Study of Paid Feeding Assistant Programs

Volume #1
Final Report
March 30, 2007

Abt

Abt Associates Inc.

Abt Associates Inc.

Study of Paid Feeding Assistant Programs Volume # 1

Contract No. 500-00-0049 / TO No. 2

Final Report

March 30, 2007

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

Contents

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.

References

Blaum, CS, Fries, BE and MA Fiatarone (1995). *Factors associated with low body mass index and weight loss in nursing home residents*. Journals of Gerontology Series A: Biological Sciences and Medical Sciences, Vol 50, Issue 3 M162-M168.

Centers for Medicare & Medicaid Services (2004). Request for Task Order Proposal No. CMS-04-012/VAC, "Study of Paid Feeding Assistant Programs".

Federal Register "Requirements for Paid Feeding Assistants in Long Term Care Facilities." Vol. 68, No.187. 26 Sep. 2003: 55528-55539.

Kayser-Jones, J. (1996). Mealtime in nursing homes; the importance of individualized care. Journal of Gerontological Nursing, 3, 26-31.

Kayser-Jones J., Schell, E. (1997). The effect of staffing on the quality of care at mealtime. Nursing Outlook, 45, 64-72.

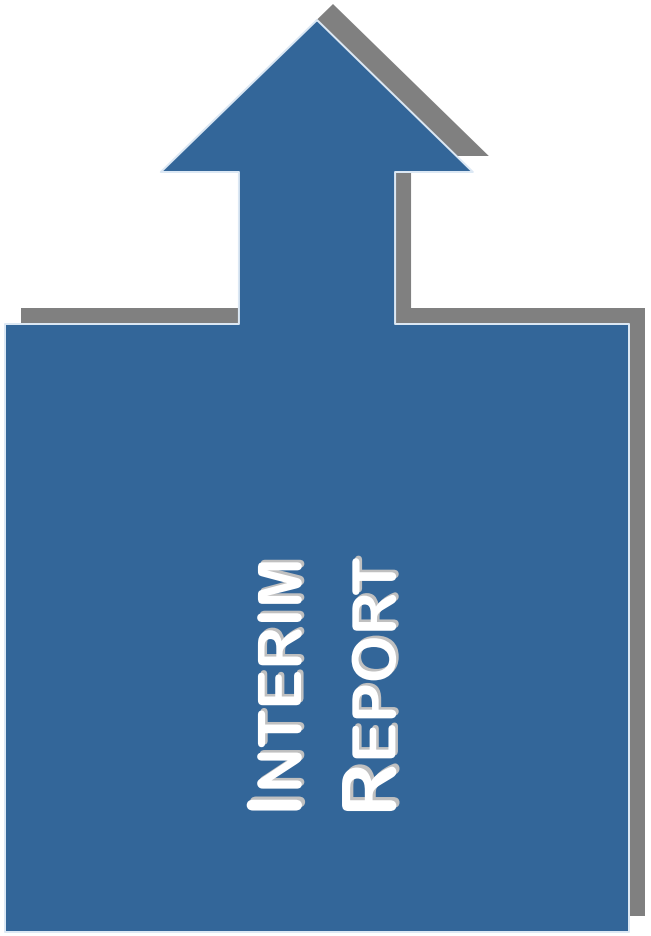
Kayser-Jones J, Schell ES, Porter C, Barbaccia JC, Shaw H. (1999). *Factors contributing to dehydration in nursing homes: inadequate staffing and lack of professional supervision*. J Am Geriatr Soc. 1999 Oct; 47(10):1187-94.

Remsburg, R.E. (2004). Pros and cons of using paid feeding assistants in nursing homes. Geriatric Nursing, 25(3):176-177.

Simmons S.F., Babinou S., Garcia E., Schnelle J.F. (2002). Quality assessment in nursing homes by systematic direct observations: Feeding assistance. *Journal of Gerontology: Medical Sciences,* 57A(10), M665-M671.

Simmons S.F., Garcia E.F., Cadogan M.P., Al-Samarrai N.R., Levy-Storms L.F., Osterweil D., Schnelle J.F. (2003). The Minimum Data Set weight loss quality indicator: Does it reflect differences in care processes related to weight loss? Journal of the American Geriatrics Society, 51(10), 1410-1418.

Appendix 1 Appendix 1 Appendix 1



Abt Associates Inc.

Study of Paid Feeding Assistant Programs: Interim Report

Contract No. 500-00-0049/TO#2

Cambridge, MA
Lexington, MA
Hadley, MA
Bethesda, MD
Chicago, IL

February , 2005

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

Prepared by
Terry Moore
Donna Hurd
Vicki Shier
Rebecca Sweetland

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Contents

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) has ongoing concerns about the quality of care provided in nursing homes, especially with regard to nurse and nurse aide staffing, and to nutrition and hydration. 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). Specifically, studies conducted by the University of California at Los Angeles Borun Center for Gerontological Research (UCLA–Borun Center) and others have shown that most residents in need of assistance do not receive enough to ensure adequate nutrition and hydration.

In response to concerns about the quality of feeding assistance care and about certified nurse aide staffing shortages, on September 26, 2003, CMS published a Federal Register notice enabling long-term care facilities to use paid feeding assistants who are not necessarily professionals. The feeding assistant legislation, "Requirements for Paid Feeding Assistants in Long-term Care Facilities" (68 FR 55528), was intended to improve quality of care by mandating some degree of uniform implementation and monitoring by states.

This report, a component of the Phase I Study of Paid Feeding Assistant Programs, presents the findings of an all-state inventory of state regulatory agencies' responses to the federal rule. Using data collected during the telephone inventory, the report shows which states have taken action related to the feeding assistant legislation, the degree to which states have implemented the federal rule, and common program elements among states. Issues reviewed included: the process for state review and approval of nursing facility feeding assistant training programs, the content of state-specified training curricula, state oversight procedures of facility paid feeding assistant (PFA) training and feeding programs, and stakeholder input and reactions to state implementation of paid feeding assistant programs.

Key Findings

Of 50 states and the District of Columbia, 28 are considered "active" states, in that they allow the use of paid feeding assistants. Sixteen "pending" states (not yet active states) are working toward program implementation. Almost all active states exceeded the federal requirements when developing their training programs. Almost half exceed the eight-hour training minimum articulated in the federal rule; 12 specify additional training topics; and most have deemed a particular curriculum as their "state-approved" curriculum. Twenty of the 28 active states specify requirements for competency testing. Additional findings are as follows.

- Twenty-one of the 28 active states reported that providers/provider associations promoted the measure to implement a PFA program, and cited staffing shortages and quality of care issues as the most significant reasons why they chose to implement a PFA rule.

- State Agencies have limited knowledge about how facilities have actually implemented feeding assistant programs, though most were of the opinion that facilities are more likely to train existing staff to serve as feeding assistants, rather than to hire new employees to perform this function.

- States varied in their degree of PFA program oversight. When rated according to an "oversight" scale derived from select program characteristics and program monitoring functions, the following states were categorized as having the "highest" level of program oversight: Delaware, Illinois, Maine, Mississippi, North Dakota, Ohio, South Carolina, West Virginia, and Wisconsin. These states have all implemented a formal process of review and approval of nursing facility PFA training curricula, and their PFA programs exceed the requirements set out in the federal rule on one or more measures (e.g., more than eight hours of training required, specification of PFA trainer qualifications). States with lower levels of program oversight cited lack of funding for this program, and the nursing home industry's lack of interest.

- Active states were more likely to cite a staffing shortage as a key reason implementing the PFA program (64 percent).

- Ten of the 28 active states reported that survey procedures to monitor the PFA program had been developed and/or implemented: Illinois, Maine, Nebraska, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, and Wisconsin. The types of survey activities to be performed in these states included survey observations of residents receiving assistance from PFAs, and review of personnel and PFA training records. No states have developed or implemented a measure of the impact of this program on quality of care or of life for residents who receive dining assistance from these trained assistants.

Conclusions

Using data collected during a telephone inventory of 50 states and Washington, DC, researchers identified which states have taken action related to the feeding assistant rule, the degree to which states have implemented the rule, and variation among states in how feeding assistant programs have been implemented.

A majority of states (86 percent) interviewed had already implemented or were in the process of implementing a state PFA program (active or pending states). Most that have done so have acted with the support of, and often at the behest of, the long-term care industry. Despite arguments to the contrary by the federal rule's detractors, state respondents did not express concern about quality of care or other issues in allowing the use of paid feeding assistants.

Considerable variation exists among states with active PFA programs in training requirements, reporting, and approval requirements. Many states adopted more stringent training requirements than those articulated in the federal rule (e.g., more hours of training required, more training topics, resident-specific training). Many states do not have a formal training curricula approval process, and most have no plans to gather and monitor lists or registries of trained PFAs.

This level of variation in training requirements was likely anticipated by CMS, and does not appear problematic. However, the lack of program monitoring or program oversight among states may have potentially negative consequences for CMS in the future. Despite low levels of facility-level program implementation to date, it would seem that CMS may want a program monitoring mechanism in place, in the event that facilities become more active users of PFAs.

Similarly, 37 percent of active states monitor facility quality related to PFAs through the long-term care survey and certification process. They reportedly do this by adding residents assisted by PFAs to the resident sample, observing residents that receive PFA assistance during dining observations, and/or reviewing personnel and training records when conducting the annual on-site survey. Though this appears to be an excellent vehicle of quality oversight of PFA programs, CMS may wish to have a uniform, standard survey component to achieve this quality monitoring, rather than many state-specific survey processes.

Finally, this study was limited in its scope, and therefore able to answer program design and implementation questions only at the *state level*. Little is known about the degree of *facility-level* program implementation, such as what type of personnel are trained to become feeding assistants, whether this job category is desirable enough for nursing facilities to successfully attract these single task workers, whether nurses and nurse aides in facilities that utilize PFAs are more able to provide direct care to residents, and whether residents who are assisted by trained feeding assistants have better nutrition-related outcomes or a higher quality of life.

In order to gain a better understanding of *facility-level* program implementation, and of *facility-level* quality of care in relation to the use of PFAs, CMS should consider funding Phase II of this study. The Phase II study would evaluate differences in quality of care between facilities that use PFAs versus facilities that do not, in order to detect quality of care differences— if any—between both types of facilities. Data from Phase II of this study may also contribute to improvements in nutritional and other nursing facility care quality through dissemination of information about "best practices" in these research areas.

1.0 Background and Purpose of Study

The Centers for Medicare & Medicaid Services (CMS) awarded this "Study of Paid Feeding Assistant Programs" through a competitive procurement process to Abt Associates Inc. and its partner, the University of California at Los Angeles Borun Center for Gerontological Research (UCLA-Borun Center), in September 2004. In Phase I of this contract, CMS seeks to identify which states and facilities have taken action related to a 2003 announcement in the Federal Register ("Requirements for Paid Feeding Assistants in Long-term Care Facilities", 68 FR 55528) that allows long-term care (LTC) facilities to use paid feeding assistants, as long as this rule is consistent with state laws. If Phase I shows that enough states are indeed using paid feeding assistants, CMS may then direct the Abt Associates project team to conduct a second phase of the study that will examine the impact of paid feeding assistant programs on quality of care in nursing facilities.

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). Specifically, studies conducted by the UCLA-Borun Center and others have shown that most residents in need of assistance do not receive enough assistance to ensure adequate nutrition and hydration. Simmons and Schnelle (2004) found that one-on-one mealtime assistance can significantly increase residents' food and fluid intake, but considerable staff time is required to achieve these positive results.

CMS has ongoing concerns about the quality of care provided in nursing homes, especially with regard to nurse and nurse aide staffing, and to nutrition and hydration. A "Nutrition and Hydration Awareness Campaign" for nursing home providers and state survey and certification staff was initiated as part of the CMS "Nursing Home Oversight and Monitoring Program" (CMS, 2001). Specific quality of care protocols for unintended weight loss and dehydration have been developed and incorporated into the survey and certification process, as well.

In response to concerns about the quality of feeding assistance care and about certified nurse aide staffing shortages, on September 26, 2003, CMS published a Federal Register notice (i.e., a rule) enabling LTC facilities to use paid feeding assistants who are not necessarily professionals. The feeding assistant legislation, "Requirements for Paid Feeding Assistants in Long-term Care Facilities" (68 FR 55528), was intended to improve quality of care by mandating some degree of uniform implementation and monitoring by states. The final rule requires that:

- feeding assistants successfully complete a state-approved training course before feeding residents[1];
- a feeding assistant work under the supervision of an RN or LPN; and
- facilities ensure that feeding assistants feed only residents who have no complicated feeding problems.

[1] The training course must include a minimum of eight hours of training in: feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, appropriate responses to resident behavior, safety and emergency procedures including the Heimlich maneuver, infection control, resident rights, and recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

Since the rule was published there has been some controversy surrounding its impact, and a lawsuit was filed against the U.S. Department of Health and Human Services by the Resident Councils of Washington, joined by other consumers and nursing home advocates. The lawsuit was dismissed by the United States District Court, Western District of Washington at Seattle on August 31, 2005. The Plaintiffs alleged in this lawsuit (subsequently dismissed) that the feeding assistant regulations place residents at risk of future injury. The rule's supporters argue that feeding assistants can provide some needed relief to the nurse shortage and give residents more individual attention. Further, they argue that the rule may free up other staff to attend to those residents with more complex eating problems. This study is one attempt to understand the impact of this rule.

2.0 Overview of the Report

This report represents one component of the Phase I Study of Paid Feeding Assistants, and presents the findings of an all-state inventory of state regulatory agencies' responses to the federal rule. Other study components that will be reported on in the future include an observational study of PFA program implementation at a small number of volunteer nursing homes, and interviews with stakeholders (e.g., long-term care ombudsmen, nursing home industry representatives) about the use of paid feeding assistants.

Using data collected during the telephone inventory, this report identifies active states (states that allow facilities to use paid feeding assistants), pending states (states that are in the process of implementing the program, and no-program states (states that have placed implementation on hold or have not taken any action toward implementing a PFA program). This report shows which states have taken action related to the feeding assistant legislation, the degree to which states have implemented the federal rule, and common program elements among states. This report begins by describing state training and program characteristics. It then analyzes program oversight by states, the relationship between staffing and training/program implementation, and quality oversight mechanisms. Finally, the report presents the researchers' conclusions and the next steps for CMS to consider in assessing the degree to which facilities use feeding assistants, and in assessing how facilities actually implement the federal rule.

3.0 Research Questions and Methods

3.1 Overview of Project Team and Design

Abt Associates, in collaboration with staff at the UCLA-Borun Center and CMS, developed the design, discussion guides, data collection and analysis plan for the work reported here. The design was elaborated on by a distinguished group of technical experts with intimate knowledge of the operational, training, and implementation issues that facilities and others (e.g., state surveyors) could encounter when attempting to implement the federal feeding assistant rule.

3.2 Research Questions

It is important to understand in detail how states have moved forward with implementation of the federal feeding assistant rule. This detailed understanding will inform later analysis on the rule's impact on the quality of resident care. This study sought answers to the following research questions:

1. To what extent has the PFA rule been implemented nationally—or, how far along, at what "stage of readiness," 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 (e.g., 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?

5. To what extent do facilities use volunteers or other mechanisms to enhance the quality of feeding assistance?

Other, secondary, questions of interest that more directly address implementation at the *facility-level* (vs. the state-level) include those listed below. CMS is currently attempting to answer these questions through an industry-sponsored survey of nursing facilities, and through a small observational and descriptive study of nursing facilities in several states. Findings will be reported in the Phase I Final Report and are not presented here:

1. To what extent do facilities allow unpaid persons (e.g., volunteers, family members) or non-traditional paid staff (e.g., social activities personnel) to help provide foods and fluids to residents?

2. What nutritional care tasks are unpaid, or non-traditional paid, staff allowed to perform, and what training and/or supervision do these staff receive?

3. Within facilities that use paid feeding assistants, do direct observational measures in a small sample of facilities show a difference between paid assistants and traditional nurse aides in quality of feeding assistance care?

3.3 Data Collection Methods

Telephone Interviews

Telephone interviews were conducted with 50 states and the District of Columbia during February through October 2005. Target respondents were individuals in the survey and certification group in each state that had responsibility for implementing the state feeding assistant training program, and for ongoing approval of facility feeding assistant training curricula. Occasionally, researchers conducted discussions with two or more state staff, depending upon their level of knowledge of the feeding assistant program, or with staff employed by the Board of Nursing.

These state contacts were identified using information from a study conducted in the previous year by the Kansas State Nurses Association, on the status of feeding-assistant implementation. CMS also assisted by sending an e-mail alert to State Agencies asking them to forward their feeding assistant staff contact information to Abt Associates. For several states, interviews were also conducted with the provider association(s). Interviews were conducted by two Abt staff, using paper and pencil, with the results then being entered into an MS-Access database. To supplement the information collected

during telephone discussions, staff used their state contacts and Internet searches, to obtain memos, regulations, training materials, and information on state legislation.

Telephone Discussion Guide

The interviews used a telephone discussion guide that had been developed, tested, revised, and shared with the project's technical experts. The guide consisted of 55 closed- and open-ended questions covering the following domains:

- *Status of PFA program.* Covers the status of legislation/regulation, groups in favor of or opposing, barriers or aides to implementation, and significant reasons for decision to move forward (or delay).

- *Program Characteristics*. Addresses how the state's program dovetails with the federal rule regarding number of hours, topics, resident selection criteria, supervision requirements, and facility records.

- *Program Implementation*. Describes the state's program approval process, curriculum requirements, record-keeping on approved programs, and knowledge of facility implementation.

- *Quality and Regulatory Oversight.* Addresses the measures (if any) that the state has implemented to oversee PFA program implementation.

- *Training, Testing and Eligibility Requirements.* Describes state requirements regarding testing, criminal background checks, checking of the nurse aide registry, annual in-services or employee reviews, data on the number of PFAs, the portability of training, and trainer qualifications.

- *Reimbursement Issues.* Addresses whether PFAs are listed in the Medicaid Cost Report, whether the state instituted any changes to reimbursement to account for PFAs, and the type of Medicaid reimbursement system.

- *State Characteristics.* Covers any state minimum staffing requirement, how staffing data are collected and audited, and information regarding staffing shortages.

- *Other.* Includes discussants' opinions regarding the PFA program, any positive or negative experiences, concerns, and whether the state has any regulations regarding the use of family members or volunteers for dining assistance.

- *Additional Information.* Includes the total number of facilities in the state and whether the state would be a candidate for site visits.

The Provider of Service (POS) file was used to obtain information on facilities (e.g., rural and urban, bed size, profit status, chain affiliation, hospital-based), and the number of nursing home beds in each state.

Return to Report

Discussion questions were mapped to the research questions to ensure that all research questions were addressed. State agency contacts were asked for details on facility-level implementation, though more-detailed information will be gathered during on-site visits at the facilities.

4.0 Study Findings

4.1 Status of PFA Implementation

Most state agency contacts (60 percent) expressed the belief that the paid feeding assistant program is a good idea, and more than half of all states expressed no concerns about the use of feeding assistants. Those of the opinion that the program is a good idea made comments such as the following:

- "I feel confident more residents are getting assistance with the PFA program".
- "[The program] … provides another option for facilities to improve staffing. It improves the competency of those who are assisting with meals. It frees up nurses and aides to focus on the residents with complicated feeding issues".
- "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".

At the time of interview, there were 28 active states, states that allow facilities to use feeding assistants. Sixteen pending states are in the process of enacting regulations or programs to allow it. Of the remaining no-program states, the program is on hold in three states and three states and Washington, DC, have not taken any action towards implementing the rule (Table 1). Table 2 displays descriptive findings from the 50 states and Washington, DC, which are discussed below. The ensuing discussion focuses primarily on the 28 active states at the time of this inventory.

Respondents were asked whether their state had passed legislation to allow facilities to use paid feeding assistants. Many had not done so. They had instead passed regulations, issued a memo, bulletin, or policy change; or they did not need to make any changes in order to implement the rule. Some states had passed legislation but not yet implemented the program. The 28 active states implemented the program in several ways: 13 passed legislation or regulations, 13 issued guidance through a memo, bulletin or policy change, and the other 2 required no change to allow the use of feeding assistants. Twenty-one of these 28 active states reported that providers/provider associations promoted the measure to implement a PFA program, and cited staffing shortages and quality of care issues as the most significant reasons why they chose to do so.

The 16 pending states have not yet implemented a program, but are in the process; these include Arizona, Florida, Indiana, and Kansas, who have already passed regulations or legislation. Louisiana, Michigan, and Vermont are currently conducting pilot programs. Nine other states are drafting or have pending passage of legislations or regulations. Based on discussions with the states, an estimated half that are pending will allow the use of feeding assistants within the next six months.

The seven no-program states have either placed the program on hold or not taken any steps toward implementing a program. In Kentucky and New Mexico, the program is currently on hold because of

the federal lawsuit referenced earlier (Resident Councils of Washington versus the U.S. Department of Health and Human Services). The program is also on hold in New Jersey, for cost reasons: the state actually would like to have even more comprehensive requirements than those in the federal rule, but has neither the budget nor the staff.

Only three states plus Washington, DC, have not taken any steps toward implementing the federal feeding assistant rule, and at this point do not intend to. Hawaii has not implemented the rule mainly due to their Nurse Practice Act. Washington, DC, does not intend to allow feeding assistants because there are only a few nursing facilities there and the industry is not in favor of the initiative. California and New York have not implemented the rule[2].

Generally, states that implemented PFA programs expanded on the federal requirements. Of the 28 active states, 25 have requirements that exceed the federal minimum in at least one of the areas that were evaluated. The data suggests that at many facilities, non-nursing staff and volunteers were already assisting with meals during busy times, and the feeding assistant rule has served to legitimize this practice and to provide guidelines for proper training.

