAs) and Paid Feeding Assistants (PFAs)

Feeding Assistance Care Process Measures	CNAs n = 126 resident-meals		PFAs n = 70 resident-meals	
1. Resident eats < 50% and receives < 1 min of assistance	9%*	(11)	1%	(1)
2. Resident eats < 50% and not offered a substitute	33%	(42)	29%	(20)
3. Resident receives < 5 min of assistance and a supplement	1%	(1)	0%	(0)
4. Resident independent but receives physical assistance	24%	(30)	29%	(20)
5. Resident receives physical assistance without verbal cue	3%	(4)	1%	(1)

*p<.05 *Source: Abt Associates Inc. 2006*

Interpretation and Resulting Recommendation:

Based on direct observation of the dining assistance provided by both PFAs and CNAs, we found that PFA staff perform at least as well as CNAs in feeding or assisting residents to eat. CMS and AHRQ should support continued research in this area in order to provide an evidence-base for how adequate assistance during mealtimes can influence residents' oral intake and can be readily implemented by facilities in the form of paid feeding assistant programs.

The use of non-certified staff to assist with resident feeding is not a new premise. Facilities reported that they often used non-nursing staff in times of severe staff shortage or as a general procedure to boost staffing during mealtimes. The passage of the PFA rule requires that these staff be trained, an improvement over the previous practice of permitting these staff to help as needed without a clear mandate for training. In view of the limited evidence presented here that these additional, minimally-trained staff can contribute to improved mealtime assistance, it seems to follow that the study of this practice should continue, to provide further evidence to enhance and refine PFA programs.

There may be reason for concern regarding both the supervision of PFAs and the appropriate assessment of residents with complicated feeding assistance needs.

Although facility staff reported that licensed nurses were present in the dining room during mealtime, the on-site research team did not consistently observe this. A licensed staff member was present in the dining room during 66 percent of meal observations.

Both CNAs and PFAs were observed providing assistance to residents with modified texture diets (i.e., ground, mechanical soft, or pureed texture), which suggests swallowing and/or chewing difficulties.

Both the nurse educators and the directors of nursing at all sites reported that only residents "without complicated feeding assistance care needs" were assigned to PFA staff, but the criteria used to define those with complicated needs was unclear at all sites (e.g., "based on care plan"). In our limited sample, both CNAs and PFAs were observed providing assistance to residents with modified texture diets (i.e., ground, mechanical soft, or pureed texture), reflecting possible swallowing and/or chewing difficulties.

Interpretation and Resulting Recommendation:

Based on the small sample of facilities assessed in this study, reasonable questions were raised regarding the inconsistent supervision of PFAs and the possibility of them assisting residents who have swallowing and/or chewing difficulties.

Additional research utilizing larger samples of randomly selected facilities should be conducted to determine the extent of inappropriate resident assignments. In addition, CMS program requirements should include specific guidelines regarding both PFA supervision and the determination of resident eligibility for feeding assistance by a trained PFA.

PFAs rarely provide assistance with aspects of resident care beyond mealtime feeding tasks.

Of the 39 feeding assistants interviewed, most reported helping with the following mealtime tasks **(Appendix 9.1)**:

> **"Different departments working together during meals … reminds us that we're all here for the same thing. Staff feel they have extra assistance, [and they] don't feel so stressed."**
> **(Facility Manager)**

transporting residents to/from the dining room (82 percent); meal tray delivery, set-up, and pick up (85 percent); food and fluid intake documentation (42 percent); retrieval of substitutions from the kitchen (75 percent); and delivery of additional foods and fluids between meals (54 percent). Direct observations during meals substantiated these self-reported data, and indicate the advantage of having extra hands available during mealtime to perform other tasks in addition to assisting with eating. The PFA duties observed on-site varied, and did not always involve actual feeding. These findings suggest that PFAs can help to alleviate the burden placed on nursing staff during mealtime, not only by providing feeding assistance but also by performing other meal-related tasks.