Table 1

Status of State Implementation of Paid Feeding Assistant Rule

	State	Number of States
Active States*	Colorado, Delaware, Georgia, Idaho, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin	28
Pending States**	Alabama, Alaska, Arizona, Arkansas, Connecticut, Florida, Indiana, Kansas, Louisiana, Michigan, Nevada, Oklahoma, Rhode Island, Utah, Vermont, Wyoming	16
No-Program States***	California, District of Columbia, Hawaii, Kentucky, New Jersey, New Mexico, New York	6, and DC

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

*States with active PFA Program
** States with pending PFA Program

*** States with no interest in PFA Program or Program on hold

[2] California cited budget constraints and other reasons; researchers were unable to ascertain why New York has not implemented the rule.

Table 2

Status of PFA Implementation

State	Status of State Implementation	How Did the State Implement the Program?	Does the State Have a List of Approved Facilities?	Does the State Have Nurse Aide Minimum Staffing Requirements?	Does the State Have Direct Care Minimum Staffing Requirements?	Is the State Experiencing a Nursing Shortage?	Number of Facilities in the State
Alabama	Pending	Legislation/Regulations	N/A	No	No	Yes	226
Alaska	Pending	N/A	N/A	No	No	Info Not Available	14
Arizona	Pending	Legislation/Regulations	N/A	No	No	Info Not Available	132
Arkansas	Pending	Legislation/Regulations	N/A	Yes	No	Info Not Available	204
Colorado	Active	Legislation/Regulations	Yes	No	Yes	Yes	215
California	No-Program	N/A	N/A	No	Yes	No	1,220
Connecticut	Pending	Legislation/Regulations	N/A	No	Yes	Yes	248
Delaware	Active	Legislation/Regulations	Yes	No	Yes	Yes	37
Washington DC	No-Program	N/A	N/A	No	Yes	Info Not Available	19
Florida	Pending	Legislation/Regulations	N/A	Yes	No	Info Not Available	686
Georgia	Active	Legislation/Regulations	No	No	Yes	Yes	333
Hawaii	No-Program	N/A	N/A	No	No	Yes	41
Idaho	Active	Memo / Bulletin / Policy Change	Info Not Available	No	Yes	Yes	77
Illinois	Active	No change needed	Yes	No	Yes	Yes	681
Indiana	Pending	Legislation/Regulations	N/A	No	No	No	480
Iowa	Active	Legislation/Regulations	Yes	No	Yes	Yes	404
Kansas	Pending	Legislation/Regulations	N/A	No	Yes	Info Not Available	266
Kentucky	No-Program	Legislation/Regulations	N/A	No	No	Yes	296
Louisiana	Pending	Pilot Program	N/A	No	Yes	Yes	302
Maine	Active	Legislation/Regulations	Yes	No	Yes	Yes	116

Table 2

Status of PFA Implementation

State	Status of State Implementation	How Did the State Implement the Program?	Does the State Have a List of Approved Facilities?	Does the State Have Nurse Aide Minimum Staffing Requirements?	Does the State Have Direct Care Minimum Staffing Requirements?	Is the State Experiencing a Nursing Shortage?	Number of Facilities in the State
Maryland	Active	Legislation/Regulations	Info Not Available	No	Yes	Yes	229
Massachusetts	Active	Memo / Bulletin / Policy Change	Yes	No	Yes	Yes	455
Michigan	Pending	Pilot Program	N/A	No	Yes	Yes	395
Minnesota	Active	Legislation/Regulations	Yes	No	Yes	Yes	396
Mississippi	Active	Memo / Bulletin / Policy Change	Yes	No	Yes	Yes	167
Missouri	Active	Memo / Bulletin / Policy Change	No	No	No	Yes	481
Montana	Active	Memo / Bulletin / Policy Change	Yes	Yes	No	Yes	99
Nebraska	Active	Legislation/Regulations	Yes	No	No	No	186
Nevada	Pending	N/A	N/A	No	No	Yes	41
New Hampshire	Active	Memo / Bulletin / Policy Change	Yes	No	No	Yes	73
New Jersey	No-Program	N/A	N/A	No	Yes	Yes	360
New Mexico	No-Program	N/A	N/A	No	Yes	Info Not Available	72
New York	No-Program	N/A	N/A	No	No	Info Not Available	659
North Carolina	Active	Memo / Bulletin / Policy Change	No	No	Yes	Yes	419
North Dakota	Active	Legislation/Regulations	Yes	No	No	Yes	83
Ohio	Active	Legislation/Regulations	Yes	No	Yes	Yes	941
Oklahoma	Pending	Legislation/Regulations	N/A	No	Yes	Yes	275
Oregon	Active	Legislation/Regulations	No	Yes	Yes	Yes	120
Pennsylvania	Active	Memo / Bulletin / Policy Change	Yes	Yes	Yes	Yes	708

Table 2

Status of PFA Implementation

State	Status of State Implementation	How Did the State Implement the Program?	Does the State Have a List of Approved Facilities?	Does the State Have Nurse Aide Minimum Staffing Requirements?	Does the State Have Direct Care Minimum Staffing Requirements?	Is the State Experiencing a Nursing Shortage?	Number of Facilities in the State
Rhode Island	Pending	N/A	N/A	No	Yes	Yes	95
South Carolina	Active	Legislation/Regulations	No	Yes	No	Yes	176
South Dakota	Active	Legislation/Regulations	No	No	No	Yes	91
Tennessee	Active	Memo / Bulletin / Policy Change	Yes	No	Yes	Yes	303
Texas	Active	Legislation/Regulations	No	No	No	Info Not Available	1032
Utah	Pending	N/A	N/A	No	No	Yes	83
Vermont	Pending	Pilot Program	N/A	No	No	Yes	41
Virginia	Active	Memo / Bulletin / Policy Change	Yes	No	No	Yes	252
Washington	Active	No change needed	No	No	No	Yes	240
West Virginia	Active	Memo / Bulletin / Policy Change	No	No	Yes	Yes	121
Wisconsin	Active	Memo / Bulletin / Policy Change	Yes	No	Yes	Yes	369
Wyoming	Pending	Memo / Bulletin / Policy Change	N/A	No	Yes	Yes	39

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

4.2 Overarching Themes

One purpose of the all-state inventory was to determine the extent to which state requirements and implementation of the paid feeding assistant program vary at the state level from the guidance provided in the federal rule. The researchers found—through discussions with the states, and by reviewing the applicable state legislation, regulations, and policy changes—considerable variation in the way states implemented the rule. States varied in their training and implementation requirements, and degree of oversight and monitoring of nursing facilities with PFA programs. This section discusses each significant dimension of state variation in PFA program design and/or implementation.

4.2.1 Training Program Requirements

The analysts compared the training requirements discussed by states, and described in states' feeding assistant program guidelines, with those required by the federal PFA rule. Table 3 displays these findings for the subset of the states that allow the use of paid feeding assistants and have established more stringent training requirements than those required by the federal rule.

Minimum Hours of Training Required of Feeding Assistants
The federal rule requires the state-approved training course to be a minimum of eight hours. Of the 28 active states, almost half (13) require more hours of training than the federally mandated eight hours

- Mississippi requires 16 hours of training; it had originally wanted 24 hours, but then abandoned this plan in order not to differ too dramatically from the federal requirements.
- Similarly, Massachusetts had considered a 16-hour training requirement but ultimately decided against it in order to avoid having to pass legislation on this issue.
- Missouri requires 11 hours 15 minutes of classroom training and 5 hours 45 minutes of on-the-job training.
- West Virginia requires between 8 and 24 hours of training (8 for existing employees and an additional 16 for all new employees that will have direct contact with the patients).

Training Topics
The federal feeding assistant rule states that the topics addressed during training must include feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, appropriate responses to resident behavior, safety and emergency procedures (including the Heimlich Maneuver), infection control, resident rights, and recognizing changes in residents that are inconsistent with their normal behavior, which are then reported to the supervisory nurse.

Twelve active states specify additional topics that must be covered in the training. Two states require training to be specific to the facility:

- Illinois requires training on the feeding and hydration needs of the specific residents that the feeding assistant will assist.

- Wisconsin requires instruction on the facility's resident population that will be served by feeding assistants.

States have added other training topics.

- Additional topics include monitoring and reporting intake, special needs of residents with medical conditions such as stroke or dementia, human anatomy and physiology, and state-specific general nursing facility training.

- Mississippi based its guidelines on the nurse's aide training program. It thus requires training on methods for determining percentage intake of food or fluids and recording resident intake, feeding problems for residents with dementia, instruction on before meal/after meal tasks that will be performed by a CNA or nurse, and instruction on the Mississippi Vulnerable Adults Act.

There does appear to be a relationship between state-required training hours and training topics.

- 12 active states have additional training topics requirements
    - 10 of these also require additional training hours.
- 16 active states do *not* require additional training topics
    - 3 of these require additional training hours.

Specific Time Allotments For Training Topics
The federal rule did not specify time allotments for each of the training topics, but six active states do. The time allotments are specified in either the state training manual or the state-issued guidelines.

Competency Testing
Federal guidelines do not require states to evaluate the PFAs' competency, but 20 of the 28 active states specify requirements for competency testing. These states require skills demonstration, written examination, or a combination of both skills and written exam. Some states are more prescriptive than others.

- Iowa requires feeding assistant trainees to obtain an 80 percent or higher score on a 50-question multiple-choice written test, and successfully feed a resident in a clinical setting.

- North Dakota requires competency evaluation but leaves it up to the facility to decide the evaluation criteria; it also requires facilities to submit their plan for competency evaluation with their training program application.

- Maine requires students to feed six residents with varying degrees of difficulty.

- West Virginia feeding assistant trainees are observed assisting five residents for five full meals.

- Three states have requirements regarding retesting of PFAs.

- Colorado and Iowa guidelines state that the feeding assistants may not retest without repeating the training if they do not pass the competency exam on the second attempt.

- Massachusetts requires annual retesting.

Table 3

States with Training Program Requirements That Exceed the Federal Minimum

Active State	Number of Training Hours	Additional Training Topics	Time Allotment Per Topic	Competency Testing	State-Approved Curriculum	Instructor Qualifications
Federal Requirements	8	NA	NA	NA	NA	PFA may not train others
Colorado	12		✓	✓	State	✓
Delaware	12	✓		✓	Rehab Dynamics	✓
Georgia	16	✓		✓		✓
Idaho					AHCA	✓
Illinois	13	✓	✓	✓		✓
Iowa				✓		✓
Maine	16	✓		✓	AHCA	✓
Maryland				✓		✓
Massachusetts			✓	✓	State	
Mississippi	16	✓				✓
Missouri		✓	✓		State	
Minnesota				✓	State	✓
Montana				✓		✓
Nebraska		✓		✓	State, AHCA	
New Hampshire				✓		
North Carolina					State	✓
North Dakota				✓		✓
Ohio	10	✓	✓	✓	State	✓
Oregon	16	✓		✓	AHCA, Hartman	✓
South Carolina		✓	✓		State	✓
South Dakota	10	✓		✓	✓	✓
Tennessee				✓	AHCA	✓
Texas	16			✓	State	
West Virginia	8 - 24			✓	AHCA	✓
Wisconsin	12 - 16	✓		✓	State	✓

n = 28 states.

Note: If blank, state has same requirements as federal rule. NA indicates not specified in the federal rule.

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

State-approved Curriculum

The federal rule requires PFAs to complete a state-approved curriculum. Of the 28 active states, 19 have identified and approved a particular curriculum—usually one specifically created for that state, though some of them also use the American Health Care Association curriculum titled, "Assisted Dining: The Role and Skills of Feeding Assistants," or another existing curriculum. Seven of the 19 states will not permit facilities to use any curriculum but the one the state has designated. The remaining states are more permissive and will allow individual facilities to submit their own facility-specific curricula for approval.

Instructor Qualifications

The federal PFA rule restricts feeding assistants from training other feeding assistants, but is silent as to the necessary qualifications for instructors. All 20 active states that reported requirements for instructors permit Registered Nurses (RNs) to be qualified trainers. Many states also permit the following professionals to train PFAs: Licensed Practical Nurses (LPNs), Registered Dieticians (RDs), Speech Language Pathologists (SLPs), and Registered Occupational Therapists (OTs). Other state-specific descriptions regarding instructor qualifications are as follows:

- Idaho requires instructors to take a train-the-trainer course before training feeding assistants.
- Maine requires the instructor to be an RN who completed a train-the-trainer course or is an approved CNA instructor.
- Wisconsin requires the instructor to be licensed, but the facility is expected to determine trainer qualifications based on the needs of the selected resident.

Additional Training Requirements

A few active states have additional training requirements that are not addressed in the federal rule.

- Colorado and Ohio limit feeding assistant trainee class size and require feeding assistants to be retrained if they have not worked as a feeding assistant for more than 24 and 12 months, respectively.
- Colorado and Oregon both require volunteers to complete the training before feeding residents.

4.2.2 Guidance on Feeding Assistant Program Implementation

The federal feeding assistant rule also includes program guidelines for facilities that use feeding assistants, such as worker eligibility, record maintenance, how to determine which residents can be fed by feeding assistants, and supervision of feeding assistants. Table 4 displays the 15 active states that have specified implementation guidelines in addition to those required by the federal rule. A blank cell indicates that the state has the same requirements as the federal rule.

Eligibility Requirements

The federal feeding assistant rule does not specify a minimum level of education, age, or language requirement for feeding assistants. Eight active states set eligibility requirements for feeding assistants. Most of the states with an eligibility requirement set a minimum age of 16 years.

- Illinois requires the feeding assistant to speak and understand English.
- Nebraska requires the feeding assistant to speak the language of the resident he or she is assisting.

Table 4

States with Specific Guidance on Program Implementation

Active State	Eligibility Requirements	Record Maintenance	Criteria to Identify Residents	Supervision Requirements	Tasks Feeding Assistants Perform
Colorado	✓	✓		✓	
Delaware		✓			✓
Georgia	✓	✓		✓	
Illinois	✓				✓
Maine	✓				
Maryland					
Mississippi		✓			
Missouri					✓
Montana	✓				
Nebraska		✓			
Ohio					✓
Oregon	✓		✓		✓
South Dakota			✓		
West Virginia	✓				✓
Wisconsin	✓	✓		✓	✓

n = 28.

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

Maintenance of Records

Federal guidelines require each facility to maintain a record of individuals the facility uses as trained feeding assistants. Six active states are more specific about how and what records must be kept.

- Colorado and Wisconsin require records of feeding assistants to be maintained for a minimum of three years.
- In Georgia, Nebraska, and Wisconsin, records for each feeding assistant must include the name and address of the feeding assistant and nursing home, name and signature of the instructor, date the training program was successfully completed, current job descriptions, number of hours each feeding assistant has worked, verification that the

facility checked the nurse aide registry, and copies of all student skill checklists and written exams.

Criteria to Identify Resident

According to the federal rule, a facility may use a feeding assistant to assist residents who meet the following conditions:

- Need assistance with eating and drinking.
- Based on the comprehensive assessment, do not have a complicated feeding problem that includes, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

"The decision about whether a resident is to be fed by a feeding assistant is based on the charge nurse's assessment and the resident's latest assessment of care".[3] Only two active states provide additional guidance on how to identify residents that may be fed by feeding assistants:

- Oregon specifies that the resident assessment take into account risk factors including nausea, difficulty swallowing, seizure disorders, acute gastrointestinal issues, and vomiting.
- South Dakota lists examples of complicated feeding problems: 1) high risk for choking related to chewing, swallowing or cognition; 2) depressed cough or gag reflex; 3) positioning during meals; 4) decreased gastric motility; 5) paralysis, trauma, or surgery of face, mouth, or neck.

Supervision Requirements

According to the federal rule, feeding assistants must call a supervisory nurse for help during an emergency.

- In Colorado, in addition to supervision, feeding assistants are to be given instruction specific to the feeding and hydration needs of each resident the feeding assistant is assigned to assist. Feeding assistants may feed residents in their room if the charge nurse deems this acceptable.
- Georgia requires that feeding assistants be in the same room as an RN or LPN.
- Alternatively, in Mississippi, feeding assistants are not allowed to feed residents in isolation.
- Wisconsin has different supervision requirements for feeding assistants who are between the ages of 16 and 18: those under 18 must be supervised more closely, and directly by a licensed nurse.

[3] "Requirements for Paid Feeding Assistants in Long-term Care Facilities" (68 FR 55528).

Tasks Feeding Assistants May Perform

The federal rule states that feeding assistants may help residents with eating and drinking. Seven active states are more specific about the tasks that feeding assistants may or may not perform. Analysts determined whether states allow feeding assistants to perform tasks, basing the determination on state discussions, state policy, and training topics in the state curriculum. Some of these seven states allow feeding assistants to perform many more duties than other states.

- West Virginia and Wisconsin restrict feeding assistants from performing any other nursing or nursing-related duties, such as measuring or recording input or output, applying adaptive devices for meals, transferring, or toileting.

- In contrast, Oregon allows feeding assistants to transport residents to and from dining areas; distribute meal trays; ensure accurate meal delivery by verification with accompanying meal card; provide assistance in preparing residents for meals, including placement of eyeglasses, washing hands and face, and placement of clothing protector; assist with insertion of dentures for residents that self-direct care; set up meal tray for residents, including opening food packets; position and cut the food; provide minimal assistance with positioning as needed for feeding and hydration; and measure and record food and fluid intake.

4.2.3 Program Implementation

During discussion with State Agencies, project staff asked about facilities' use of feeding assistants and the degree to which nursing facilities have implemented feeding assistant programs. The agencies generally knew little about this, possibly because the program is new, and possibly also because these questions were not directed to LTC surveyors in the states, who may be more familiar with facilities that actively use feeding assistants. The following discussion provides some insight into facility-level implementation of the federal rule; the Phase I Final Report is expected to provide further detail.

Recruitment of Feeding Assistants

According to State Agency respondents, most active facilities are training existing, non-nursing staff as feeding assistants to be used on an as-needed basis or to help during specific mealtimes. Of the 20 active states that had some idea of how the role of feeding assistant was being filled, 16 thought that facilities were using existing staff or a mix of existing staff and members of the community. Four states thought that feeding assistants were mainly being recruited from the community, in the person of high school students or volunteers in existing volunteer programs.

Barriers to Implementation of Feeding Assistant Program

Seven state contacts described barriers to implementation. For example, one discussant mentioned that training is a large and potentially expensive undertaking for facilities. In Georgia, currently no facilities are known to be using or training feeding assistants, based on surveyor and ombudsman reports. The Georgia state regulations that require a RN/LPN to be in the same room as the feeding assistant were identified as a barrier to implementation. Other state contacts reported that facilities were hesitant to use feeding assistants because of the federal lawsuit, confusion over what is and is not a complicated feeding problem, and fear of survey "issues" (e.g., negative findings, more stringent oversight by LTC surveyors)**.** An additional barrier was that the PFA position is not high-paying, so that facilities may have difficulty recruiting.

4.2.4 Program Oversight

As stated earlier, stakeholders opposed to the PFA rule cited as a major concern the potential risk to resident safety posed by introducing "minimally" trained staff into day-to-day resident care. CMS has an interest in understanding whether or not these concerns are realistic. Therefore, this analysis and report attempts to quantify, to the extent possible, the level of training and general PFA program oversight by states. To do this, "levels of oversight"—high, medium, and low—have been assigned to all states that allow the use of PFAs, based on a variety of features of their respective PFA programs, as shown in Table 5. The table displays a good deal of variation. A slight majority of active states fell into the medium level of oversight category, and about an equal number of states fell into the low- and high-oversight categories. The rationale for these groupings is discussed below.

Table 5

Degree of PFA Program Oversight Among Active States

Level of Oversight	Active State	Number of States
High	Delaware, Illinois, Maine, Mississippi, North Dakota, Ohio, South Carolina, West Virginia, Wisconsin	9
Medium	Colorado, Idaho, Iowa, Maryland, Minnesota, Montana, Nebraska, New Hampshire, Pennsylvania, South Carolina, Virginia	11
Low	Georgia, Massachusetts, Missouri, North Carolina, Oregon, Tennessee, Texas, Washington	8

n = 28.

Source: Abt Associates Inc. 2005.

Oversight Categorization Method

Multiple aspects (oversight measures) of states' PFA programs were considered; they can be divided into three categories: program characteristics, the program approval process, and monitoring of and reporting on PFA programs. Exhibit 1 shows the breakdown of the specific measures used within these categories

To derive the oversight-level categorizations, the Abt project team collectively made value judgments about the relative weight of each "oversight measure" and the relative weight of each of the three dimensions or domains of oversight (e.g., program characteristics, program approval processes). Measures and domains that the group believes represent a higher level of stringency in program oversight were weighted more heavily than others. The following sections describe in more detail why the analysts believe the measures chosen best represent program oversight. They highlight general findings related to oversight across states, and unique program characteristics that may be of interest to CMS.

Exhibit 1

PFA Program Oversight Measures

Program Characteristics
State Requires PFA Trainers to Attend State Sponsored Training
Trainer Qualifications Exceed Federal Requirements
PFA Training is Not Portable Among Facilities
Required Training Hours Exceed Federal Rule Requirements
Program Approval Processes
Formal Review and Approval of PFA Program Curricula Required
State Notification of Program Required
No Program Approval Requirement/Unknown
Program Monitoring and Reporting
State Has Names of Feeding Assistants
State Knows Numbers of Feeding Assistants
State Does Not Know Numbers or Names of Feeding Assistants

Source: Abt Associates Inc. 2005.

Program Characteristics

State-Sponsored Training

Although only two active states (Idaho and Maine) require that all PFA trainers complete a train-the-trainer program, this oversight measure is included because this requirement indicates a significant level of oversight and concern with the quality, thoroughness, and uniformity of PFA trainer qualifications.

Trainer Qualifications

Since the federal rule was silent with regard to trainer qualifications (other than prohibiting PFAs from providing the training), it was important to assign weight to any state that actually set standards for trainer qualifications. Twenty of the 28 active states specified trainer qualifications.