A minority of PFAs also reported helping existing nurse aide staff with other aspects of resident daily care, including: transporting to/from social activities (63 percent); helping transfer in or out of bed (8 percent); and providing toileting assistance (5 percent) and walking assistance (29 percent). With one exception, the PFAs who reported helping residents get in or out of bed or providing toileting assistance were also certified nursing assistants. In addition, providing assistance with ADLs is likely to be unrelated to serving as a PFA. That is, these tasks were probably performed as members of the nursing home staff outside of their PFA responsibilities.

> **Most PFA programs recruit and employ existing, non-nursing facility staff as PFAs.**

Interpretation and Resulting Recommendation:

To underscore the responsibilities of the PFA and the limitations regarding assistance with resident ADLs, CMS should consider providing more guidance on program implementation, and should set parameters around PFAs' performance of non-feeding tasks. There appears to be sufficient variation in PFA program implementation practices to support the need for such guidance.

In addition, a randomized intervention trial that includes pre- and post-test interviews and analyses on the outcomes of these programs—including the collection of resident-level data related to medical conditions (i.e., diagnosis of dysphagia, history of aspiration), nutritional status (i.e., body weight, history of weight loss) and physical impairment (i.e., eating dependency, ambulation problems, fall risk)—would determine to what extent these care activities pose a threat to resident safety.

Most PFA programs recruit and employ existing, non-nursing facility staff as PFAs.

Most (65 percent) state agency respondents who had knowledge of the PFA programs in their states reported that facilities always or most often used existing facility staff rather than hiring new single-task employees. Twenty percent reported that facilities used both existing staff and recruited from the community, and 15 percent cited recruitment from the community only. The majority of AHCA members who responded to a **web-based survey (Appendix 4.1)** 93 percent) reported that member facilities used their existing non-nursing staff as PFAs. Finally, PFA interviews revealed that 84 percent of trained PFAs had been recruited from existing staff in non-nursing departments including: social services, activities, dietary, administration, housekeeping, and laundry.

Many of the existing non-nursing staff interviewed reported that they enjoyed working as PFAs, and all respondents reported being comfortable with their resident assignments. Administrators and directors of nursing reported being more comfortable recruiting from existing non-nursing staff because they are known to residents and their families. A staff member at one facility described the following benefit of using existing staff for this position: "Residents like to see a familiar face," also noting that using existing staff as PFAs allows residents to get to know a staff member "as a person."

Voluntary and mandatory recruitment processes were reported. Mandatory recruitment had obvious disadvantages. Even when the program was identified as "voluntary," some staff felt pressure to participate, which occasionally led to job dissatisfaction. Additionally, a small minority of staff interviewed felt that they had been forced to participate in the feeding assistant program, and reported anxiety about their ability to complete their primary job duties in addition to their PFA responsibilities. When one facility opted to wait for staff to volunteer as PFAs, the program lost momentum.

PFAs from non-nursing departments often worked for two supervisors—their primary job supervisor and someone outside their department who supervised the PFA program. This arrangement could potentially lead to role conflict and confusion, as well as to inadequate supervision. For example, in one facility, the non-nursing department supervisor was the also the supervisor for those in her department who were PFAs, which necessitated that this individual provide guidance for her PFA staff around issues of resident feeding, a job which she was not qualified or trained to perform.

Interpretation and Resulting Recommendation:

The findings from this study suggest that existing, non-nursing staff may be ideal recruits for the PFA program, and that therefore the term "paid" feeding assistant does not reflect real-world implementation of this program.

In addition to considering a different name for this type of trained staff member (e.g., dining assistant, feeding assistant), CMS and AHRQ should provide more guidance for facilities on in-house recruitment, such as tips on motivating staff, integrating non-nursing and nursing staff, facilitating inter-departmental communication and cooperation, and sensitivity to worker role conflict. Cross training staff for roles outside their primary job responsibility is not a new concept. It was adopted, at least in part, to deal with the staff shortages that prompted the original interest in PFA programs, and it continues to be a major issue facing facilities. CMS and AHRQ should take the lead in developing and disseminating best practices for cross training staff to become feeding assistants in order to help facilities avoid employee job dissatisfaction, staff turnover and potential negative resident outcomes.