Training Portability

Five active states (Mississippi, Missouri, North Dakota, Ohio, and Wisconsin) require PFA training to be facility-specific (in other words, not portable) among nursing facilities. Most of these states mentioned that they do so because they believe training should be specific to the resident population at the facility in which the PFA will work. This requirement indicates a greater degree of concern on the part of the state for assuring the quality of PFA training programs, in that requiring retraining of PFAs who move from facility to facility effectively makes each facility directly responsible for the quality and comprehensiveness of the training of the PFAs it employs.

A facility-specific training requirement also makes it more likely that the state will know which facilities are actually using PFAs (another oversight issue that will be discussed in more detail below). In some states vocational-technical (vo-tec) schools or community colleges can train PFAs; and, in some of these states, a facility does not need to get approval to use PFAs if they have been trained by an approved vo-tec program. This is the case in Iowa, where most PFA programs are run by community colleges. The Iowa Division of Health Facilities does not have a complete list of facilities that are likely to be using PFAs. This indicates a lower level of PFA program oversight.

Hours

Initially it was thought that a requirement for training hours above the eight required by the federal rule would be a significant indicator of a state's higher level of concern for the quality and thoroughness of PFA programs. However, when the researchers spoke with states they heard varied opinions on the importance of and rationale for including additional hours. Some states strongly believed that eight hours is not sufficient to train on all of the topics required by the federal rule. Others disagreed. In particular, a few states noted that eight hours of instruction on feeding is more than many states include in CNA training. Considering these perspectives, the analysts included training hours in the oversight measure, but did not weight it particularly heavily.

Approval Process

There appears to be wide variation in PFA program approval procedures across states. Most active states (19) require formal review and approval of the PFA training curriculum for entities seeking to create a PFA training program. About half of these 19 states require review of trainer qualifications and program materials, including competency exams. The remaining states have less stringent requirements for establishment of a PFA program:

- Three do not require training entities to submit curricula or instructor qualifications for review, but do require training entities to submit to the state an attestation form, stating that their program will meet the federal and state requirements (Colorado, Massachusetts, and South Carolina).

- Six states (Georgia, Missouri, North Carolina, Oregon, Tennessee, Texas, and Washington) do not require that training entities submit curricula or instructor qualifications or notify the state that they intend to create a program.

The program approval process is a significant component of a state's degree of program oversight. In those active states that did not create a formal approval process for PFA training programs, staff often do not know which facilities are using PFAs. It is assumed that in the states with a formal approval process, the state knows which entities (which are most often nursing homes) have approved PFA programs. Because this knowledge is necessary in order for a state to have any degree of program oversight or conduct any program monitoring, the analysts weighted this item heavily in the "program oversight" scale.

Program Monitoring and Record Keeping

Knowledge of facility-level implementation of PFA programs is a second level of program oversight above and beyond knowledge of which facilities have approved PFA programs. This second-level oversight was defined by whether or not states could specify the numbers of PFAs trained by facilities or the names of trained PFAs. Most active states did not know which of the facilities that had been approved to create a PFA program had actually trained PFAs. Of the three states that did know the number of trained PFAs (Illinois, Nebraska, and Wisconsin), only one had a mechanism in place to keep track of the names of PFAs. Many states reported that the industry had clamored for state guidelines or regulations to allow the use of PFAs, but that since that original movement it seemed that most facilities in fact had not adopted the program It was also interesting to discover that most states had no systematic way of monitoring to what degree PFAs were being used. Given stakeholders' concern about the potential harm that could be caused by less-trained staff working in

nursing homes, it is surprising that so little state-level monitoring of PFA program implementation exists.

The notable exceptions to this finding were the following:

- In Illinois, facilities must submit a roster of training program attendees to the state.
- Nebraska created a PFA registry similar to the CNA registry. Facilities are required to place all PFAs on this registry[4].
- Wisconsin requires facilities to report to their survey office the number of PFAs trained each year. (The Wisconsin survey agency provided a list of facilities and numbers of trained PFAs by facility.)

Summary of Program Oversight Findings

Nine of 28 active states do not require review of PFA curricula or trainer qualifications before approving PFA programs. Only three states had concrete knowledge of facility-level implementation of PFA programs. It should be noted that a few states reported that their level of program oversight was limited due to the lack of additional funding for the program. In addition, some states noted that because of the lack of interest in the program, it did not seem necessary to put in place (at the present time) any formal mechanisms for oversight. Many states reported that although ongoing oversight of PFA programs had not been implemented, more oversight measures would likely be developed over time.

4.2.5 Relationship of Staffing to Implementation of PFA Training and/or Program Implementation

Staffing Shortage

Staffing shortages were thought to be one reason that states might move quickly to implement a PFA program. Discussions with states included questions related to staffing (e.g., was a staffing shortage a key reason for initiating a program, and in general, was the state currently experiencing a staffing shortage?). Discussions also touched on the history and/or timing of the program, to understand how soon after the federal rule was passed the state moved forward with implementation. States with active programs were more likely to state that staffing shortages were a reason for program implementation. Sixty-four percent of the active states mentioned staffing shortages as a key reason for implementation, in contrast to only, 35 percent of states with programs pending or on hold (Table 6).

[4] Note that at the time of the interview with the state representative from Nebraska, there were not yet any PFAs on the registry.

Table 6

States Reporting a Staffing Shortage as a Reason for Implementing a PFA Program

Reason for Implementation	Active States		Pending and No-Program States	
	Number	Percent	Number	Percent
Staffing Shortage	18	64	8	35
No Staffing Shortage	10	36	15	65
Total	**28**	**100**	**23**	**100**

Note: Results include 50 states and Washington, DC.

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

Minimum Staffing Requirements

States with minimum staffing requirements were more likely to have an active PFA program. This may be because of a desire to 1) augment current NA staffing, 2) increase awareness of NA work, and 3) possibly recruit interested candidates for enrollment in NA training. Table 7 shows that active states were more likely to report a minimum nurse staffing requirement (64 percent vs. 40 percent).

Table 7

States With Minimum Nurse Staffing Requirements

Minimum Staffing Requirement	Active States		Pending and No-Program States	
	Number	Percent	Number	Percent
Yes	18	64	9	40
No	8	29	7	30
Don't Know	2	7	7	30
Total	**28**	**100**	**23**	**100**

Note: Results include 50 states and Washington, DC.

Source: Abt Associates Inc. telephone discussions with state feeding assistant training staff, 2005.

State Demographics

Based on conversations with states, rural facilities seemed most affected by staffing shortages. Analysts looked at PFA program implementation in terms of the percentage of rural facilities in the state and found that, except for states with very few rural facilities, PFA program implementation was fairly evenly distributed across states regardless of the percentage of rural facilities.

In terms of facility size, analysts looked to see whether PFA program implementation varied according to the distribution of small (<75 beds), medium (76 – 150 beds), and large facilities (>150 beds). Active states are more likely to have a higher percentage of small facilities (Table 8). Whether or not facilities were for-profit or not-for-profit did not appear to have any impact on PFA program implementation. States with a higher percentage of chains were more likely to have implemented a PFA program.

Table 8

PFA Program Implementation According to Small Bed Size (< 75 beds)

Percentage of Small Facilities	Active States		Pending and No-Program States	
	Number	Percent	Number	Percent
< 25%	5	18	10	43
26-50%	15	54	10	43
> 50%	8	28	3	13

Note: Results from 50 states and Washington, DC.

Source: Abt Associates Inc., Provider of Service data 2004.

4.2.6 Quality Oversight Mechanisms

State Agencies were asked if they had developed and/or implemented any form of quality oversight of the PFA program. Specifically, they were asked whether survey procedures had been developed and/or implemented, whether any "non-survey" quality oversight had been developed and/or implemented, and whether any measure of the impact of the use of paid feeding assistants had been formulated or tested. The vast majority of discussants had not developed or implemented any such measures. Specific findings are as follows:

- Ten of the 28 active PFA states reported that survey procedures to monitor the PFA program had been developed and/or implemented: Illinois, Maine, Nebraska, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, and Wisconsin.

- Of those states, six stated that they plan to have PFAs observed while providing feeding assistance (Illinois, North Dakota, Oregon, Pennsylvania, South Carolina, and Wisconsin). Six states also plan to review personnel records to verify PFA training (Illinois, Maine, North Dakota, Oregon, Pennsylvania, and Wisconsin).

- North Dakota, Oregon, and Wisconsin had the most complete plans for survey oversight. In addition to the survey activities described above, they each plan to have surveyors review resident records to verify evidence of appropriate assessment of residents in the feeding assistance program. North Dakota also plans to have surveyors review nursing facilities' training curricula, and to observe if licensed nurses supervise feeding assistants. Oregon will also review PFA trainer qualifications and check the PFA records for verification of competency.

- Three states reported quality oversight plans that were outside of the survey process. Delaware plans to send a dietician out to facilities that use PFAs. Maine's facility trainer will review PFA program documents when conducting educational visits. Wisconsin reported that the Ombudsmen are monitoring the PFA programs in that state.

- None of the 28 active states reported the development or implementation of any measure regarding the impact of the paid feeding assistant program.

4.3 Summary of Findings

Of 50 states and the District of Columbia, 28 (active states) at the time of interview allowed the use of paid feeding assistants through a variety of regulatory or non-regulatory vehicles (e.g., new legislation, regulations, program memoranda), and 16 (pending states) are working toward program implementation. Almost all active states exceeded the federal requirements when developing their training programs. Almost half exceed the eight-hour training minimum articulated in the federal rule; 12 specify additional training topics; and most have deemed a particular curriculum as their "state-approved" curriculum (e.g., the AHCA dining assistant curriculum). Twenty of the 28 active states that allow the use of PFAs specify requirements for competency testing.

Twenty-one of the 28 active states reported that providers/provider associations promoted the measure to implement a PFA program, and cited staffing shortages and quality of care issues as the most significant reasons why they chose to implement a PFA rule.

State Agencies have limited knowledge about how facilities have actually implemented feeding assistant programs, though most were of the opinion that facilities are more likely to train existing staff to serve as dining assistants, rather than to hire new employees to perform this function.

States varied in their degree of PFA program oversight. When rated according to an "oversight" scale derived from select program characteristics and program monitoring functions, the following states were categorized as having the "highest" level of program oversight: Delaware, Illinois, Maine, Mississippi, North Dakota, Ohio, South Carolina, West Virginia, and Wisconsin. These states have all implemented a formal process of review and approval of nursing facility PFA training curricula, and their PFA programs exceed the requirements set out in the federal rule on one or more measures (e.g., more than eight hours of training required, specification of PFA trainer qualifications). States with lower levels of program oversight cited lack of funding for this program, and the nursing home industry's lack of interest.

The researchers analyzed the relationship between reported staffing shortages, staffing minimum requirements, and implementation of the federal feeding assistant rule. Active states were more likely to cite a staffing shortage as a key reason implementing the PFA program (64 percent).

Ten of the 28 active states reported that survey procedures to monitor the PFA program had been developed and/or implemented: Illinois, Maine, Nebraska, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, and Wisconsin. The types of survey activities to be performed in these states included survey observations of residents receiving assistance from PFAs, and review of personnel and PFA training records. No states have developed or implemented a measure of the impact of this program on quality of care or of life for residents who receive dining assistance from these trained assistants.

5.0 Conclusions

This all-state telephone inventory, one component of the Phase I Study of Paid Feeding Assistants, was completed in order to provide CMS and other interested stakeholders with information on the degree of nationwide

adoption/implementation of the federal paid feeding assistant rule, published in final in September 2003. This rule, if implemented by the state, allows nursing facilities to train and use non-nursing staff to assist low-risk residents with dining. Using data collected during a telephone inventory of 50 states and Washington, DC, researchers identified which states have taken action related to the feeding assistant rule, the degree to which states have implemented the rule, and variation among states in how feeding assistant programs have been implemented.

A majority of states (86 percent) interviewed had already implemented (active states) or were in the process of implementing a state PFA program (pending states). Most that have done so have acted with the support of, and often at the behest of, the long-term care industry. Despite arguments to the contrary by the federal rule's detractors, state respondents did not express concern about quality of care or other issues in allowing the use of paid feeding assistants.

Considerable variation exists among active states in training requirements, reporting, and approval requirements. Many states adopted more stringent training requirements than those articulated in the federal rule (e.g., more hours of training required, more training topics, resident-specific training). Many states do not have a formal training curricula approval process, and most have no plans to gather and monitor lists or registries of trained PFAs.

Variation in training requirements creates potential for negative consequences in the future

This level of variation in training requirements was likely anticipated by CMS, and does not appear problematic. However, the lack of program monitoring or program oversight among states may have potentially negative consequences for CMS in the future. **Despite low levels of facility-level program implementation to date, it would seem that CMS may want a program monitoring mechanism in place, in the event that facilities become more active users of PFAs.**

Differences in state oversight processes may be problematic for CMS

Similarly, 37 percent of active states monitor facility quality related to PFAs through the long-term care survey and certification process. They reportedly do this by adding residents assisted by PFAs to the resident sample, observing residents that receive PFA assistance during dining observations, and/or reviewing personnel and training records when conducting the annual on-site survey. Though this appears to be an excellent vehicle of quality oversight of PFA programs, CMS may wish to have a uniform, standard survey component to achieve this quality monitoring, rather than many state-specific survey processes.

Study limitations create a need for further research

Finally, this study was limited in its scope, and therefore able to answer program design and implementation questions only at the *state level*. Little is known about the degree of *facility-level* program implementation, such as what type of personnel are trained to become feeding assistants, whether this job category is desirable enough for nursing facilities to successfully attract these single task workers, whether nurses and nurse aides in facilities that utilize PFAs are more able to provide direct care to residents, and whether residents who are assisted by trained feeding assistants have better nutrition-related outcomes or a higher quality of life.

6.0 Next Steps

In order to gain a better understanding of *facility-level* program implementation, and of *facility-level* quality of care in relation to the use of PFAs, the project team will conduct a study of program implementation in a small sample of nursing homes in three states. This extension of the Phase I project will consist of both observations of PFAs and other staff assisting residents in dining, and interviews of facility staff to gain a better understanding of staff impressions of the program and how the programs are implemented across a small number of volunteer nursing facilities.

In addition to continuing the Phase I work of gathering observational and experiential data on a small sample of facilities that have implemented PFA programs, CMS should consider funding Phase II of this study. The Phase II study would evaluate differences in quality of care between facilities that use PFAs versus facilities that do not, in order to detect quality of care differences─ if any─between both types of facilities. Data from Phase II of this study may also contribute to improvements in nutritional and other nursing facility care quality through dissemination of information about "best practices" in these research areas.

References

Blaum, CS, Fries, BE and MA Fiatarone (1995). *Factors associated with low body mass index and weight loss in nursing home residents*. Journals of Gerontology Series A: Biological Sciences and Medical Sciences, Vol 50, Issue 3 M162-M168.

CMS Director Survey and Certification Group/CMSO (2001). *Training Request for CMS's Nutrition/Hydration Awareness Campaign: S&C 02-03*. URL: http://www.cms.hhs.gov/medicaid/survey-cert/103001.asp, accessed 27 November 2005.

Kayser-Jones J, Schell ES, Porter C, Barbaccia JC, Shaw H. (1999). *Factors contributing to dehydration in nursing homes: inadequate staffing and lack of professional supervision*. J Am Geriatr Soc. 1999 Oct;47(10):1187-94.

Simmons, SF, and JF Schnelle (2004). *Individualized Feeding Assistance Care for Nursing Home Residents: Staffing Requirements to Implement Two Interventions*. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 59:M966-M973.

Simmons SF, Lim B, Schnelle JF (2002). *Accuracy of minimum data set in identifying residents at risk for undernutrition: oral intake and food complaints*. J Am Med Dir Assoc. May-Jun;3(3):140-5.

Return to Report

Study of Paid Feeding Assistant Programs

Discussion Guide: State Agencies and State Provider Association Affiliates

Position/Title _____

Agency Name and Type_____

What is your agency's role in relation to the PFA program?_____

Are there any other agencies or people we should talk to who are involved in the PFA program in your state/Is responsibility for the program split among several agencies?_____

_____

SECTION I: Status of Paid Feeding Assistant Programs

Confirm the status of paid feeding assistant programs. Has the state introduced legislation, regulations or policy to implement a paid feeding assistant program?

☐ 01 Yes _____

☐ 02 No – **SKIP TO QUESTION 5**

☐ 03 Don't know – **SKIP TO APPROPRIATE QUESTION**

☐ 04 Other [please specify]_____ – **SKIP TO APPROPRIATE QUESTION**

1a. If yes, what is the status of the legislation?

☐ 01 Introduced and passed – **SKIP TO QUESTION 2**

☐ 02 Introduced and pending passage – **SKIP TO QUESTION 3**

☐ 03 Introduced and defeated – **SKIP TO QUESTION 4**

☐ 04 Other – **SKIP TO APPROPRIATE QUESTION**

Were you involved in or aware of the initial discussion of whether or not to implement PFA programs in your state?

☐ 01 Yes

☐ 02 No –

2a. If yes, when the legislation passed, who/what groups promoted the measure?

_____

2b. Who/what groups opposed the measure?
_____

2c. What were the most significant reasons why the state implemented a PFA rule?
CHECK ALL THAT APPLY

☐ 01 Staffing shortages

☐ 02 Quality of care

☐ 03 Funding

☐ 04 Other [Please specify.]
_____

☐ 05 Don't know

2d. When was the legislation initiated?
_____

2e. Please provide date and reference in state laws or regulations
_____ and request copy or link to on-line reference.

2f. Were there any barriers to implementation?
(Prompts: Payment system issue, other laws that needed to be changed, administrative procedures)

☐ 01 Yes

☐ 02 No

Comments; _____

2g. What made it possible for your state to move forward to allow PFA programs in your state? What support or guidance did you have that made this possible?
_____

SKIP TO QUESTION 6.

If legislation is currently pending, Who/what groups are in favor of the legislation?
_____

3a. Who/what groups are opposed to passage of the legislation? _____

3b. What are main reasons for opposition? _____

3c. What are the most significant reasons the state or other groups wanted to implement the PFA rule? **CHECK ALL THAT APPLY**

☐ 01 Staffing shortage

☐ 02 Quality of care concerns

☐ 03 Funding concerns

☐ 04 Lack of interest

☐ 05 Other [Please specify.]

_____

☐ 06 Don't know

3d. When was the legislation initiated?

_____

3e. Please provide date and reference in state laws or regulations _____ and request copy or link to on-line reference.

3f. Are there barriers to passage?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

3g. If Yes, please explain.

_____

3h. How likely is it that the legislation will pass?

☐ 01 Very likely **SKIP TO QUESTION 6**

☐ 02 Somewhat likely **SKIP TO QUESTION 6**

☐ 03 Not likely **SKIP TO QUESTION 42**

☐ 04 Other [Please specify.] _____ **SKIP TO QUESTION 6**

☐ 05 Don't know **SKIP TO QUESTION 6**

3i. What would make this program more feasible for your state to implement?

_____

When the legislation was defeated, who/what groups opposed the measure? _____

4a. What were the main reasons it was defeated?

☐ 01 Staffing shortage

☐ 02 Quality of care concerns

☐ 03 Funding

☐ 04 Lack of interest in PFA program

☐ 05 Other [Please specify.] _____

☐ 06 Don't know

4b. Who/what groups promoted the measure? _____

4c. What were the most significant reasons the state or other groups wanted to implement the PFA rule?

☐ 01 Staffing shortage

☐ 02 Quality of care

☐ 03 Funding

☐ 04 Lack of interest in PFA program

☐ 05 Other [Please specify.] _____

☐ 06 Don't know

4d. When was the legislation initiated? _____

4e. Please provide date and reference in state laws or regulations _____ and request copy or link to on-line reference.

4f. What were the barriers to passage of the legislation?

☐ 01 Yes

☐ 02 No - **SKIP TO QUESTION 42**

☐ 03 Don't know **SKIP TO QUESTION 42**

4g. If Yes, please explain. _____**SKIP TO QUESTION 42**

4h. What would make this program more feasible for your state to implement?
_____

If no legislation has been introduced, what are the most significant issues?

☐ 01 Staffing shortage

☐ 02 Quality of care concerns

☐ 03 Funding

☐ 04 Lack of interest in PFA program

☐ 05 Other [Please specify.] _____

☐ 06 Don't know

5a. Are there plans to introduce legislation in the future?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

5b. Are there barriers to introducing legislation?

☐ 01 Yes

☐ 02 No – **SKIP TO QUESTION 42**

☐ 03 Don't know **SKIP TO QUESTION 42**

5c. If Yes, please explain. _____**SKIP TO QUESTION 42**

5d. What would make this program more feasible for your state to implement?
_____

SECTION II: State PFA Program Characteristics

Please provide information on the PFA program for the following areas:

Number of hours required by state law/regulation or state training program

☐ 1 Eight hours

☐ 2 More than eight hours

6a. If "More than eight hours," please provide number of hours _____

Supervision requirements specified by state law/regulation or state training program

☐ 1 RN/LPN Supervision

☐ 2 Other

7a. If "Other," please explain _____

What are the criteria specified by state law/regulation or state training program used to identify residents able to be fed by PFAs?

☐ 1 Specific criteria (e.g., MDS items) have been established to identify appropriate residents, including: _____.

☐ 2 No specific criteria; left to facility discretion.

☐ 3 Other

8a. If 'Other,' please explain._____

Facility records of training required by state law/regulation or state training program

☐ 1 Facility must maintain a record of individuals successfully completing FA training

☐ 2 Other

9a. If 'Other,' please explain _____

Topics covered in training required by state law/regulation or state training program

☐ 1 Feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, appropriate responses to resident behavior, safety and emergency procedures, infection control, resident rights and recognizing changes in residents condition and importance of reporting changes to supervisor nurse.

☐ 2 Other

10a. If 'Other,' please explain _____

Who in the facility according to state law/regulations or state training program is responsible for identifying residents appropriate for paid feeding assistants? _____
(Federal rule states that the selection is made by the charge nurse.)

Does the state law/regulation or state training program list the actual tasks that the paid feeding assistants may perform?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

12a. If yes, please provide reference to law/regulation or training program guidance.
_____

Responsible agency/contact person if not already recorded. _____

SECTION III: Program Implementation

Training Approval Process

What does the state require of nursing homes seeking approval of their PFA program?

☐ 01 State reviews and formally approves curriculum

☐ 02 Facility notifies state of training program

☐ 03 Facility submits policies and procedures for PFAs

☐ 04 Facility notifies state of implementation

☐ 05 No formal requirement

☐ 06 Other

COMMENTS_____

14a. What is the timeframe for receiving approval? _____

Has a state-approved curriculum been developed and made available to facilities?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

15a. If yes, may we obtain a copy of the curriculum or the Internet link to the electronic version? _____

15b. If No, what is the status of curriculum development and approximate completion date? _____

Are training programs allowed to modify the curriculum? (e.g., add hours, topics)

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

16a. If Yes, what will be the process for approving individual facility curricula? _____

Have specific time allotments been made for each topic included in training? (Refer back to question 10 for any differences between federal and state training topics.)

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

17a. If yes, please explain._____

Are there any other approved programs (other than the state-specified curriculum)?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

18a. If Yes, what are these programs? _____

18b. Do you have a sense of which types of facilities have sought approval for training programs? (Urban vs. rural, large vs. small, profit vs. not-for-profit)

☐ 01 Yes _____

☐ 02 No

☐ 03 Don't know

18c. If No, is there someone else that might have information on training programs in the state? (e.g., provider associations?) _____

18d. Does the state have a list of approved programs?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

18e. If Yes, could we get a copy of the list? _____

18f. Are you aware of data available on the number of nursing homes that have implemented a PFA training programs?

☐ 01 Yes

☐ 02 No

☐ 03 Don't Know

18g. If Yes, please provide the number of nursing homes that have implemented a training program, and as of what date?

18h. If No, are there groups or individuals who might be aware of sources for training data on PFAs, e.g., state provider association, survey agency?

Program Implementation at Facilities

Do you have a sense of how many facilities that sought approval for training are actually using PFAs?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

19a. If yes, how many are using PFAs? _____

19b. If you are not sure about an exact number, about what proportion of nursing homes are using PFAs?

☐ 01 More than 75 percent of nursing homes are using paid feeding assistants

☐ 02 Between 50 and 74 percent of nursing homes are using paid feeding assistants

☐ 03 Between 11 and 49 percent of nursing homes are using paid feeding assistants

☐ 04 Less than 10 percent of nursing homes are using paid feeding assistants

☐ 05 Other

☐ 06 Don't know

19c. If yes, what is the source of your data or estimate?

☐ 01 Agency records/data

☐ 02 Hearsay

☐ 03 Personal opinion

☐ 04 Other _____.

If data are available on the numbers of nursing homes that have implemented a paid feeding assistant program, has implementation of programs been more prevalent among particular types of nursing homes?

a) Rural ☐ 1 Yes ☐ 2 No

b) Urban ☐ 1 Yes ☐ 2 No

c) Independent facilities ☐ 1 Yes ☐ 2 No

d) Multi-facility chains ☐ 1 Yes ☐ 2 No

e) Large facilities (over 150 beds) ☐ 1 Yes ☐ 2 No

f) Medium facilities (75 – 149 beds) ☐ 1 Yes ☐ 2 No

g) Small size facilities (under 75 beds) ☐ 1 Yes ☐ 2 No

h) For-profit facilities ☐ 1 Yes ☐ 2 No

i) Not for-profit facilities ☐ 1 Yes ☐ 2 No

j) Facilities with high Medicare census ☐ 1 Yes ☐ 2 No

k) Don't know ☐

From what sources have nursing homes recruited PFA staff?

☐ 01 a) Trained their own non-nursing staff

☐ 02 b) Recruited from the community

☐ 03 c) Both a and b, please explain._____

☐ 04 d) Other, please explain._____

☐ 05 e) Don't know

For facilities that have a PFA program in place, to what degree have the facilities implemented the paid feeding assistant program?

☐ 01 a) High implementation (> 75 percent of meals covered and residents assisted).

☐ 02 b) Moderate implementation (50 percent of meals covered and residents assisted).

☐ 03 c) Minimal implementation (<25 percent of covered and residents assisted).

☐ 04 d) Other

☐ 05 e) Don't know

Are there barriers to implementation at the facility level?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

23a. If Yes, please explain. _____

In Part 2 of our study, we may be traveling to facilities to observe the use of PFAs. Are you aware of specific facilities using paid feeding assistants?

☐ 01 Yes

☐ 02 No

24a. If yes, please provide facility contact information for those facilities using PFAs.
_____

SECTION IV: Quality and Regulatory Oversight

Has the state developed and/or implemented any specific survey procedures for facilities that use PFAs?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

25a. If yes, please describe how the state agency provides regulatory oversight? (Ask open ended, use prompts if needed)
Prompts:

☐ 01 Addition of an oversight module (state specific) covering the use of paid feeding assistants

☐ 02 Observation of residents with feeding assistants during meals

☐ 03 Review of training curriculum and attendance records

☐ 04 Review of trainer qualifications

☐ 05 Review of personnel and training records

☐ 06 Review of resident records showing evidence of selection process

☐ 07 Review of resident records for documentation regarding use of feeding assistants

☐ 08 Observation of RN/LPN supervision of feeding assistants

☐ 09 Discussion with residents/family members/resident council regarding use of feeding assistants

☐ 10 Other [please specify] _____

25b. Has the state developed and/or implemented any non-survey quality oversight of PFA programs?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

25c. If Yes, please explain._____

If a facility's' ability to train nurse aides is rescinded for a substandard quality of care finding, is the facility's paid feeding assistant program affected?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

26a. If yes, please explain _____

Has any measure of the impact of the use of paid feeding assistants been formulated or tested?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

27a. If yes, please explain _____

Does the state collect and report family or resident satisfaction measures?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

28a. If Yes, is there a measure regarding satisfaction with the “dining experience”?

☐ 01 Yes

☐ 02 No

☐ 03 Don’t know

28b. If Yes, Is there a measure that specifically addresses satisfaction with PFAs?

☐ 01 Yes

☐ 02 No

☐ 03 Don’t know

SECTION V: Training, Testing and Eligibility Requirements

What agency is responsible for overseeing the training? _____

29a. Contact information

_____

_____

Does the state specify eligibility requirements for feeding assistants? (For example, minimum age, high school diploma or equivalency)

☐ 01 Yes

☐ 02 No

☐ 03 Don’t know

30a. If Yes, please explain. _____

Does the state require that criminal background checks be conducted on paid feeding assistants?

☐ 01 Yes

☐ 02 No

☐ 03 Don’t know

31a. If Yes, please explain. _____

Does the state require that facilities check the nurse aide registry prior to training PFAs?

☐ 01 Yes

☐ 02 No

☐ 03 Don’t know

Are there data available on the number of feeding assistants trained?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

33a. If yes, please provide number trained _____ as of _____ date.

33b. Does the data contain the name of the facility or program that trained the PFA?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

Does the state require the use of competency examinations for feeding assistants?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

34a. If yes, how is this process handled?

_____

34b. If yes, are there data available on the number of feeding assistants tested?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

34c. If yes, please provide number tested _____ as of _____ date.

34d. If no, how is competency of the FA determined? _____

34e. Is PFA training portable? (Do PFAs need to be retrained when they change employers?)

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

Does the state require annual in-services for paid feeding assistants?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

35a. If Yes, what topics are required? _____

Does the state require annual employee reviews for paid feeding assistants?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

Does the state mandate specific feeding assistant trainer qualifications and/or experience?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

37a. If yes, please explain. _____

Any other training or training –related requirements?

☐ 01 Yes

If yes, please explain. _____

☐ 02 No

☐ 03 Don't know

SECTION VI: Reimbursement Issues

Is there a line item in the Medicaid Cost Report to specifically capture the wages of paid feeding assistants?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

40a. If not, is there any other source that captures data on paid feeding assistant wages? Please explain.

_____

Has the state modified the payment system to take into account PFAs?_____

What type of Medicaid reimbursement system does the state use? (e.g., flat rate, casemix based on RUGs, casemix based on another assessment) _____

SECTION VII: State Characteristics (Most data to be captured through POS)

Does the state have a minimum nurse staffing requirement?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

43a. If Yes, please explain. _____

Does the state collect staffing data at intervals outside the annual survey?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

44a. If yes, how often and in what format is staffing information reported? _____

44b. If Yes, is information on PFAs captured?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

Does the state audit reported staffing information?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

45a. If Yes, please explain the process. _____

Is the state currently experiencing a staffing shortage?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

46a. If Yes, please explain. _____

SECTION VIII: Other

Overall, do you think the PFA program is a good idea? _____

Have you heard of facilities that have had positive experiences using PFAs? _____

Have you heard of facilities that have had negative experiences using PFAs? _____

Based on your knowledge and experience, do you have any concerns about the use of feeding assistants? _____

Does the state have any particular regulations regarding family members and volunteers assisting with meals?

☐ 01 Yes

☐ 02 No

☐ 03 Don't know

51a. If Yes, are the regulations specific to mealtime tasks that family members may perform? Please explain. _____

51b. If Yes, are the regulations specific to mealtime tasks that volunteers may perform? Please explain. _____

51c. If Yes, do the regulations address training requirements for family members around feeding? Please explain. _____

51d. If Yes, do the regulations address training requirements for volunteers around feeding? Please explain. _____

51e. If Yes, do the regulations address supervision of family members engaged in feeding? Please explain. _____

51f. If Yes, do the regulations address supervision of volunteers engaged in feeding? Please explain. _____

51g. If Yes, may we obtain a copy of the regulations or the Internet link to the electronic version? _____

SECTION IX: Additional Information

Overall Additional Comments _____

Action Items _____

Is this state a possible option for site visits?

☐ 01 Yes

☐ 02 No

[The following items should be gathered prior to telephone discussions through a review of POS data and other sources].

Approximate total number of nursing facilities in the state _____

Please complete the following tables:

a)

	Number of Facilities
Rural	
Urban	

b)

	Number of Facilities
Under 75 beds	
76 – 150 beds	
Over 150 beds	

c)

	Number of Facilities
For-profit	
Not for-profit	

d)

	Number of Facilities
Part of a Multi-facility chain	
Independent	

e)

	Number of Facilities
Hospital-based	
Free standing	

f)

	Percent of Population
White	
Black	
Hispanic	
Asian	
Native American	
Other	

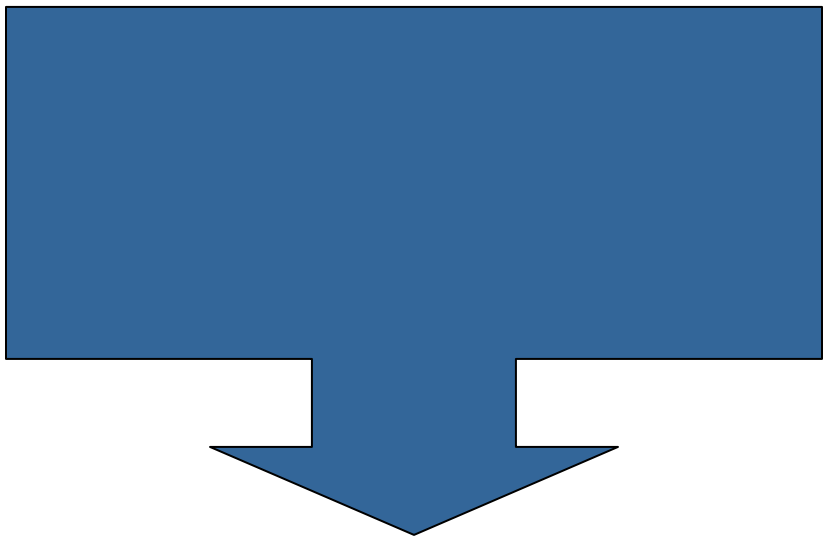
g) Percent of population cognitively impaired _____

h) Level of Medicaid reimbursement _____

i) Number of nursing homes beds per total population _____

Does the state currently allow facilities to use paid feeding assistants?_____

Appendix 2 Appendix 2 Appendix 2



Assessment: Mealtime Observational Protocol
Nurse Educator Interview Guide
Charge Nurse Interview Guide
DON Interview Guide
Administrator Interview guide
PFA Interview Guide
CNA Interview Guide

Return to Report

MEALTIME OBSERVATIONAL PROTOCOL

One observer will target observations toward "feeding assistants" in one location (dining room or residents' rooms in the same hall); while, the second observer will target observations toward residents in one location (dining room or hallway) who do not have an assigned "feeding assistant" and who meet the following criteria: s/he receives no staff attention and engages in no independent eating behaviors within the first 5 minutes of the observation period. This strategy will allow data to be collected for both those residents to whom "feeding assistants" are (not) assigned during each scheduled meal (breakfast, lunch, and dinner).

If there are no "feeding assistants" present during a meal, then both observers will target residents who receive no staff attention and engage in no independent eating behavior within the first five minutes of the observation period up to a maximum of 16-20 total residents (8-10 residents per observer); and, one observer will target the dining room while the second observer will target a group of residents' rooms within the same hallway. This strategy will allow data collection in both the dining room and residents' rooms.

If the "feeding assistants" are working with fewer than 10 residents in one location during the meal, the same observer will observe those residents in addition to other residents (in the same location) under the care of traditional nurse aide staff using the same selection criteria (not eating and no assistance) to maximize the data collected per observer/meal.

The primary target of observation will be residents to whom "feeding assistants" are assigned; thus, if a "feeding assistant" is assigned to help the same resident(s) across multiple meals, then observations will be conducted on the same residents across multiple meals. If the "feeding assistant" is assigned to different residents during each meal, then observations will be conducted with different residents.

DATA COLLECTION FORM: INSTRUCTIONS AND OPERATIONAL DEFINITIONS

Staff Observer Name: write name or initials.

Facility: write name or code number.

Date: date of data collection.

Meal: check mark the meal being observed.

Location (Dining Room versus Hall/Room observations): check mark location of observed residents as a group.

Begin Time: time when you began the observation period. Record hour and minutes.

End Time: time when you stopped the observation period Record hour and minutes

Licensed Nurse in Dining Room (NOT passing medications): check "present" if a licensed nurse (RN, LVN, DON) is present at any point during the mealtime period and NOT engaged in passing medications. Use the comment section to record the time the licensed nurse entered/left the dining room to yield an estimate of the "total time in minutes" that the licensed nurse was present. The observer should check for the presence of a licensed nurse throughout the mealtime period such that the arrival of a licensed nurse at any point during the meal is recorded.

Resident: intended for observer use only to denote some descriptive information (first name of resident, room number, table number) to allow tracking of the residents throughout the meal period or day. Identifying information should be deleted at the end of the observation period such that all data is by number only (1-5 on the form).

*Assisted By (PFA, CNA, LPN, Family): i*ndicate who assisted this resident, either feeding assistant, nurse aide, nurse, or family. Some residents may be assisted by a few people and therefore more than one type of staff may be indicated.

Position: reflects the sitting position of the resident during *most* of the meal. Upright, or 90 degree angle, is the desired position and the typical position if a resident is seated in a wheelchair or regular chair for eating. Although, some residents seated in wheelchairs are "slumped" forward or to one side of the chair and this should be noted. In addition, the resident may be seated "upright" *to the greatest extent possible* but still not at a perfect 90 degree angle, due to poor posture or curvature of the spine. Reclined, or 45 degrees, is the typical position when a resident is in bed and the bed has not been raised sufficiently. The primary purpose of these data is to measure the extent to which staff ensure that the resident is in a proper seating position for eating, to the best of their ability. This is particularly important for residents who have swallowing difficulties.

Served Diet: can be determined based on the place card on the meal tray, which usually lists specific diet orders, as well as the visual appearance of the food. The primary purpose of this variable is to differentiate "regular" versus "modified" *textures* because a "modified" texture suggests that the resident has a chewing or swallowing problem. Thus, we are less concerned about "No Added Salt (NAS)" or "No Concentrated Sugars (NAS)" types of diet orders and more concerned about the presence of "ground texture", "mechanical soft", "puree" and/or "thickened liquids" based on the place card and visual observation of the meal tray.

Total Percent Eaten: the space at the bottom of the form is used to list the food and fluid items on the meal tray (easiest if noted at the point of tray delivery) and indicate if the staff offered a "substitute" for the original served meal (e.g., resident was served chicken, rice, and broccoli but refused to eat it so the staff took the plate away and brought back a sandwich or fruit and cottage cheese). Listing the individual food/fluid items at the bottom of the form is helpful in calculating percent intake; although, for our purposes, we can crudely estimate if the resident at less or more than half (50%) of the served meal (e.g., main entrée, salad, bread, dessert, milk, juice, water) instead of a continuous measure of intake (0% to 100%). We usually do not give credit for intake of coffee or tea. Also, note that supplement information is recorded separately, but list it as a tray item if it was delivered on the tray as opposed to being given separate from the served tray.

Type of Assistance: codes are at the bottom of the observation form. Check all types that occur at any point during the meal (one or more episodes). Record both Independent and/or Assisted and type of assistance (none versus all types listed below).

Independent (I): resident was directly observed to feed self at least one bite/drink during the meal.

Assisted (A): resident was directly observed to receive at least one episode of staff assistance (of any type) during the meal. So, a resident could be "A+I" in that both of the above was observed. If "A" was observed, then record all types. If no assistance was observed, record "N" for "none".

Types of Assistance (A): Record **all types** of assistance provided **directly to the resident** (not to a group of residents simultaneously) by any indigenous nursing home staff member (including nurse aides, licensed nurses, administrator, activities personnel) **during the meal** (between meal tray delivery and pick-up) including the following:

All types below must be <u>specifically directed toward eating</u> and related to items on meal tray:

- *Verbal cueing/prompting* (V): A statement made by the staff to the resident explicitly directed toward eating (e.g., "Try a bite of eggs"; "Would you like a sip of juice?") or step-by-step instructions to eat (e.g., "Open your mouth", "Take a bite", "chew", "swallow"). Staff offer of a meal substitution ("would you like something else instead?") counts. Staff offer of items independent of the meal tray (e.g., coffee, water, bread, second helpings) does NOT count as a prompt. If the resident accepts the additional item, then that item becomes a meal tray item and corresponding prompts to encourage intake count. We are also including Social Stimulation and Verbal Encouragement in this category.

    - Social Stimulation is a verbal statement made by the staff to the resident not related to eating, per se (e.g., "Good Morning, Ruth"; "How are you today?"; "It's good to see you this morning?"). Note that social interaction between residents does not count.
    - *Verbal Encouragement to eat* (E) includes comments made by the staff related to eating or the food but which do not provide explicit instructions to eat (e.g., "*What are you having for breakfast this morning?"; "Are you hungry for breakfast today?"; "You're eating well"; "Good job. You finished all your lunch!*"). Encouragement that does NOT count is defined as brief one-to-two word phrases, such as the use of the resident's name in isolation, "*come on", "(that's) good", "thank you*". Encouragement must be a complete sentence that pertains to the food and eating but does not meet the criteria for a verbal prompt (i.e. explicit instruction to eat).

- *Physical Guidance* (PG): Staff member uses physical contact with the resident to initiate eating (e.g., guide resident's hand to utensil, help resident hold utensil or cup).

- *Physical Feeding* (P): Staff member physically feeds the resident in that the staff member delivers the bite of food or drink from the tray to the resident's mouth with no assistance from the resident.

- A *new episode* of each type of assistance is defined as a break in the previous episode by: return of the food/fluid item to the tray, movement of the food/fluid item out of reach of the resident's mouth. If a staff member holds food/fluid items to the resident's mouth and offers repeated prompts for the resident to take it, this represents *one* episode.

- *IF the resident did not receive any assistance, record None (N).*

Total Assistance Time (in minutes): The total number of minutes during the meal that a resident received any type of assistance from (any type of) staff. This data element requires that you total the assistance time across all episodes and types of assistance. Use the comment section to record each episode of assistance. The general rule is that a "continuous" episode of assistance should have a begin and end time; while, "sporadic" episodes of assistance can be measured with tic marks, such that the staff member receives credit for one minute of assistance per every four tic marks. Write detailed comments and then tally across all episodes at the end of the observation period to calculate a total time. Also indicate if one staff is providing assistance to more than one resident as a ratio.

Supplement: Oral liquid nutritional supplement (e.g., HPN, Resource, Ensure, Mighty Shake) delivery during (or immediately following) the meal. Record *Yes/No* for supplement provided by staff at any point during the meal.

If Yes, record:

Assistance provided by staff to encourage consumption: see type and amount of assist above.
Amount consumed of the supplement in fluid ounces.

Comments: This section should be used to make note of any of the following:

- Evidence of chewing or swallowing difficulties exhibited by the resident (coughing, spitting, drooling)
- Evidence of mood disturbance (crying, tearfulness, verbal or physical agitation – repetitive movements or verbalizations without a specific purpose, verbal or physical aggression – yelling, hitting, pushing)
- Resident refusal of food and/or staff assistance (e.g., verbally states, "go away, leave me alone, I don't want it, I'm not hungry" or non-verbally pushes tray away, turns head or clamps mouth shut when staff offer the food).
- Resident complaints about the food service and/or food quality or requests a substitution ("I don't like this", "It's cold", "can I get a sandwich?")
- Resident complaints of pain
- Resident alertness (e.g., "asleep during most of the meal period", "staff talked to her but she showed no response")
- Any other miscellaneous information that might be relevant to the staff ability to provide assistance and/or the resident's responsiveness to it (e.g., noise level in the dining room, special event, family visitation)

On Back of Sheet:

Indicate number of resident assisted by each PFA and the tasks performed by each PFA.