Many states have implemented programs; however, few are knowledgeable about actual PFA operations.

At the time the **all-state telephone inventory (Appendix 1.9)** was conducted, 28 states reported having active programs (i.e., they allowed facilities to use PFAs). Sixteen states had programs pending (had not yet implemented a program but were in the process) and seven states had no program (implementation was on hold, or the state had no interest).[3] Despite the level of interest in PFA programs, stakeholders and state agency respondents had limited knowledge about facility-level implementation. Less than two-thirds of active states were able to identify facilities with approved training programs, and only three states had concrete knowledge of facility-level implementation. Although the data are limited regarding states' knowledge of PFA programs, the general impression is that relatively few facilities have implemented the program.

Despite the level of interest in PFA programs, stakeholders and state agency respondents had limited knowledge about facility-level implementation.

Interpretation and Resulting Recommendation:

CMS should investigate reasons why more information is not available on the extent of PFA program implementation. It should also identify any significant barriers to implementation at the state- and facility-level.

While PFA programs appear to enjoy significant interest and support, the apparent low level of implementation may be evidence of barriers to program implementation that CMS is not aware of. These could involve funding limitations, or hesitation on the part of facilities resulting from the lawsuit filed against the U.S. Department of Health and Human

[3] For convenience purposes, the District of Columbia was counted as a state.

Services by the Resident Councils of Washington, joined by other consumer and nursing advocates. The lawsuit's allegations were founded on concerns related to resident safety. Information on PFA programs, and public release of this research report, may help to allay such concerns.

States provide little oversight for PFA programs.

Program oversight (Appendix 1.21) includes activities around the initial program-approval process, ongoing program monitoring, and program evaluation, as well as monitoring individuals filling PFA positions. We found few examples of states with formal approval and tracking processes either for facility implementation of PFA programs or of individuals trained as PFAs. Twenty-one percent of active states do not require any formal notification to the state that the facility intends to create a program, and three states require only that the facility training program submit an attestation statement that it meets federal and state requirements. Only 36 percent of active states reported that survey procedures had been modified to include protocols for monitoring PFA programs.[4] Most states do not have a systematic way of monitoring how many PFAs have been trained, with only three of the active states planning to track PFAs through a registry. Furthermore, no states were involved in the development or implementation of any measure regarding the impact of the PFA program.

Interpretation and Resulting Recommendations:

CMS should consider adding the monitoring of PFA programs to existing State Survey Agency requirements that mandate oversight of nurse aide training program approval and recertification.

State survey agencies are responsible for approving and recertifying nurse aide training programs. Federal requirements stipulate that the state initially approve and then recertify these programs every two years, through examination of programs' records during an on-site visit. It may be feasible for states to conduct PFA program review and approval in conjunction with ongoing monitoring activities for nurse aide training, as these state staff are trained and experienced in the review of educational materials.

CMS should provide guidance to surveyors for identifying facilities that use PFAs, and for verifying that programs meet federal rule requirements.

With so few states aware of which facilities have implemented a PFA program, surveyors are likely to need guidance in order to target those facilities that do. Therefore, CMS should emphasize, in its survey protocol development, the use of screening questions early in the survey process. These could include whether the facility has a PFA program, as well as

[4] Since the time of our interviews, CMS has begun development of survey guidelines for quality monitoring of PFA programs.

questions to identify which meals and which residents are assisted. Issues of resident selection and licensed nursing supervision could also be incorporated into the care plan review and staff discussions, provided these issues are identified early in the survey process.

CMS should identify and share states' best practices with regard to PFA program approval, oversight, and quality monitoring.
Some states have been able to provide a higher level of program monitoring within their current resources. Information on these states may be extremely valuable to their counterparts that wish to provide additional oversight. Such a "promising practices" program would require that CMS set standards for "best practice" for various oversight components, receive and evaluate state processes, and then share these practices through written materials or Internet postings.

Conclusions

This evaluation study, jointly sponsored by CMS and AHRQ, determined that over half of the states (n=28) had implemented the federal regulation to allow nursing facilities to use PFAs, and 16 additional states were in the process of creating policies to allow the program to be implemented. This suggests national interest in using these types of workers to supplement existing facility staffing resources.

Site visits conducted in a convenience sample of seven nursing homes in three states showed that staff trained as feeding assistants provided care comparable to, and in some instances significantly better than, the care provided by indigenous nurse aide staff, according to five care process measures. In addition, the majority of PFAs observed were non-nursing staff within the facility (84 percent), or CNAs who worked in other nursing homes (8 percent), as opposed to single-task workers hired from the community (8 percent). This finding indicates that the title "*Paid* Feeding Assistant" is misleading, as most feeding assistants are not reimbursed specifically for their work in providing feeding or dining assistance to residents.

Findings from Phase I of the **"Study of Paid Feeding Assistant Programs" (Appendix 8.1)** addressed four primary stakeholder concerns, and in most cases should allay those concerns. Specifically,

1. ***Concern that inadequate training and supervision of staff responsible for providing feeding assistance will result in poor-quality assistance.***
   Findings from the all-state telephone inventory and from on-site interviews and observations revealed that PFAs receive comparable training to

certified nursing assistants in the area of nutritional care. Also, most states provided more training hours than the federal requirement, added specific instructor qualifications and mandated competency testing. With regard to supervision of PFAs, 66 percent of the facilities that we observed provided adequate mealtime supervision. In the remainder of the facilities, licensed nurses were not always present in the dining room during our observations.

2. ***Concern that resident safety will be jeopardized by allowing inadequately trained staff to assist residents with complicated feeding assistance needs (e.g., those with swallowing difficulties).***
Despite staff reports that only residents without complicated feeding needs were assigned to feeding assistants, PFAs in our sample of facilities were observed helping many residents to eat who had modified texture diets (e.g., pureed) and/or required physical assistance (spoon to mouth feeding). Both modified-texture diets and the need for physical assistance to eat suggest that residents helped by PFAs may have had swallowing or chewing difficulties, and/or other physical impairments that placed them at risk for feeding complications. This finding indicates that facilities need assistance in determining which residents are appropriate to be safely assisted by a feeding assistant.[5] On the other hand, PFAs were observed to spend more time providing feeding assistance when compared with CNAs, and the quality of that assistance was as good if not better than that provided by CNAs. Although these findings should be interpreted with caution due to the small sample of volunteer facilities, it may be hypothesized that the single task worker, devoted only to providing feeding assistance without the distractions of other duties and functions, is better able to enhance the quality of the residents' dining experience.

Site visit data do not support the concern that single-task workers will be used to replace existing nurse aide or other staff.

3. ***Concern that PFAs will be used to provide other aspects of daily care for which they have not received proper training (e.g., transferring residents in or out of bed; toileting, dressing, and/or walking assistance).***
PFAs do not appear, at least in this small observational study, to be providing non-nutritional care to residents for which they have not been trained (e.g., transferring, toileting). CMS may need to enhance programmatic guidance to states and facilities on this topic, and may need to provide more oversight of PFA programs and facility quality in order to assure strict adherence.

[5] This finding may also indicate that facilities inappropriately serve modified texture diets to residents who do not require mechanical alteration of foods to safely eat, an important issue but not one studied during this project.

4. ***Concern that PFAs will be used to replace existing nurse aide staff who require more training and supervision and higher pay, resulting in lower overall staffing and complaints among existing nurse aides and licensed nurses.***
   The site visit data collected in this study do not support the concern that single-task workers will be used to replace existing nurse aide or other staff. No changes were reported in existing staffing levels due to PFA program implementation. Again, it should be noted that these data are limited by a small sample of volunteer facilities that may be biased toward high quality care.