ASSESSMENT: MEALTIME OBSERVATIONAL PROTOCOL

Staff Observer Name: _____ **Facility:**_____ **Date:**_____/_____/_____

MEAL: __**Breakfast** __**Lunch** __**Dinner** **LOCATION:** __**Dining Room** __ **Hall/Room** **Begin Time:** ___ : ___ **am/pm** **End Time:** ___ : ___ **am/pm**

Licensed Nurse in Dining Room (NOT passing medication):___**Present** ___**Absent**

	RESIDENT	Assisted by PFA	CNA	LPN	F	Position (Upright vs Reclined)	Served Diet (Regular vs. modified)	Total % Eaten Less 50% More 50%	Type of Assistance V	P	PG	I	Total Assist Time (minutes)	Supplement Given at Meal Y/N	Amount Consumed
1)															**oz**
2)															**oz**
3)															**oz**
4)															**oz**
5)															**oz**

Comments: (note evidence of chewing or swallowing problems, resident complaints or request for substitutions, refusals, mood, alertness)

1)

2)

3)

4)

5)

	Resident									
	1) Substitution Offered: ___Yes ___No		2) Substitution Offered: ___Yes ___No		3) Substitution Offered: ___Yes ___No		4) Substitution Offered: ___Yes ___No		5) Substitution Offered: ___Yes ___No	
	Food/Fluid Items	%	Food/Fluid Items	%	Food/Fluid Items	%	Food/Fluid Items	%	Food/Fluid Items	%
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Codes for Type of Assist: Independent (I) any independent feeding action completed spoon to mouth, cup to mouth, successfully take a bite independently,
None = N (no assistance provided) Physical = P (e.g., aide feeds resident) Physical Guidance. = PG (e.g., aide guides resident to feed self)
Verbal = V (e.g., “Pick up your spoon & take a bite”; “Swallow” “How are you today?”; “How are you feeling?”; “You’re eating well today.”)

Residents that PFA helped_____

_____ Take residents to/from dining room for meals
_____ Deliver, pick-up, and/or set-up meals trays
_____ Document food and fluid intake
_____ Placement of bibs
_____ Get requested substitutions from the kitchen
Other:

Return to Report

Nurse Educator Discussion Guide
PFA Program

Copy of Materials Obtained
[Check when received]

Date: _____/____/_____
Facility: _____
Research Staff Initials: _____

- ❑ **Training Curriculum**
- ❑ **Policy and Procedure**
- ❑ **Competency Training**

1. What was your main reason/s for implementing the PFA program?

_____

_____

_____

_____

Tell me about the state approval process.

2. Were there any difficulties or barriers to the implementation of the PFA program?
   - ❑ No
   - ❑ Yes If yes, please explain.

_____

_____

_____

_____

The next set of questions address the training process.

3. When did your PFA program begin (i.e., date of 1st training session)? _____

4. How many training sessions have you conducted? _____

5. How many hours over how many days is each training session conducted?

   _____Hours

   _____Days

   5a. How many hours are spent on classroom versus clinical (e.g., hand washing, feeding) training?

   _____ Hours classroom

   _____ Hours clinical

6. What is the location of your classroom training? _____

7. Who besides you provides the training? _____

8. How many people have been trained? _____

9. Of those who have been trained, how many are currently working as PFAs? _____

10. What records does the facility keep on PFAs and their training (e.g., copy of training certificate)?

_____

11. Do you use prepared training materials?

❑ Yes If yes, what materials are used (e.g., state curriculum)?
If state materials are listed, skip to Q13.

_____

_____

_____

_____

_____

❑ No If no, what materials do you use/how were they developed?

_____

_____

_____

_____

_____

12. In what ways does your curriculum differ from the State's required curriculum?

_____

_____

_____

_____

_____

13. Have you made any changes to the training curriculum since you first began the program?

❑ No

❑ Yes If yes, explain.

_____

_____

_____

_____

_____

May we please have a copy of your curriculum? [check box at top when received]

14. Did you write a policy and procedure to cover the PFA program?

❑ Yes If yes, **may we obtain a copy? [check box at top when received]**

❑ No

Next, I'd like to ask some questions regarding the recruitment process for PFAs.

15. Did you recruit trainees from the community?
    - ❑ Yes If yes, skip to Q16
    - ❑ No If no, answer 15a, THEN skip to Q18

    14a. Did you consider recruiting from the community?
    - ❑ Yes
    - ❑ No

    YES or NO responses: Please explain.

_____

_____

_____

_____

_____

16. How did you screen community trainees? For example, did you check the:
    [Interviewer: check all that apply]
    - ❑ CORI
    - ❑ Nurse aide registry
    - ❑ References

    16a. What does the state require for screening? Please explain.

_____

_____

_____

_____

_____

17. Are community trainees given an orientation to the facility when first employed?
    - ❑ Yes
    - ❑ No

18. Did you recruit from current non-nursing employees?
    - ❑ No If no, skip to Q19.
    - ❑ Yes If yes, please list the departments and ask Q18a

_____

_____

_____

_____

_____

    18a. Did non-nursing employees volunteer or did a manager select them?
    - ❑ Volunteer
    - ❑ Non-volunteer

19. On a scale of 1 to 5, where 1 is easy and 5 is very difficult, how easy or difficult has it been to recruit PFA trainees?

    1_____2_____3_____4_____5

20. Is there a minimum age eligibility requirement for PFA training?
    - ❑ Yes If yes, what is it? _____
    - ❑ No

21. Is there a requirement that the trainees speak English?
    - ❑ Yes
    - ❑ No

22. Is there a minimum education level requirement for PFA training?
    - ❑ Yes If yes, what is it? _____
    - ❑ No

23. Are there family members who visit residents during mealtime?
    - ❑ Yes If yes, ask Q23a.
    - ❑ No If no, skip to Q24

    23a. If yes, have you offered the training to family members?
    - ❑ Yes
    - ❑ No If no, why not?

_____

_____

_____

_____

_____

24. Do you have an active volunteer program at your facility?
    - ❑ Yes If yes, ask Q23a.
    - ❑ No If no, skip to Q24

    24a. If yes, have you offered the training to volunteers?
    - ❑ Yes
    - ❑ No If no, why not?

_____

_____

_____

_____

_____

The next set of questions has to do with the testing process.

25. Do you provide PFA competency testing following training?
    - ❑ No
    - ❑ Yes If yes, check the type. **May we have a copy? [check box at top when received]**
        - ❑ Written
        - ❑ Performance-based If checked, please list type/s

_____

_____

_____

_____

_____

26. Have you made any changes to the testing process since you implemented the PFA program?
    - ❑ No
    - ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

27. Do you provide follow-up, in-service programs for PFAs?
    - ❑ Yes If yes, how often? _____
    - ❑ No

28. Do PFAs get annual reviews/evaluations?
    - ❑ Yes
    - ❑ No

With the next set of questions, we will ask you to describe the implementation and impact of the PFA program at our facility.

29. How are residents identified as appropriate for PFA assistance?

    29a. Who makes the selection? _____

    29b. What criteria are used?

_____

_____

_____

_____

_____

29c. How often is the resident's condition reviewed for continued appropriateness of PF assistance?

- ❑ On-going
- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Quarterly w/MDS review

30. Are PFAs scheduled for specific meals and/or days?
    - ❑ Yes
    - ❑ No

31. Are PFAs assigned to feed specific residents?
    - ❑ Yes
    - ❑ No

32. Are PFAs required to check in with a supervisor to receive their assignment?
    - ❑ Yes
    - ❑ No

33. Are PFAs required to check in with a supervisor when their assignment is complete?
    - ❑ Yes
    - ❑ No

34. Are there licensed registered nurses, other than those passing meds, who are present in the dining room during meals?
    - ❑ Yes If yes, ask Q34a.
    - ❑ No If no, who is responsible for monitoring the PFA?

_____

_____

_____

_____

_____

34a. If an LN is present, is she/he responsible for monitoring the PFA?

- ❑ Yes
- ❑ No If no, who is responsible?

_____

_____

_____

_____

_____

35. Are PFAs involved in offering food/fluids between meals?
    - ❑ Yes

❑ No

36. Have you made any changes to the implementation of the program since it first began?
    ❑ No
    ❑ Yes If yes, explain.

_____

_____

_____

_____

_____

37. What is your impression of the PFA program? For example, what, if any, is the impact on:

    37a. Residents?

_____

_____

_____

_____

_____

    37b. Families?

_____

_____

_____

_____

    37c. Staff (including CNAs and LNs)

_____

_____

_____

_____

38. Do you have any concerns about the PFA program?
    ❑ No
    ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

39. Do you plan to continue using PFAs?

❑ Yes
❑ No If no, please explain why not.

_____

_____

_____

_____

_____

40. Have you had a state survey since implementing the PFA program?
❑ Yes If yes, ask Q40a.
❑ No If no, end interview.

40a. Did the surveyors notice your PFA program?
❑ Yes If yes, ask Q40b.
❑ No If no, end interview.

40b. Did the surveyors review the training materials/records?
❑ Yes
❑ No

Charge Nurse Discussion Guide
PFA Program

Date: _____/____/_____
Facility:_____
Research Staff Initials: _____

With the first set of questions, we will ask you to describe the implementation of the PFA program at your facility.

1. How do you identify residents who are appropriate for PFA assistance?

    1a. Who makes the selection?_____

    1b. What criteria are used?

_____

_____

_____

_____

_____

    1c. How often is the resident's condition reviewed for continued appropriateness of PF assistance?
    - ❑ On-going
    - ❑ Daily
    - ❑ Weekly
    - ❑ Monthly
    - ❑ Quarterly w/MDS review

2. Are PFAs scheduled for specific meals and/or days?
    - ❑ Yes
    - ❑ No

3. Are PFAs assigned to feed specific residents?
    - ❑ Yes
    - ❑ No

4. Are PFAs required to check in with a supervisor to receive their assignment?
    - ❑ Yes
    - ❑ No

5. Are PFAs required to check in with a supervisor when their assignment is complete?
    - ❑ Yes
    - ❑ No

6. Are there licensed registered nurses, other than those passing meds, who are present in the dining room during meals?

❑ Yes If yes, ask Q6a.
❑ No If no, who is responsible for monitoring the PFA?

_____

_____

_____

_____

_____

6a. If an LN is present, is she/he responsible for monitoring the PFA?

❑ Yes
❑ No If no, who is responsible?

_____

_____

_____

_____

_____

7. Are PFAs involved in offering food/fluids between meals?

❑ Yes
❑ No

8. What is your impression of the PFA program? For example, what, if any, is the impact on:

8a. Residents?

_____

_____

_____

_____

_____

8b. Families?

_____

_____

_____

_____

_____

8c. Staff (including CNAs and LNs)

_____

_____

_____

_____

_____

9. Do you have any concerns about the PFA program?
   - ❑ No
   - ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

10. Have you had a state survey since implementing the PFA program?
    - ❑ Yes If yes, ask Q10a.
    - ❑ No If no, end interview

10a. Did the surveyors notice your PFA program?
   - ❑ Yes
   - ❑ No

Director of Nursing Discussion Guide
PFA Program

Copy of Materials Obtained
[Check when received]

Date: _____/____/_____
Facility:_____
Research Staff Initials: _____

❑ **Policy and Procedure**

1. What was your main reason/s for implementing the PFA program?

_____

_____

_____

_____

_____

2. Did you write a policy and procedure to cover the PFA program?
   - ❑ Yes If yes, **may we obtain a copy [check box at top when received]?**
   - ❑ No

I'd like to ask you some questions regarding the recruitment process for the PFA program.

3. Did you recruit trainees from the community?
   - ❑ Yes If yes, skip to Q4
   - ❑ No If no, answer 3a, THEN skip to Q5

   3a. Did you consider recruiting from the community?
   - ❑ Yes
   - ❑ No

   YES or NO responses: Please explain.

_____

_____

_____

_____

_____

4. How did you screen the community trainees? For example, did you check the:
   [Interviewer: check all that apply]
   - ❑ CORI
   - ❑ Nurse aide registry
   - ❑ References

4a. What does the state require for screening? Please explain.

_____

_____

_____

_____

_____

5. Did you recruit from current non-nursing employees?
   - ❑ No If no, skip to Q6.
   - ❑ Yes If yes, please list the departments and ask Q5a

_____

_____

_____

_____

_____

5a. Did non-nursing employees volunteer or did a manager select them?
   - ❑ Volunteer
   - ❑ Non-volunteer

6. Are there family members who visit residents during mealtime?
   - ❑ Yes If yes, ask Q6a.
   - ❑ No If no, skip to Q7

6a. If yes, have you offered the training to family members?
   - ❑ Yes
   - ❑ No If no, why not?

_____

_____

_____

_____

_____

7. Do you have an active volunteer program at your facility?
   - ❑ Yes If yes, ask Q7a.
   - ❑ No If no, skip to Q8

7a. If yes, have you offered the training to volunteers?

- ❑ Yes
- ❑ No If no, why not?

_____

_____

_____

_____

_____

With the next set of questions, we will ask you to describe the implementation and impact of the PFA program at your facility.

8. How are residents identified as appropriate for PFA assistance?

8a. Who makes the selection? _____

8b. What criteria are used?

_____

_____

_____

_____

_____

8c. How often is the resident's condition reviewed for continued appropriateness of PF assistance?

- ❑ On-going
- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Quarterly w/MDS review

9. Are PFAs scheduled for specific meals and/or days?
   - ❑ Yes
   - ❑ No

10. Are PFAs assigned to feed specific residents?
   - ❑ Yes
   - ❑ No

11. Are PFAs required to check in with a supervisor to receive their assignment?
   - ❑ Yes
   - ❑ No

12. Are PFAs required to check in with a supervisor when their assignment is complete?
   - ❑ Yes
   - ❑ No

13. Are there licensed registered nurses, other than those passing meds, who are present in the dining room during meals?

- ❑ Yes If yes, ask Q13a.
- ❑ No If no, who is responsible for monitoring the PFA?

_____

_____

_____

_____

_____

13a. If a LN is present, is she/he responsible for monitoring the PFA?

- ❑ Yes
- ❑ No If no, who is responsible?

_____

_____

_____

_____

_____

14. Are PFAs involved in offering food/fluids between meals?

- ❑ Yes
- ❑ No

15. Have you made any changes to the implementation of the program since it first began?

- ❑ No If no, skip to Q16
- ❑ Yes If yes, explain

_____

_____

_____

_____

_____

16. Have you made any changes to your staffing levels or configuration since implementation of the PFA program?

- ❑ No
- ❑ Yes If yes, please explain

_____

_____

_____

_____

_____

17. Were there any difficulties or barriers to the implementation of the PFA program?

- ❑ No
- ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

18. Are you measuring the impact of the program in any way?

- ❑ Yes If yes, ask Q18a-d
- ❑ No If no, skip to Q19

18a. If yes, have you conducted staff satisfaction surveys?

- ❑ Yes
- ❑ No

18b. If yes, have you conducted family satisfaction surveys?

- ❑ Yes
- ❑ No

18c. If yes, do you monitor food and/or fluid intake?

- ❑ Yes, food only
- ❑ Yes, fluid only
- ❑ Yes, both
- ❑ Neither

18d. Other, please describe any other type of impact study or monitoring that you conduct.

_____

_____

_____

_____

_____

19. What is your impression of the PFA program? For example, please explain the impact, if any, on:

19a. Residents?

19b. Families?

19c. Staff (including CNAs and LNs)

20. Do you have any concerns about the PFA program?

- ❑ No
- ❑ Yes If yes, please explain.

21. Do you plan to continue using PFAs?

- ❑ Yes
- ❑ No If no, please explain why.

22. Have you had a state survey since implementing the PFA program?

- ❑ Yes
- ❑ No If no, skip to Q23

22a. Did the surveyors notice your PFA program?

- ❑ Yes
- ❑ No If no, skip to Q23

22b. Did the surveyors review the training materials/records?

- ❑ Yes
- ❑ No

Please tell us about reimbursement for PFA expenses.

23. Will you be able to get reimbursement for training, testing, OR labor hours from:

23a. Medicaid?

- ❑ Yes
- ❑ No
- ❑ D/K

23b. Medicare?

- ❑ Yes
- ❑ No
- ❑ D/K

Administrator Discussion Guide
PFA Program

Date: _____/____/_____
Facility: _____
Research Staff Initials: _____

1. What was your main reason/s for implementing the PFA program?

_____

_____

_____

_____

_____

I'd like to ask you some questions regarding the recruitment process for the PFA program.

2. Did you recruit trainees from the community?
   - ❑ Yes If yes, skip to Q3
   - ❑ No If no, answer 2a, THEN skip to Q4

   2a. Did you consider recruiting from the community?
   - ❑ Yes
   - ❑ No

   YES or NO responses: Please explain.

_____

_____

_____

_____

_____

3. How did you screen the community trainees? For example, did you check:
   [Interviewer: check all that apply]
   - ❑ CORI
   - ❑ Nurse aide registry
   - ❑ References

3a. What does the state require for screening? Please explain.

_____

_____

_____

_____

_____

4. Did you recruit from current non-nursing employees?
   - ❑ No If no, skip to Q5.
   - ❑ Yes If yes, please list the departments and ask Q4a

_____

_____

_____

_____

_____

4a. Did non-nursing employees volunteer or did a manager select them?
   - ❑ Volunteer
   - ❑ Non-volunteer

5. Are there family members who visit residents during mealtime?
   - ❑ Yes If yes, ask Q5a.
   - ❑ No If no, skip to Q6.

5a. If yes, have you offered the training to family members?
   - ❑ Yes
   - ❑ No If no, why not?

_____

_____

_____

_____

_____

6. Do you have an active volunteer program at your facility?
   - ❑ Yes If yes, ask Q6a.
   - ❑ No If no, skip to Q7

6a. If yes, have you offered the training to volunteers?

- ❑ Yes
- ❑ No If no, why not?

_____

_____

_____

_____

_____

With the next set of questions, we will ask you to describe the implementation and impact of the PFA program at your facility.

7. Have you made any changes to your staffing levels or configuration since implementing the PFA program?
   - ❑ No
   - ❑ Yes If yes, please explain

_____

_____

_____

_____

_____

8. Were there any difficulties or barriers to the implementation of the PFA program?
   - ❑ No
   - ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

9. Are you measuring the impact of the program in any way?
   - ❑ Yes If yes, ask Q9a-d
   - ❑ No If no, skip to Q10

9a. If yes, have you conducted staff satisfaction surveys?

- ❑ Yes
- ❑ No

9b. If yes, have you conducted family satisfaction surveys?

- ❑ Yes
- ❑ No

9c. If yes, do you monitor food and/or fluid intake?

- ❑ Yes, food only
- ❑ Yes, fluid only
- ❑ Yes, both
- ❑ Neither

9d. Other, please describe any other type of impact study or monitoring that you conduct.

_____

_____

_____

_____

_____

10. What is your impression of the PFA program? For example, what, if any, is the impact on:

10a. Residents?

_____

_____

_____

_____

_____

10b. Families?

_____

_____

_____

_____

_____

10c. Staff (including CNAs and LNs)

_____

_____

_____

_____

_____

11. Do you have any concerns about the PFA program?
- ❑ No
- ❑ Yes If yes, please explain.

_____

_____

_____

_____

_____

12. Do you plan to continue using PFAs?
- ❑ Yes
- ❑ No If no, please explain why not.

_____

_____

_____

_____

_____

13. Have you had a state survey since implementing the PFA program?
- ❑ Yes
- ❑ No If no, skip to Q14

13a. Did the surveyors notice your PFA program?
- ❑ Yes
- ❑ No If no, skip to Q14

13b. Did the surveyors review the training materials/records?
- ❑ Yes
- ❑ No

Please tell us about reimbursement for PFA expenses.