Another concern raised as a result of this study is the apparent lack of state oversight of facility-level program implementation. States have little knowledge of program operations, and can thus provide no insight on the impact of PFAs on resident care quality. CMS has recently drafted surveyor guidelines for review of PFA programs in order to address this aspect of their oversight responsibility; it is unclear when these guidelines will be released and incorporated into the survey and certification process for long-term care facilities. Given past criticisms regarding a lack of oversight and monitoring, it is hoped that information from this study can inform the development of survey guidelines for assessment of PFA programs. For example, CMS has been charged with a lack of oversight of nurse aide training, particularly in ensuring that facilities are compliant with nurse aide training requirements. Rather than endure such criticism again in this program, it would behoove the Agency to quickly develop and implement mechanisms designed to oversee facility-level processes for PFA training and competency testing.

Limitations

The study of Paid Feeding Assistant Programs has provided evidence to allay most of the advocates' concerns; however, the results should be interpreted in light of the following limitations:

- The study utilized a small convenience sample of nursing homes in only three states. It is likely that these facilities reflect a bias, both in overall staffing levels and the quality of nutritional care provided to all residents. In fact, both PFA and CNA staff observed during site visits provided *better* feeding assistance care than that observed in previous studies using the same care process measures (Simmons *et al.* 2002; Simmons *et al.* 2003; Schnelle *et al,* 2004).
- The small facility sample size prohibited comparisons to be made between nursing homes with different staffing levels, or between shifts within the same nursing home, or to determine to what extent PFA staff contributed to total staffing resources.

- There was a lack of resident- and family-level data to more specifically address the impact of PFAs on resident safety and clinical outcomes (e.g., weight loss).

Next Steps

A participatory study could help translate these research findings into "best practice" feeding assistant programs.

The work of Phase I of this project revealed relatively good quality in the level of assistance provided by trained feeding assistants in a small, volunteer sample of nursing homes. There were also indications that feeding assistants may be assisting higher risk residents than the federal rule had anticipated (i.e., 57 percent of residents that we observed PFAs assisting had modified texture diets, which suggest swallowing or chewing difficulties and/or complicated feeding needs in those residents). We believe that with hands-on training assistance, as well as tools that facility management staff can use to monitor feeding assistant program implementation, significant improvements in nutritional care quality can be achieved. Thus, one next step in the implementation and evaluation of this national program is the design and implementation of a participatory study in order to translate these research findings into operational guidelines for facilities to implement "best practice" feeding assistant programs.

To validate the findings reported in this study, and to more confidently respond to stakeholder concerns regarding the implementation of the PFA program, a randomized participatory study is recommended. Building on the current study, a randomized trial will control for bias toward higher quality care inherent in a volunteer sample. In addition, a larger project will allow comparisons to be made based on factors such as staffing levels, volunteer versus mandatory participation, and various work shifts to explore the extent to which these factors impact resident dining care and the implementation of the PFA program. The current study should also be expanded to include face-to-face interviews with residents and family members to assess important clinical and quality of life concerns. The results from a randomized study will serve to inform the development of an operational manual to guide facilities as they implement the feeding assistant program.

Additional steps that CMS and AHRQ should consider to strengthen PFA program implementation and quality oversight of PFA programs nationally, given the findings of this report, include:

- Determine what (if any) barriers are impacting state- and facility-level program implementation;

- Develop and disseminate best practice information on state-and facility-level implementation;
- Investigate the rationale and impact of more stringent state training requirements to determine if the federal requirements should be strengthened;
- Support continued research that expands on the current study to determine the impact of PFAs on resident outcomes;
- Provide additional guidance for facilities regarding the supervision of PFAs and the selection of appropriate residents for feeding assistance;
- Continue efforts to guide surveyors in accurately assessing compliance of PFA programs with federal program and quality of care requirements; and
- Consider enhancing oversight of state program approval and recertification of PFA training programs.

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