14. Will you be able to get reimbursement for training, testing, OR labor hours from:

14a. Medicaid?
- ❑ Yes
- ❑ No
- ❑ D/K

14b. Medicare?
- ❑ Yes
- ❑ No
- ❑ D/K

Staff Interview: Feeding Assistant

Date: _____/_____/_____ **Facility: _____**

Shift: _____Day 7am – 3pm _____Evening 3pm – 11pm Other ____ **Research Staff Initials**: _____

Type of Staff: ___ Volunteer ___Family member ___Single Task Worker
___Existing Staff in other area (specify:_____) ___Other (specify:_____)

Interviewer Script: *Hello, my name is _____. I am with ABT/UCLA and we are conducting a project to evaluate the use of feeding assistants in nursing homes. I would like to ask you a few questions about your experience in taking care of residents and the tasks that you are responsible for. You may refuse to answer the questions and it will in no way affect your job. All of your answers will be kept confidential, meaning that I won't share what you tell me with the staff here. Is it okay for me to begin?*

1. How long have you worked in the nursing home setting? ___ < 6 mths ___ 6-12 mths ___ 1-2 years ___ >2 yrs

2. How many residents are you helping to eat today? _____

3. Of the (*fill in number from question 2*) residents you are helping to eat today, how many need:
_____(full assistance/completely dependent) _____(partial assistance/partially independent)
Full: you physically feed the resident each bite/drink Partial: resident feeds him/herself and you help (e.g., cut up meat)

4. Do you feel comfortable with your resident assignment and their assistance needs (*as reported in questions 2 and 3*)?
___Yes ___No ___Sometimes ___No Response/Refused to Answer

5. Are you able to get help from licensed staff (nurses and/or nurse aides) when/if you need it?
___Yes ___No ___Sometimes ___No Response/Refused to Answer

6. Do you usually help the same residents to eat or does your resident assignment change (*daily or weekly*)?
_____Usually the Same Residents _____Residents Change Daily or Weekly

7. Did you participate in a training program to help residents eat?

8. What other job tasks do you do related to meals? (*check all that apply*)
a. Take residents to/from dining room for meals: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

b. Deliver, pick-up, and/or set-up meals trays ___Yes ___No ___Sometimes ___No Response/Refused to Answer

c. Document food and fluid intake: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

d. Offer residents foods/fluids between meals ___Yes ___No ___Sometimes ___No Response/Refused to Answer

e. Get requested substitutions from the kitchen ___Yes ___No ___Sometimes ___No Response/Refused to Answer

f. Other (describe):

9. What other job tasks do you do? (*check all that apply*)
a. Take residents to social activities ___Yes ___No ___Sometimes ___No Response/Refused to Answer

b. Help residents get in/out of bed: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

c. Help residents get dressed ___Yes ___No ___Sometimes ___No Response/Refused to Answer

d. Help residents to use the toilet ___Yes ___No ___Sometimes ___No Response/Refused to Answer

e. Help residents to walk ___Yes ___No ___Sometimes ___No Response/Refused to Answer

f. Other (describe):

10. Is there anything else you would like to share with me about your job tasks?

Staff Interview: Certified Nursing Assistant

Date: _____/_____/_____ **Facility: _____**

Shift: ___(1) Day 7am – 3pm ___(2) Evening 3pm – 11pm Other ____ **Research Staff Initials**: _____

Interviewer Script: *Hello, my name is _____. I am with ABT/UCLA and we are conducting a project to evaluate the use of feeding assistants in nursing homes. I would like to ask you a few questions about your experience in taking care of residents and the tasks that you are responsible for. You may refuse to answer the questions and it will in no way affect your job. All of your answers will be kept confidential, meaning that I won't share what you tell me with the staff here. Is it okay for me to begin?*

1. How long have you worked in the nursing home setting? ___ < 6 mths ___ 6-12 mths ___ 1-2 years ___ >2 yrs

2. How many residents are you assigned today? _____

3. How many residents are you usually assigned during the *day/evening* shift? _____

4. How many residents are you **helping to eat** today? _____

5. Of the (*fill in number from question 6*) residents you are **helping to eat** today, how many need:

_____(full assistance/completely dependent) _____(partial assistance/partially independent)

Full: you physically feed the resident each bite/drink Partial: resident feeds him/herself and you help (e.g., cut up meat)

6. Do you usually help the same residents to eat or does your resident assignment change (*daily or weekly*)?

_____Usually the Same Residents _____Residents Change Daily or Weekly

7. Have you received any special training on feeding residents, outside of your certification training?

8. What other job tasks do you do related to meals? (*check all that apply*)

a. Take residents to/from dining room for meals: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

b. Deliver, pick-up, and/or set-up meals trays: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

c. Document food and fluid intake: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

d. Offer residents foods/fluids between meals: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

e. Get requested substitutions from the kitchen: ___Yes ___No ___Sometimes ___No Response/Refused to Answer

f. Other (describe):

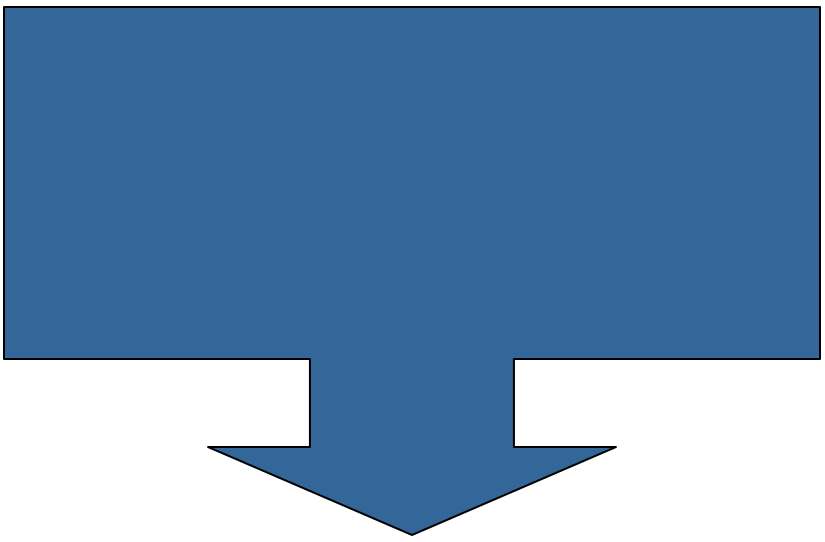
9. Do you think it is helpful to have the "feeding assistant" staff present during meals?
___Yes ___No ___Sometimes ___No Response/Refused to Answer

9a. **If Yes/sometimes**: What do they do that is helpful to you? / **If No**: Why not?

10. Do you have any concerns about the use of PFAs?

11. Is there anything else you would like to share with me about your job tasks?

Return to Report



Surveyor Interview Guide
Ombudsman Interview Guide
AHCA and AAHSA Interview Guide

Study of Paid Feeding Assistant Programs
Discussion Guide: Surveyors

Date _____

State _____

Research staff initials _____

SECTION I: General Surveyor Questions

1. Are you familiar with the PFA program in your state?

   No _____
   Yes _____ If yes, How did you learn about it (e.g., national organization, meetings with state, state-sponsored training, publications)

2. Have you been in a facility with a PFA Program?

   No _____
   Yes _____ If yes, please ask Q2a – Q2c

   2a) Did you know ahead of time that the facility had a PFA program?

   No _____
   Yes _____ If yes, how did you know? Please explain.

   2b) Did you do anything differently in your survey preparations?

   No _____
   Yes _____ If yes, please describe.

   2c) Did you do anything different during the survey process?

   No _____
   Yes _____ If yes, did you

   Observe a PFA feeding a resident?
   Observe supervision of the PFA?
   Note any infection control concerns or issues?

2d) Did you cite any F-tags related to nutrition, weight loss QI, dehydration QI?

No _____
Yes _____ If yes, please list

SECTION II: Program Implementation

3. What staff have facilities trained to function as PFAs? (check all that apply).

Non-nursing staff _____
Family members _____
Community volunteers _____
Others, please list

4. Does your state require that volunteers complete PFA training?

Yes _____ If yes, skip to Q5
No _____

4a) Are you aware of any facilities that have required that volunteers complete the FA training?

Yes _____
No _____

4b) How do you feel about requiring volunteers to complete the FA training?

5. What have you observed regarding the delivery of PFA training across facilities? In general, would you say that it is consistent or inconsistent?

Consistent _____
In-consistent ___ If inconsistent, please explain.

6. Of the nursing homes that you know utilize the PFA program, are PFAs detailed: [Please check all that apply]

As needed _____
Scheduled regularly _____
If both are check, please explain.

7. Who provides supervision of PFAs?

   7a) Do you have any concerns about the supervision of PFAs in the facilities?

   Yes _____ If yes, please describe your concerns
   No _____

8. In general, are you satisfied with the implementation of the PFA program (e.g., number of PFA programs in use; number of meals/days involving PFAs; scheduling of PFAs)?

   Yes _____
   No _____ If no, please explain?

9. Have you seen any positive quality of care outcomes as a result of the PFA program?

   Yes _____
   No _____

10. Have you seen any negative quality of care outcomes as a result of the PFA program?

11. Have you observed PFAs performing tasks other than feeding assistance?

    No _____
    Yes _____ If yes, please list what tasks you have observed PFAs performing.

    11a) If yes, do you have concerns about this?

    No _____
    Yes _____ If yes, what are your specific concerns?

12. Are you concerned about the selection of residents to be fed by feeding assistants?

    No _____
    Yes _____ If yes, can you be specific?

SECTION III: Positive/Negatives of Program

13. Overall, are you satisfied with the rate of PFA training?

    Yes _____

    No _____

14. Overall, are you satisfied with the quality of the PFA training?

    Yes _____

    No _____

15. Have any facilities reported positive experiences with the PFA program?

    No _____

    Yes _____ If yes, what did they say?

16. Have any facilities reported negative experiences with the PFA program? Explain:

    No _____

    Yes _____ If yes, what were the complaints?

17. What do you view as the benefits of the PFA program in your state?

18. What do you view as the disadvantages of the PFA program in your state?

19. Overall, do you think this is a good program? Please elaborate.

Study of Paid Feeding Assistant Programs
Discussion Guide: Ombudsman

Date _____

State _____

Research staff initials _____

SECTION I: General Questions

1. Are you familiar with the PFA program in your state?

   No _____

   Yes _____ If yes, How did you learn about it (e.g., national organization, meetings with state, state-sponsored training, publications)

2. Of the nursing homes in your state with which you have had contact, what would you estimate as the percentage of facilities that have trained PFAs?

   _____%

   Or, how many facilities do you know that have trained FAs?_____

SECTION II: Program Implementation

3. From your observation, has the use of the PFA program been more or less prevalent among particular types of nursing homes? For example, has it been more or less prevalent among:

   3a) Rural vs. Urban

   No _____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent.

   3b) Independent vs. Multi-facility chains

   No ____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent

   3c) For profit vs. non-profit

   No _____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent.

   3d) What about the size the facilities?

   No _____

   Yes _____ If yes, please note the size in which the PFA program is more prevalent.

4. Are you aware of who has been trained as part of the PFA program? Please check all that apply.

   Non-nursing staff _____
   Community volunteers _____
   Family members _____
   Others, please list

5. Are you aware of how FAs are being utilized? For example, are they used:

   As needed ?_____
   Scheduled regularly ?_____
   If both are checked, please explain.

6. Does your state require that volunteers complete PFA training?

   Yes _____ If yes, skip to Q5b
   No _____

   6a) Are you aware of any facilities that have required that volunteers complete the FA training?

      Yes _____
      No _____

   6b) How do you feel about requiring volunteers to complete the FA training?

7. Are you aware of who supervises PFAs in the facilities?

      Yes _____
      No _____

   7a) Do you have any concerns about the supervision of PFAs in the facilities?

8. Are you aware of any barriers to the implementation of the program at the facility level (e.g., financial, recruitment, survey concerns, legal liability)?

   No _____
   Yes _____ If yes, please explain.

9. Do you have any concerns about how facilities implement their PFA programs?

   No _____
   Yes _____ If yes, please explain.

10. Have you observed PFAs performing tasks other than feeding assistance?

    No _____
    Yes _____ If yes, please list what tasks you have observed PFAs performing.

    10a) If yes, do you have concerns about this?

    No _____
    Yes _____ If yes, what are your specific concerns?

SECTION III: Program Oversight

11. Are you aware of what the surveyors look at with regard to PFA programs?
    No _____
    Don't Know _____
    Yes _____ If yes, please explain

12. Do you think this level of oversight is adequate?

    Yes _____
    No _____ If no, please explain

13. Have you heard any complaints from facilities regarding Survey and FA Programs?

    No _____
    Yes _____ If yes, please explain.

14. Have you heard any complaints from residents or families regarding the PFA programs?

    No _____
    Yes _____ If yes, please explain.

15. Are you aware of any quality monitoring of the impact of the program by facilities or by the state?

SECTION IV: Positive/Negatives of Program

16. Have any facilities reported positive experiences with the PFA program?

    No _____
    Yes _____ If yes, what did they say?

17. Have any facilities reported negative experiences with the PFA program? Explain:

    No _____
    Yes _____ If yes, what were the complaints?

18. Have any residents or families reported positive experiences with the PFA program? Explain:

    No _____
    Yes _____ If yes, what were the complaints?

19. Have any residents or families reported negative experiences with the PFA program? Explain:

    No _____
    Yes _____ If yes, what were the complaints?

20. What do you view as the benefits of the PFA program in your state?

21. What do you view as the disadvantages of the PFA program in your state?

22. Overall, do you think this is a good program? Any concern?

    Yes _____
    No _____

Study of Paid Feeding Assistant Programs
Discussion Guide: Provider Association Affiliate

Date _____

State _____

Research staff initials _____

SECTION I: General Questions

1. Are you familiar with the PFA program in your state?

   No _____

   Yes _____ If yes, How did you learn about it (e.g., national organization, meetings with state, state-sponsored training, publications)

2. In terms of your member facilities, what would you estimate as the percentage of facilities that implemented a training program for Feeding Assistants?

   _____%

   Or, how many of your member facilities have trained FAs?_____

SECTION II: Program Implementation

3. From your experience with member facilities, do you think that the use of the FA programs has been more or less prevalent among particular types of nursing homes? For example, has it been more or less prevalent among:

   3a) Rural vs. Urban

   No _____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent.

   3b) Independent vs. Multi-facility chains

   No _____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent

   3c) For profit vs. non-profit

   No _____

   Yes _____ If yes, please circle in which type the PFA program is more prevalent.

3d) What about the size the facilities?

No _____
Yes _____ If yes, please note the size in which the PFA program is more prevalent.

4. Are you aware of who is being recruited to work as FAs? [Please check all that apply]

Non-nursing staff _____
Community volunteers _____
Family members _____
Others, please list

5. Are you aware of how FAs are being utilized? For example, are they used:

As needed ?_____
Scheduled regularly ?_____
If both are checked, please explain.

6. Does your state require that volunteers complete PFA training?

Yes _____ If yes, skip to Q5b
No _____

6a) Are you aware of any facilities that have required that volunteers complete the FA training?

Yes _____
No _____

6b) How do you feel about requiring volunteers to complete the FA training?

7. Are you aware of any barriers to the implementation of the program at the facility level (e.g., financial, recruitment, survey concerns, legal liability?)

No _____
Yes _____ If yes, please explain.

8. Did the state provide guidance or support to facilities interested in implementing a FA program? For example, did the state provide:
Train-the-trainer sessions
Sample policies
Curriculum and other training materials

If yes, please explain.

If No, did this impact the ability of facilities to move forward with implementation? In what way?

9. Could the state have done anything differently to assist facilities with implementation? If yes, please explain.

10. Could CMS have done anything differently, for example any programmatic changes that would have made it easier for the state or facilities to implement programs?

SECTION III: Program Oversight

11. What has been your experience with survey since implementation of FA programs?

12. Have surveyors been looking at the PFA programs?

    No _____
    Don't Know _____
    Yes _____ If yes, please explain

13. Have you had any complaints from facilities regarding Survey and FA Programs?

    No _____
    Yes _____ If yes, please explain.

14. Are you aware of any quality monitoring of the impact of the program by facilities or by the state?

SECTION IV: Positive/Negatives of Program

15. Have any facilities reported positive experiences with the PFA program?

    No _____
    Yes _____ If yes, what did they say?

16. Have any facilities reported negative experiences with the PFA program? Explain:

    No _____
    Yes _____ If yes, what were the complaints?

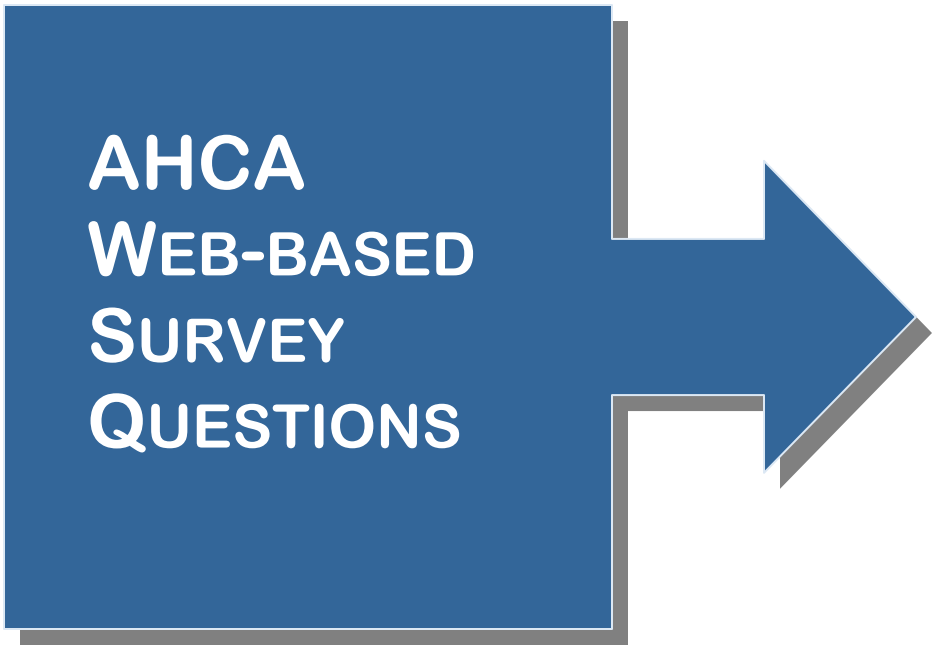
17. What do you view as the benefits of the PFA program in your state?

18. What do you view as the disadvantages of the PFA program in your state?

19. Overall, do you think this is a good program? Any concern?

Return to Report

AHCA Web-based Survey Questions



American Health Care Association
Survey on Implementation of the Paid Feeding Assistant Program.

Respondent Type:

Email: **Name:**

Custom Data: **IP Address:**

Stated Survey: **Ended Survey:**

1. Is the facility participating in a State-approved feeding assistant program?

2. If yes to Question 1, who has been trained? (Please check all that apply)

   - ❑ Current facility staff from non-nursing departments (e.g., social work, activities, Housekeeping, administrative personnel)
   - ❑ Individuals from the community
   - ❑ Family members
   - ❑ Others

3. If yes to "Others," please describe:

4. How many Nutrition/Hydration Assistants have been trained since the State allowed their use?

5. Are Nutrition/Hydration Assistants scheduled to work or used on an "as needed basis"?

6. What is the total number of residents currently receiving assistance from Nutrition/Hydration Assistants?

7. Would your facility be interested in participating in an on-site research project to study how State-approved feeding assistant programs operate and contribute to quality of care for residents?

8. Contact phone number:

9. State:

10. Number of Certified Beds:

Return to Report

AHCA Survey Results

Appendix 4 Appendix 4

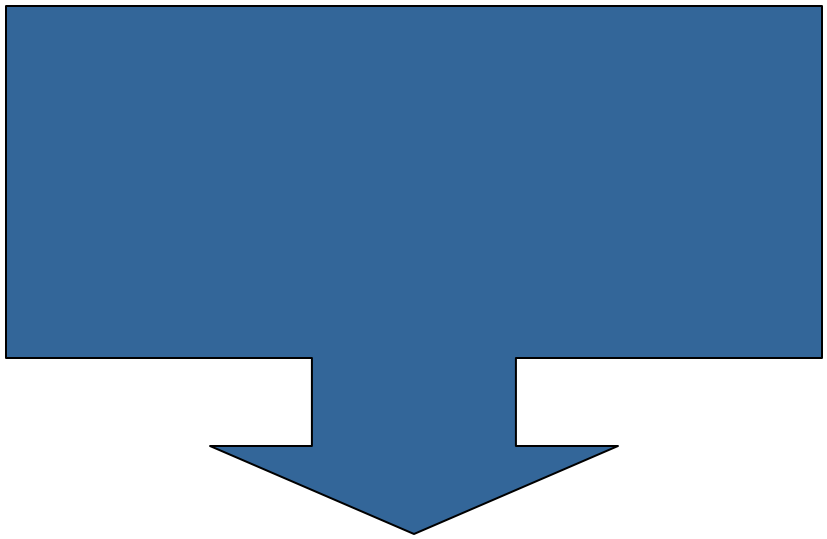
Table of the American Health Care Association (AHCA) Survey Results Showing Averages for Members Participating in the PFA Program

	Who Has Been Trained?				How PFAs are Employed		Agree to Site-visit Study	FAs/ Site	Residents Receiving Feeding Assistance /Site	Beds/ Site
	Non-nursing Staff	Community Members	Family Members	Others	Scheduled	As Needed				
Percent of PFA sites	.93	.17	.15	.10	.37	.55	.37			
Total Number	80	15	13	09	32	47	32			
Average Number								09	20	112
Range								0-35	0-100	28-300

Note. 274 AHCA members responded to the survey; 86 (31%) reported participation in the PFA program.

Return to Report

Appendix 5
Appendix 5



Nursing Facility Staff Informed Consent

Oral Consent form

Study of Paid Feeding Assistant Programs

Abt Associates Inc.

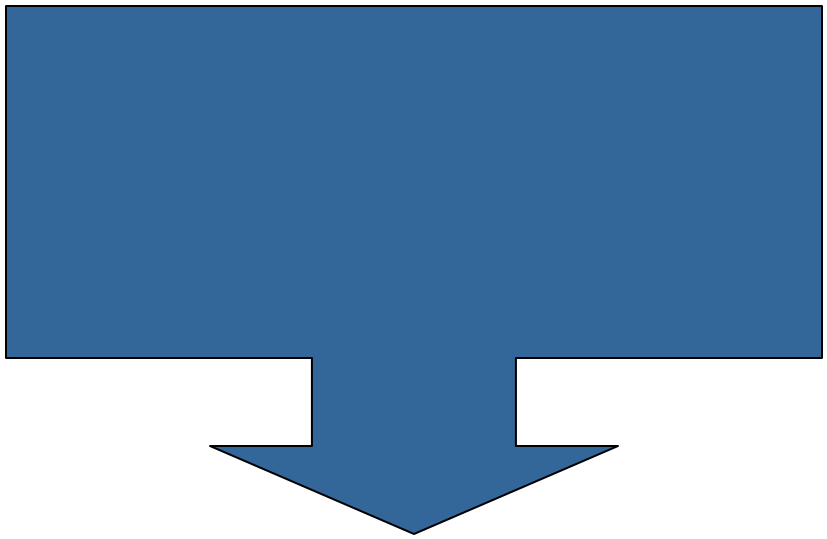
Date: _____
Facility Name: _____
Information Provided by _____ Title _____
Project Staff: _____

The goal of this project is to provide the Centers for Medicare & Medicaid Services (CMS) with information about how widely the federal rule regarding the use of Paid Feeding Assistants in nursing homes has been adopted, and in how facilities like yours have implemented Paid Feeding Assistant programs. Answers to the following questions will provide a "picture" of how meal service is implemented here, and will help us to understand how you utilize and train Paid Feeding Assistants to enhance the quality of your meal service.

Your participation is voluntary and you can end this conversation at any time, or you can refuse to answer any question. It is important to emphasize that no data collected during the course of this project will be reported that will in any way allow results to be traced to a particular facility. The results of the study will be presented to CMS in the aggregate with no direct quotes attributable to individuals or nursing facilities. Individual facility data will not be shared in any way with CMS or the state licensure and certification agency. However, researchers must report to the CMS Regional Office observations that indicate an immediate jeopardy or serious threat to a resident or residents.

Do we have your agreement to talk with us about paid feeding assistant programs in your state? ❑ Yes ❑ No

Thank you for your time and interest.



Oral Consent Form

Oral Consent form

Abt Associates Inc.

Study of Paid Feeding Assistant Programs

Abt Associates Inc. has been awarded a contract by the Centers for Medicare & Medicaid Services (CMS) to study Paid Feeding Assistant Programs in the US. The purpose of this study is to identify which states and facilities have taken action related to the Federal Register announcement on September 26, 2003 "Requirements for Paid Feeding Assistant in Long Term Care Facilities" (68 FR 55528), which allows Long Term Care facilities to use paid feeding assistants, as long as the rule is consistent with state laws.

We would like to ask you some questions about actions taken in your state and expect that your participation will take no longer than 45 minutes. Unless you tell us otherwise, you should assume that anything you tell us is "on the record." If you would like anything you say to be kept confidential and not reported, or reported and not attributable to you, please inform us of this; and we will protect the confidentiality of this information to the fullest extent of our abilities and to the fullest extent of the law.

Your participation is voluntary and you can end this conversation at any time, or you can refuse to answer any question. We anticipate this study will not present more than minimal risk to you as a respondent. The primary risk to participation is violation of confidentiality. We will interview 50-150 study participants (including all 50 state regulatory agencies and state affiliates of the American Healthcare Association and the American Association of Homes and Services for the Aging.) The results of the study will be presented to CMS in the aggregate with no direct quotes attributable to individuals. However, with your oral consent, we will include your name and contact information in an appendix to the report. We will also deliver study results to CMS in an Access database, which will be stripped of all information identifying individual study participants.

If you have any questions about this that I cannot answer, you may want to contact our study director, Ms. Terry Moore, at Abt Associates Inc., in Cambridge, Massachusetts. Her direct line is 617-347-2463.

Do we have your agreement to talk with us about paid feeding assistant programs in your state?

❑ Yes ❑ No

Date_____

Respondent's name: _____

Interviewer's name:_____

Return to Report

Appendix 6

Appendix 6
Appendix 6

Table 1

Program Implementation: Stakeholder Perspectives Across States

	Familiarity with PFA program in state	Characteristics of Facilities using PFAs	Staffing PFAs	Staffing PFAs Utilization of PFAs	PFA Training	Training Requirements for Volunteers	Barriers to Facility Implementation	Guidance to Facility Implementation
Surveyors	Surveyor respondents were familiar with the PFA program, but had limited knowledge of facility-level implementation. Surveyors in two states had not been in a facility with a PFA program, but noted that they may not notice a program if an unsafe practice is not identified. In the third state, surveyors were aware of a list of facilities that had implemented the PFA program.	N/A	Surveyor respondents reported that facility non-nursing staff were being trained as PFAs; these staff include uncertified CNAs, unit clerks, ancillary staff, social workers, activity staff, and administrative staff. One surveyor believed that facilities were not recruiting new workers from the community. Another surveyor noted that volunteers and family members helped feed residents, but they are not trained as PFAs.	Surveyor respondents had limited knowledge about how often PFAs are used, although one surveyor reported that she had seen facilities regularly schedule PFAs and use as needed.	In general, surveyors were unfamiliar with facility implementation of PFA training, although surveyors from one state noted that since training requirements are outlined and there are standardized curriculums, training across facilities must be consistent.	Surveyors from all three states reported that their state does not require that volunteers complete PFA training in order to help feed residents. Surveyors in one state reported that facilities have trained volunteers as PFAs.	N/A	N/A
Ombudsman	Respondents from this group were familiar with the PFA programs in their state, but had limited knowledge of facility-level implementation. Two ombudsmen were involved with state discussions regarding the decision to allow facilities to use PFAs prior to the passing of the federal rule. None of the respondents knew the number of facilities in their state that had trained PFAs although one had observed PFAs working in a facility.	Although some trends were noted, overall, ombudsman did not believe that the implementation of the PFA program was more or less prevalent in particular types of nursing facilities. One ombudsman reported that larger facilities may be more likely to use PFAs since they have greater difficulty delivering meals to residents in a timely manner. Another ombudsman stated that implementation may be more prevalent in rural areas, but did not believe there were any other patterns.	All ombudsman respondents reported that facility non-nursing staff were trained as PFAs. One ombudsman reported that predominantly housekeeping and activities staff were trained while the others reported that non-nursing staff and volunteers, including older adults and high school students were trained.	Ombudsman respondents had limited knowledge regarding how often PFAs are used, although one reported that PFAs were scheduled regularly.	N/A	Reported volunteer training requirements varied across the three site visit states. One ombudsman responded that his state does not require volunteers to complete the PFA training, while another ombudsman reported that his state requires that volunteers be trained. One ombudsman was unaware of volunteer training requirements but believed that volunteers who are not family members should be trained to feed.	Ombudsman did not report any current barriers to implementation for facilities in their states. One respondent noted that although there were no current barriers, some facilities had originally expressed concerns about legal issues and supervision of PFAs; these concerns were resolved when the state posted answers to FAQs on their website.	N/A

Table 1

Program Implementation: Stakeholder Perspectives Across States

	Familiarity with PFA program in state	Characteristics of Facilities using PFAs	Staffing PFAs	Staffing PFAs Utilization of PFAs	PFA Training	Training Requirements for Volunteers	Barriers to Facility Implementation	Guidance to Facility Implementation
Industry	All Industry representatives were familiar with the PFA program; however,with one exception, they did not know the prevalence of facility-level implementation. One AAHSA industry representative reported that she had advocaded in support of the federal regulation and both state Health Care Association representatives reported that their state agency was involved with AHCA at the national level in the fight for the regulation.	Industry respondents did not believe that the implementation of the PFA program was more or less prevalent in particular types of nursing facilities.	All 4 respondents said they believed nursing homes only used existing staff as PFAs.	One respondent reported that PFAs were scheduled. A second noted they were only used on an as-needed basis. A third responded that PFAs were utilized both as-needed and by scheduling.		Varied training requirements for volunteers were reported by Industry representatives. One respondent reported that volunteers were required to complete the training. Two respondents said that volunteer training was not required although one of these respondents said that all the volunteers she knew of had been trained. The fourth respondent did not know.	Three respondents reported potential barriers to facility-level implementation of the PFA program. One respondent cited low unemployment rates and low PFA wages as potential barriers to recruitment. Two respondents stated that the definition of complicated feeding problems is too restrictive and may encompass too many residents who need certified nursing assistance if the definition is taken to the extreme. The fourth respondent stated that although the state was worried that the curriculum requirements were too burdensome, they were able to create a curriculum that was feasible for facilities in their state to use.	Three respondents said curricula provided by the state or state HCA helped facilities operationalize the program. Ttwo respondents suggested ways in which CMS could better facilitate implementation of the program, and one respondent said that CMS could give greater support to states who have difficulties getting the program off the ground because of opposition from stakeholder groups. Another respondent noted that CMS should have created a process by which facilities could obtain a waiver to use PFAs to feed residents with more complicated assistance needs.

Table 2

Oversight: Stakeholder Perspectives Across States

	Surveyor Role and Experience	Quality Monitoring by Facility or State
Surveyors	Surveyors in one state reported they had been in a facility with a PFA program but did not do anything different in survey preparations or during the survey process. These surveyors did not cite F-tags related to nutrition, weight loss, or dehydration, although there was a citation for using untrained staff to feed residents. To their knowledge, surveyors in the other two states had not been in a facility with a PFA program.	N/A
Ombudsman	Most ombudsmen were not aware of survey procedures regarding the PFA program. Only one ombudsman had information on survey procedures regarding the PFA program; this respondent stated that surveyors were aware of whether or not a facility used PFAs before their visit.	Ombudsmen respondents were not aware of any quality monitoring or impact evaluation of the PFA program by facilities or by their state.
Industry	Industry respondents were not aware of any specific survey procedures directed at the PFA program. One respondent reported that the state survey agency was very positive about the program. Two respondents said they knew surveyors were looking at the program in facilities using FAs, but did not know any specifics. Respondents noted that there were no reported complaints about the program.	Industry representatives reported that they were unaware of any PFA quality monitoring efforts. One industry representative said he assumed the state would incorporate quality monitoring into the survey process.

Table 3

Opinions: Stakeholder Perspectives Across States

	Facility Experience	Resident/ Family Experiences	Benefits of PFA Program	Concerns of PFA Program
	In general, surveyors have limited feedback from facilities regarding the PFA program. In one state, surveyors reported that they have received no feedback from facilities using PFAs. In another state, they note that facilities have reported positive experiences such as more staff to assist residents during mealtime.	N/A	Surveyors in all states reported benefits of the PFA program. Surveyors in one state reported that the benefits of the PFA program include more staff to assist with meals, residents are not rushed and can enjoy their meal, and residents receive warm food. Surveyors in another state reported that one benefit of the program is that CNAs can focus on residents who need more intensive attention. Surveyors in the third state noted that residents receive timely assistance as a result of the PFA program and the assistance provides better quality of life for the residents.	Surveyors in two states reported no concerns about the PFA program, as long as the rules are followed. In one state, surveyors noted that PFAs should not be assigned to residents with complicated feeding problems or feed too many residents.
	Ombudsman have limited feedback from facilities regarding the PFA program. One ombudsman reported receiving no feedback while another reported positive feedback from two nursing facilities.	No ombudsmen reported any complaints from residents or families regarding the PFA programs.	All ombudsman respondents responded that the PFA program provides benefits to residents in their state. Benefits mentioned include receiving hot meals, being fed in a timely fashion, more available assistance, and a more enjoyable dining experience.	In general, ombudsmen did not express concerns regarding the way in which facilities implemented the PFA program or with the supervision of PFAs. However, one ombudsman reported a concern with residents being fed in their rooms.
	Most industry representatives had not heard any feedback about the program. However, one respondent said she had heard from a facility that the presence of PFAs has led to a less frantic meal time and allows strong relationships to build between the PFAs and the residents. No respondents had heard of any negative experiences with PFAs.		All respondents were positive about the program. One respondent predicted better hydration and nutrition among residents in facilities with FAs, an increase in social interaction, and a greater sense of community among employees. Two respondents stated that the extra help provided by FAs will allow licensed staff to focus on higher acuity residents.	No respondents expressed any concerns with the program.

Return to Report

Site Visit Findings

Appendix 7 Appendix 7

Study of Paid Feeding Assistant Programs

Summary of Facility Site Visits

The purpose of this phase one evaluation study funded by CMS is two-fold:

(1) to assess the status of feeding assistant programs at the state-level through a nation-wide survey; and,
(2) to assess the status of feeding assistant programs at the facility-level through site visits to a sample of facilities with active programs.

The results of the nation-wide survey were recently provided to CMS in a previous report (Study of Paid Feeding Assistant Programs – Interim Report, March 24, 2006). This document includes a summary of the findings from the site visits; and, based on these informative data. The data collection protocols implemented by the Abt and Borun Center team during the site visits were designed to answer the research questions articulated in the Interim Report.

Facility Information

Site visits were conducted in 8 nursing facilities (one facility was used as a pilot site to establish research staff inter-rater reliability; the data from this facility are not included in the site visit results). The facilities were located in three states (New Hampshire, Wisconsin, and Colorado), based on the results of the nation-wide survey, which showed that these three states had passed state-level legislation and numerous facilities within the state had "active" programs. Of the 7 facilities, 4 were for-profit. The average bed size of the sites was 180 ($\pm$ 94), with a range from 43 to 300 certified beds. The average nurse aide to resident ratio was 8 ($\pm$ 1) residents to one nurse aide during the day (7am to 3pm, breakfast and lunch meals) shift (range 7 to 10) and 10 ($\pm$ 2) residents to one nurse aide during the evening (3pm to 11pm, dinner meal) shift (range 8 to 13). The average licensed staff ratios (registered nurses + licensed vocational nurses) were 16 ($\pm$ 4) and 22 ($\pm$ 6) during the day and evening shifts, respectively. Staffing level, in particular nurse aide staffing, has been shown to be associated with better feeding assistance care quality in previous work conducted by the UCLA Borun Center. The average number of feeding assistants who had received training was 19 ($\pm$ 16) per site (range 7 to 53); and the average number of feeding assistants that were still working at the facility at the time of the site visit was 14 ($\pm$ 11) per site (range 6 to 35).

Certified Nursing Assistant (CNA) Interviews

A total of 54 CNAs were interviewed across all sites; 67 percent represented the day shift (7am to 3pm) and the remaining 33 percent represented the evening shift (3pm to 11pm). The CNAs reported a resident assignment (number of residents per aide per shift) that was consistent with the staffing information reported by the Administrator, Director-of-Nursing and/or posted for the facility. The CNAs reported being responsible for a myriad of tasks during mealtime, beyond feeding assistance care provision, including the following:

- Transporting residents to/from the dining room
- Meal tray delivery, set up and pick up
- Food and fluid intake documentation in residents' medical records (percent eaten of meal)

- Retrieval of substitutions from the kitchen, if the resident does not like the served meal
- Delivery of additional foods and fluids between meals

A total of 96 percent of the CNAs reported that they considered the feeding assistants "helpful" for one or more of the above tasks, in addition to actual feeding assistance care provision; and, 92 percent reported that they had "no concerns" about the feeding assistant program.

Paid Feeding Assistant (PFA) Interviews

A total of 39 feeding assistants were interviewed across all sites, with the majority (85 percent) representing the day shift. Of the staff who had received training to be feeding assistants, most (84 percent) were existing non-nursing staff from other departments, including: social services, activities, dietary, administration, housekeeping, and laundry. Ninety-five percent reported having at least one year of nursing facility experience, which was comparable to the experience reported by the CNAs.

All PFAs (except those certified as nurse aides) reported that they had participated in a training program for feeding assistance care delivery, and all (100 percent) of the interviewees reported that they were "comfortable" with their feeding assignment and able to "get help from licensed staff, when needed". Each feeding assistant reported that s/he helped an average of 2-4 residents to eat per meal. Approximately half reported that they always helped the same residents to eat; whereas, the other half reported that their resident assignment changed daily or weekly. Consistent with the reports of CNAs, feeding assistants also reported that they helped with the following mealtime tasks, all of which are typically the responsibility of the nurse aide:

- Transporting residents to/from the dining room (82 percent)
- Meal tray delivery, set-up and pick up (85 percent)
- Food and fluid intake documentation in residents' medical records (42 percent)
- Retrieval of substitutions from the kitchen (75 percent)
- Delivery of additional foods and fluids between meals (54 percent)

However, a minority of interviewees also reported helping existing staff with other aspects of daily care, which are also typically the responsibility of the nurse aide, including:

- Helping residents get in/out of bed (8 percent)
- Toileting assistance (5 percent)
- Walking assistance (29 percent)

It should be noted that with one exception, the PFAs who reported helping residents get in or out of bed or providing toileting assistance were also certified as CNAs.

Interviews with Other Staff

Interviews also were conducted with the Administrator, Director-of-Nursing, Charge Nurse, and the person responsible for training at each site. These interview data consistently showed that all upper-level staff reported that they were very satisfied with the feeding assistant program in their facility and that they had no concerns about the program itself or resident safety issues. All sites reported that no changes had been made to existing staffing levels following program implementation, and all planned to continue with the program and train additional staff.

There were three primary motives reported for program implementation: (1) to increase the number of available staff during meals for assistance and to ensure timely and "hot" meal delivery; (2) to increase the individual attention and socialization that residents receive during meals; and, (3) to allow nurse aides more time for other competing tasks (e.g., incontinence care, answering call lights, helping residents who eat in their rooms). Many reported that they already used existing, non-nursing staff from other departments to assist with mealtime tasks, and the CMS regulation just allowed this practice to be more formalized. The person responsible for training reported that they used the prepared training materials available from the state, and training consisted of a minimum of 8 training hours and competency evaluations (written, performance-based). Some added other materials (hand washing, food pyramid and percent consumed estimation) to their curriculum. Both the trainer and the Director-of-Nursing reported that only residents without complicated feeding assistance care needs were assisted by feeding assistants; yet, the criteria used to define "complications" was unclear.

Observations of Feeding Assistance Care Delivery during Meals

Abt and UCLA Borun Center staff used a standardized protocol developed and validated in previous work to conduct direct observations of feeding assistance care delivery during all three scheduled meals (breakfast, lunch and dinner) at each site. Inter-rater reliability between Abt and Borun Center team members was good to excellent for all data elements based on a sample of meal observations (n=29):

- Presence of licensed staff in dining room (perfect agreement = 1.0)
- Type of served diet (perfect agreement = 1.0); total percent eaten (.985, $p < .001$)
- Type of staff providing care (perfect agreement = 1.0)
- Total amount of assistance provided in minutes (range .661 - .975, $p < .001$)
- Resident capable of eating independently (range .583 - .919, $p < .001$)
- Staff provided verbal cueing (range .509 - .784, $p < .001$)
- Staff provided physical assistance to eat (range .535 – 1.0, $p < .001$)
- Supplement given during meal (range .681 – 1.0, $p < .001$)
- Substitution offered by staff (range .632 – 1.0, $p < .001$)

These data elements were used to calculate the following nutritional care process quality indicators, which were developed and validated in previous work by the UCLA Borun Center:

(1) Resident eats less than 50 percent of the meal and receives less than one minute of staff assistance;
(2) Resident eats less than 50 percent of the meal and is not offered a substitution;
(3) Resident receives less than 5 minutes of staff assistance to encourage intake of the meal and is, instead, given a supplement;
(4) Resident is able to eat independently but receives physical assistance to eat from staff in an effort to "hurry" the resident through the meal; and,
(5) Resident receives physical assistance to eat from staff without also receiving verbal cueing to enhance independence.

The rationale and validation of these measures has been more specifically described elsewhere. Briefly, these care process measures relate to the adequacy and quality of the assistance provided by staff to encourage both meal intake (adequacy of assistance) and the resident's independence in eating (quality of assistance). These measures were compared between indigenous nursing home staff (CNAs and licensed nurses) and feeding assistants based on a total of 243 resident-meal observations across all sites.

Observations were conducted equally between the three scheduled meals: breakfast (30 percent), lunch (40 percent), and dinner (30 percent). The average observation time per meal was 59 minutes (± 17), and all observations were conducted in a common dining room area, because that is where the CNAs and feeding assistants were assigned to provide care during meals.

Results showed that a licensed staff member was present in the dining room during 66 percent of the meal observations; however, it was common for this licensed staff member to be passing medications. There were few to no significant differences in the adequacy and quality of assistance provided by regular nursing home staff (CNAs) versus feeding assistants. Feeding assistants did spend significantly more time providing help to residents to eat (an average of 17±14 minutes per resident per meal compared to 11±12 minutes for CNA staff). However, the two groups of staff were comparable on all five care process measures, described previously. Both groups of staff provided better feeding assistance care than that observed in previous studies by the UCLA Borun Center (see Table). In addition, both groups of staff were observed to help residents to eat who had modified texture diets (ground, mechanical soft, pureed), which suggests swallowing difficulties (51 percent of residents for CNAs and 57 percent of residents for feeding assistants).

Care Process Measure	Nurse Aides	Feeding Assistants
1. Resident eats < 50% and receives < 1 min of assist*	9%	1%
2. Resident eats < 50% and not offered a substitute	33%	29%
3. Resident receives < 5 min of assist and a supplement	1%	0%
4. Resident independent but receives physical assist	24%	29%
5. Resident receives physical assist without verbal cue	3%	1%

*significant difference

Summary of Findings

Training and Supervision

The training completed in all sites consisted of a minimum of 8 hours with both written and performance-based competency testing. Some sites added hours of training (up to a maximum of 18 total hours) and included additional materials beyond the state curriculum (e.g., food pyramid guidelines, percent eaten estimation). All feeding assistants (except those certified as nurse aides) reported having received formal training, and all (100 percent) reported being "comfortable" with their feeding assignment and able to "get help from licensed staff, when needed". A licensed nurse was actually observed to be present in the dining room during only 66 percent of the meal observations, but nurse aides were always present. Direct observations during meals showed that feeding assistants spent more time providing assistance to residents to eat and were comparable to nurse aides in the quality of their care provision.

Resident Safety

Interviews with the person responsible for staff training and the Director-of-Nursing at each site showed that only residents without complicated feeding assistance care needs were assigned to feeding assistants; yet, the criteria used to define "complications" was unclear. In practice, feeding assistants were observed helping residents (57 percent) to eat with modified texture diets (ground, mechanical soft, pureed) and providing physical assistance to eat (spoon to mouth feeding) for many residents. Both modified texture diets and the need for physical assistance to eat suggest that the residents being helped by feeding

assistants may have had swallowing difficulties and/or other physical impairments that placed them at risk.

PFA Tasks

A minority of feeding assistants reported helping with aspects of daily care beyond feeding and for which they had not received additional training including: helping residents get in/out of bed (8 percent); toileting assistance (5 percent); and, walking assistance (29 percent). Most of the feeding assistants who reported helping with these other aspects of daily care, which would require training more consistent with that received by a CNA, were existing non-nursing staff within the facility (92 percent), as opposed to a single task worker.

PFA Recruitment

Most (84 percent) of the feeding assistants were existing non-nursing staff from other departments within the facility (e.g., social services, activities, dietary, housekeeping). Interviews with the Administrator, Director-of-Nursing, Charge Nurse, Trainer, and Certified Nursing Assistants at each site showed no complaints about the program at any level of staff and no change in existing staffing levels as a result of program implementation. All interviewees reported positive benefits of the program to both staff and residents and an intention to continue the program.

Conclusions and Next Steps

1. ***Lack of generalizability of results due to a small, potentially biased sample of sites.***

First, site visits were conducted with a small sample of nursing homes in only three states. It is likely that these facilities are biased, both in terms of overall staffing levels and the quality of nutritional care provided to all residents. Data collection needs to be conducted in a larger, more random (and representative) sample of facilities in order to generalize the results from phase one site visits. In addition, a larger sample would allow comparisons to be made between facilities at differing staffing levels to determine to what extent feeding assistants are truly adding to total staffing resources.

2. ***Feeding assistants may be inappropriately helping residents with tasks other than eating.***

A minority of staff interviewed reported that they assisted residents with daily tasks other than eating (e.g., help getting in and out of bed, toileting and walking assistance). These other care activities are of concern because the training received by these staff is specific to feeding and, as such, does not include safety precautions necessary for providing other types of care. It is important to ascertain to what extent this problem exists in a larger sample of facilities. It may be a widespread, unsafe care practice in some facilities. Also, a phase two study should include data collection relevant to the level of physical dependency of the resident and associated medical characteristics. It may be that the residents receiving this additional help from feeding assistants are ambulatory residents who are at low risk for falls. No resident-level data were collected as part of the phase one study.

3. ***Feeding assistants may be inappropriately helping residents to eat who have complicated feeding assistance care needs, thus posing a threat to resident safety.***

Feeding assistants were observed helping residents in need of physical assistance to eat and/or modified textured diets, both of which suggest swallowing difficulties and complicated feeding needs. These direct observations of care were in contrast to the report of the Director-of-Nursing and Trainer at each site, both

of whom reported that only residents without complicated feeding needs were assigned to these workers. The collection of resident-level data related to medical (e.g., diagnosis of dysphagia, history of aspiration) and nutritional characteristics (e.g., eating dependency status) would determine to what extent this is a problem and poses a threat to resident safety.

Return to Report

Appendix 8

Appendix 8

Appendix 8

PFA Study Manuscript

A Preliminary Evaluation of the Paid Feeding Assistant regulation: Impact on feeding assistant care process quality in nursing homes

Sandra F. Simmons[1,2], Ph.D., Rosanna Bertrand[3], Ph.D., Victoria Shier[3], MPA, Rebecca Sweetland[3], BA, Therese J. Moore[3], RN, MPH, Donna T. Hurd[3], MSN, John F. Schnelle[1,2,4], Ph.D.

Affiliations:

1. University of California, Los Angeles, School of Medicine, Department of Geriatrics, Borun Center for Gerontological Research, Los Angeles, CA.
2. Jewish Home for the Aging, Reseda, CA.
3. Abt Associates, Inc., Cambridge, MA.
4. Veterans Administration Greater Los Angeles Healthcare System; Sepulveda Geriatric Research, Education, and Clinical Center, Sepulveda, CA.

Corresponding Author and Reprint Requests:

Sandra F. Simmons, Ph.D.
Jewish Home for the Aging / UCLA Borun Center for Gerontological Research
7150 Tampa Avenue, Reseda, CA 91335
Phone: (818) 774-3349; Fax: (818) 774-3346; ssimmons@ucla.edu

Contact Information for Co-Authors:

Rosanna Bertrand, Victoria Shier, Rebecca Sweetland, Therese Moore, and Donna Hurd
Abt Associates, Inc.
55 Wheeler St, Cambridge, MA 02138

Rosanna_Bertrand@abtassoc.com; Phone: (617) 349-2556

Victoria_Shier@abtassoc.com; Phone: (617) 520-3620

Rebecca_Sweetland@abtassoc.com; Phone: (617) 349-2743

Terry_Moore@abtassoc.com; Phone (617) 349-2463

Donna_Hurd@abtassoc.com; Phone (617) 349-2363

John F. Schnelle, Ph.D.
Jewish Home for the Aging / UCLA Borun Center for Gerontological Research
7150 Tampa Avenue, Reseda, CA 91335
Phone: (818) 774-3234; Fax: (818) 774-3346; jschnell@ucla.edu

ACKNOWLEDGEMENTS

The analysis upon which this publication is based were performed under contract number 500-00-0049 Task Order #2, entitled “Research, Analysis, Demonstration and Survey Design Task Order Contracts” (RADSTO), Specialty Area #2, Medicaid Research and Demonstrations, sponsored by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Health Research and Quality (AHRQ). The statements contained in this paper are solely those of the authors and do not necessarily reflect the views or policies of the funding agencies. The authors extend their thanks to all of the nursing home staff in the participating sites for their cooperation with this study.

ABSTRACT

PURPOSE: The Centers for Medicare and Medicaid Services (CMS) and The Agency for Health Research and Quality (AHRQ) sponsored a nation-wide study to evaluate the federal Paid Feeding Assistant (PFA) regulation that allows nursing homes to hire single task workers to provide feeding assistance to nursing home residents. The PFA regulation was designed to increase the number of staff available to provide assistance with eating and improve nutritional care process quality.

DESIGN AND METHODS: Trained research staff used standardized protocols to conduct direct observations during meals and face-to-face staff interviews in a convenience sample of seven facilities with PFA programs to evaluate care process quality.

RESULTS: Most (84%) of the trained PFAs in the seven site visit NHs were non-nursing staff within the facility; and the quality of feeding assistance care provided by these workers was comparable to that provided by indigenous nurse aides. There were no reported changes in existing staffing levels (nurse aide or licensed nurses) following PFA program implementation; and the majority of indigenous staff at all levels (>90%) reported positive benefits of the PFA program to both staff and residents.

IMPLICATIONS: Findings from this preliminary study indicate that the PFA regulation may serve to increase the utilization of existing non-nursing staff to improve feeding assistance care during meals without having a negative impact on existing nurse aide and licensed nurse staffing levels.

KEY WORDS: staffing, Centers for Medicare and Medicaid Services (CMS)

INTRODUCTION

Multiple studies have shown that the adequacy and quality of feeding assistance care is sub-standard for many nursing home (NH) residents (Kayser-Jones, & Schell, 1997; Simmons, Babinou, Garcia & Schnelle, 2002; Simmons et.al., 2003). In a recent study, research staff conducted direct observations during meals using a standardized protocol to measure the adequacy (amount of time) and quality (presence of verbal cueing) of feeding assistance care provision for 302 residents in 10 NHs (Simmons, et.al., 2002). Results showed that 56% of the residents with low oral intake (ate less than half of the served meal) received no help from staff. Similarly, 56% of the residents rated by staff as requiring assistance to eat received less than five minutes of assistance with meals. Thirty-five percent of those who received physical help to eat did not receive any verbal cueing to enhance independence (Simmons et.al., 2002).

Other observational studies have shown similar findings. Kayser-Jones and colleagues (1997) observed 58 residents in two NHs during all meals for seven days. These residents were considered to be "at risk" for under-nutrition due to recent weight loss and/or low oral intake. Findings showed that physical help to eat was forced upon residents who could eat independently but who did so slowly and assistance was provided in a sporadic, rapid manner to all residents, even those who ate slowly due to swallowing difficulties. The nurse aides, who provided feeding assistance, self reported that they lacked sufficient time to adequately help all of the eating-dependent residents for whom they were responsible (Kayser-Jones J. 1996; Kayser-Jones J, Schell E. 1997).

Based on these findings, it has been recommended by research and expert consensus groups that both nurse aide and licensed nurse staffing levels be increased during mealtime to ensure adequate feeding assistance and supervision (Kayser-Jones, 1996; Kayser-Jones & Schell,

1997; Mondoux,1998; Schnelle, Cretin, Saliba & Simmons, 2000). The results of a recent study in 21 NHs showed that facilities with staffing (nurse aide plus licensed nurse) above 4.1 total hours per resident per day provided significantly better feeding assistance care according to multiple care process measures (Schnelle, Simmons, Harrington, Cadogan, Garcia & Bates-Jensen, 2004). Other studies have shown an association between low staffing, eating-dependency, and under-nutrition in NH residents (Abassi & Rudman, 1993; Keller, 1993).

In response to these research findings and staffing recommendations, the Centers for Medicare and Medicaid Services (CMS) issued a federal regulation (Federal Register, September, 2003) that allows NHs to hire single task workers to provide feeding assistance care. The intent of the federal regulation was to address the staffing shortage that exists in many U.S. facilities, at least during meals, to improve one aspect of daily NH care quality.

Four major concerns have been expressed by various stakeholder groups (e.g., National Citizen's Coalition for Nursing Home Reform, Service Employees International Union, Alzheimer's Association) in response to the PFA regulation (Federal Register, 2003; Remsburg, 2004). First, the regulation requires that single task workers receive eight hours of training, substantially less than that required for a Certified Nursing Assistant (i.e., CNA; 80 total hours). Thus, one concern is that inadequate training and supervision of staff responsible for providing feeding assistance will result in poor quality assistance. A second concern also related to training is 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). A third concern related to single task NH workers to provide feeding assistance is that these workers will be used to provide other aspects of daily care for which they have not received proper training (e.g., transferring residents in/out of bed; toileting, dressing, and/or walking

assistance). The potential misuse of PFAs has been raised as a concern due to evidence that most NHs do not have adequate nurse aide staff available to provide care in a number of areas, not just feeding assistance (Schnelle et.al., 2000; Schnelle et.al., 2004). Finally, there is concern that PFAs, as a single task workforce, will be used to replace existing nurse aide staff who require more training, supervision and higher pay thus resulting in lower overall staffing and complaints among existing nurse aide and licensed nurse staffing with PFA programs.

The primary goal of this preliminary evaluation study was to assess the impact of PFA programs on feeding assistance care process quality at the facility- and individual level through site visits in a convenience sample of seven facilities with active programs. Trained research staff used standardized protocols to directly address the four major concerns raised by various stakeholder groups in response to the PFA regulation. The following specific research questions were addressed:

1. What type of staff (e.g., single task worker, volunteers, family members, non-nursing staff within the facility) is being trained as PFAs?
2. How do trained PFA staff compare to indigenous CNA staff on feeding assistance care processes measured by direct observation of care delivery?
3. Do PFAs engage in Activities of Daily Living (ADL) tasks other than feeding assistance (e.g., transfer or walking assistance) or related mealtime tasks (e.g., meal tray delivery) based on interview and direct observation of care delivery?
4. Have existing nurse aide or licensed nurse staffing ratios changed as a result of the PFA program based on staff interview?
5. Do existing nurse aide and licensed nurse staff view PFA staff as helpful based on staff interview?

METHODS

Identification of Convenience Sample of Facilities for Site Visits

A nation-wide telephone inventory, targeting individuals from the Office of Caregiver Quality, Department of Health and Human Services who are responsible for implementing the PFA training program, was conducted to generate a recruitment list of NHs with active PFA programs. The results of the telephone inventory revealed that respondents from 28 states reported having active PFA programs. Of these 28 states New Hampshire, Colorado, and Wisconsin were selected for NH site visit recruitment because these states had numerous NHs with approved programs (n=103) and provided a list of those NHs. Additional states reported the use of PFAs but had fewer NHs that had implemented the program (e.g., Delaware, Kentucky). Project resources limited the number of state visits to three.

Between June and September 2005, research staff conducted random telephone calls from the lists of NHs provided by each of the three states. Calls were made until the first site in each state agreed to participate; the second site was selected based on its proximity to the first site so that two facilities could be visited during one site visit trip. Overall, thirty-three NHs were contacted across all three states. One additional NH contacted the research team directly for study participation. Of the 34 total NHs contacted, nine agreed to participate in the study. Reasons for non-participation for the remaining 25 NHs included: PFAs were not needed or used on a regular basis; therefore, there was no guarantee of their presence in the dining room at the time of the site visit (6 NHs), PFAs were not currently being used because the facility determined they were not needed at that time (7 NHs), scheduling difficulties between research staff and NH management (5 NHs), and no response to scheduling attempts for the site visit (7

NHs). Of the 13 NHs that were not regularly or currently using PFAs, none reported dissatisfaction with the PFA program.

Of the nine NHs that agreed to participate, one NH was used to pilot test the staff interview protocols and establish inter-rater reliability among research staff for the observational protocol; and one was a hospice NH that was considered ineligible for site visit participation due to differences from other NHs on important factors, such as the demographics of the resident population. The remaining seven NHs comprised the site visit sample for this study. Participation in this study was voluntary; thus, findings may be biased toward higher quality care than that which might be found in a larger study using a randomly selected sample of NH facilities.

Staff Interviews

Trained researchers conducted face-to-face interviews with NH employees including upper-level staff (e.g., administrators, staff trainers) and assistants (i.e., CNAs, PFAs) using standardized protocols. The protocol that was used to interview CNAs was based on previous work (Schnelle et.al., 2000; Simmons et.al., 2003). All other staff interview protocols were developed specifically for the purposes of this study and field-tested in one pilot site. Interviews with upper-level staff required approximately 30-45 minutes per person, on average. Interviews with the CNAs and PFAs required less than 10 minutes per person, on average.

A waiver of signed informed consent was obtained by the Institutional Review Boards for all interview and observation protocols used in this study. A standardized script was used to introduce the interview and inform the staff member of the confidentiality of their responses and that s/he could refuse to answer the questions without any effect on their job. Interviews were

conducted in person in a private area or according to the preference of the individual staff member.

Upper-Level Staff Interviews. Research staff conducted in-person interviews with upper-level staff involved with the PFA program including administrators (n = 6), directors-of-nursing (DON; n = 7), charge nurses (n = 5), and staff developers/trainers (n = 7). Although the protocol called for one interview per facility with each of these employees, this was not always possible due to staff being unavailable for interview. No upper-level staff employee refused to be interviewed as part of this study. Additional staff who were directly involved in curriculum development, training, and/or implementation of the PFA program (i.e., unit nurses, n = 3; dieticians, n = 2; speech and swallowing therapist, n = 1; PFA supervisor, n = 1) were included as part of the upper-level staff sample. A total of 32 upper-level staff were interviewed across all sites.

Upper-level staff interviews included both open- and close-ended questions that ranged from 10 (i.e., Charge Nurse Interview) to 40 (i.e., Staff Trainer Interview) items per interview. The wide range of items per interview was due to the fact that some questions were unique to a particular staff position. For example, a set of questions that addressed the PFA training process was included only in the nurse trainer interview. Interview items analyzed in the current study are represented in Table 1.

CNA and PFA Interviews. Face-to-face interviews were also conducted with CNAs (n=54) and staff trained as feeding assistants (PFAs; n=39). During the first (7:00 am - 3:00 pm) and second (3:00 – 11:00 pm) shifts, CNAs and PFAs were approached at random by research staff and asked if they would like to participate in the study. Two CNAs agreed to participate

but were not interviewed because of scheduling difficulties. One PFA refused to be interviewed due to time restraints from NH responsibilities (e.g., housekeeping).

The CNA and PFA Interviews consisted of 15 and 18 items, respectively, with considerable overlap in the questions asked on both interview protocols. For example, both interviews included 3 multiple choice items: 1) How long have your worked in the NH setting? 6 months, 6-12 months, 1 – 2 years, > 2 years. 2) Of the residents you are helping to eat today, how many need: full assistance, partial assistance? 3) Do you usually help the same residents to eat or does your resident assignment change? Both interviews included a short answer item, "How many residents are you helping to eat today?"; a yes/no response item that addressed whether or not they received special training on feeding residents (beyond certification training for CNAs); and a series of 5 yes/no items that assessed involvement in meal-related job tasks (i.e., transporting residents to/from dining room; meal tray delivery, pick-up, set-up; documentation of food/fluid intake; offering foods/fluids between meals; getting requested substitutions).

Unique to the CNA interview protocol were two short answer questions that assessed their resident assignment; and two yes/no items that assessed whether the CNA thought it was helpful to have the feeding assistant staff present during meals, and whether the CNA had any concerns about the use of the PFA program. If the CNA responded "yes" to the final question, s/he was asked to elaborate.

The PFA interview protocol included an additional seven yes/no items specific to the role of a feeding assistant that were not included on the CNA interview protocol: 1) Do you feel comfortable with your resident assignment and their assistance needs? 2) Are you able to get help from licensed staff when/if you need it? The five remaining yes/no items assessed whether

the PFA assisted residents with non-meal related ADL tasks (i.e., transporting to social activities, transferring, dressing, toileting, walking).

Mealtime Observational Protocol and Care Process Measures

A standardized observational protocol was used in this study to conduct direct observations of feeding assistance care delivery by both CNAs and PFAs at each site during all three scheduled meals (breakfast, n = 71; lunch, n = 98; dinner, n = 74). Residents were primarily selected for observation based on whether or not they received assistance from a CNA or PFA. On occasion, residents who were assisted by family members or did not receive assistance at all were also included in the observations. The rationale for including residents who did not receive assistance at all was that some of these residents may be eating poorly on their own and, therefore, need staff attention. Research staff observed a minimum of four and a maximum of eight residents at any given meal.

The inter-rater reliability, stability and validity of the observational protocol and the feeding assistance care process measures have been established in previous work (Schnelle et al., 2004; Simmons et al., 2002; Simmons et al., 2003). Specifically, a previous study showed that acceptable inter-rater reliability was achieved among multiple trained observers and the measures were stable across different meals and days (Simmons et al., 2002). A separate previous study showed that the measures differentiated between facilities with staffing above 4.1 total hours per resident per day and staffing below this level, with higher staffed facilities performing significantly better on all measures (Simmons et al., 2003).

Inter-rater reliability between five research staff observers was established in this study (n=29 resident-meal observations in the pilot training site). Reliability (as measured by pearson correlation coefficients for continuous variables or Spearman's rho coefficients for categorical

variables) ranged from good to excellent between the five observers for all data elements used to score the feeding assistance care process measures. These data elements included the following: total percent eaten ($r = .985$, $p < .001$); total assistance time in minutes (r range among research staff = .661 - .975, $p < .001$); resident capable of eating independently (r range = .583 - .919, $p < .001$); staff provision of verbal cueing (r range = .509 - .784, $p < .001$), staff provision of physical assistance to eat (r range = .535 – 1.0, $p < .001$); supplement given during meal (r range = .681 – 1.0, $p < .001$); meal substitution offered by staff (r range = .632 – 1.0, $p < .001$). These data elements were used to calculate five feeding assistance care process measures, which relate to the adequacy and quality of staff assistance to encourage both meal intake (adequacy of assistance) and the resident's independence in eating (quality of assistance). The scoring rule and rationale for each of the five measures is described below.

Feeding Assistance Care Process Measures Scoring Rule and Rationale

1. Staff ability to provide assistance to at-risk residents.

Scoring Rule: Score as "fail" any resident who consumes less than 50% of the food and fluid items on his or her meal tray and receives less than one minute of assistance from staff.

Rationale: The federal criterion for low oral intake is defined as "leaves 25% or more of food uneaten", or consumes less than 75% of most meals (Health Care Financing Administration, 1999). Recent evidence, however, suggests that NH residents who consistently consume less than 50% of most meals are at a significantly higher risk for weight loss (Gilmore et.al., 1995). Thus, if a resident who consumes less than 50% of a meal also receives less than one minute of attention from staff, then the staff is providing potentially substandard feeding assistance, failing to recognize an oral intake problem, or both (Simmons et.al., 2002; Simmons et.al., 2003).

2. Staff ability to offer an alternative, or meal substitution, when a resident does not like the served meal.

Scoring Rule: Score as "fail" any resident who consumes less than 50% of the served meal without being offered a meal substitution.

Rationale: The ability of NH residents to obtain a substitute if they do not like a particular served meal has been defined as an indicator of nutritional care quality within state deficiency citation source codes. If a resident consumes less than 50% of the served meal, s/he should be offered at least one alternative to encourage meal consumption.

3. Staff ability to provide adequate assistance to residents who receive an oral liquid nutritional supplement during meals.

Scoring Rule: Score as "fail" any resident who receives an oral liquid nutritional supplement and less than five minutes of staff assistance to eat during the meal.

Rationale: Oral liquid nutritional supplements are most effective in increasing daily caloric intake among NH residents when provided between regularly-scheduled meals (Simmons & Schnelle, 2004). Direct observational data suggest that supplements are often inappropriately given with meals and may be used as a substitute for quality feeding assistance (Kayser-Jones et.al., 1998; Simmons & Patel, 2006).

4. Staff ability to provide assistance that enhances a resident's independence in eating.

Scoring Rule: Score as "fail" any resident who receives physical assistance to eat when s/he is capable of eating independently.

Rationale: Observational data indicate that NH staff often provide excessive physical assistance to residents who could otherwise eat independently with just verbal prompting or encouragement (Simmons et.al., 2002; Simmons et.al., 2003; Simmons & Schnelle, 2004).

5. *Staff ability to provide a verbal prompt to residents who receive physical assistance to eat.*

Scoring Rule: Score as "fail" any resident who receives physical assistance to eat without also receiving at least one episode of verbal prompting (e.g., "Try some of your soup.").

Rationale: Graduated prompting protocols using verbal prompting have been shown to increase residents' independent eating behaviors and oral food and fluid intake (Lange-Alberts & Shott, 1994; Simmons et.al., 2002; Simmons et.al., 2003; Simmons & Schnelle, 2004; Van Ort & Phillips, 1995).

RESULTS

Setting for Site Visits: Facility Information for Convenience Sample

Of the seven NHs that participated in site visits, four were for-profit. The average bed size was 180 (± 94), with a range from 43 to 300 beds. The average nurse aide to resident ratio, as reported by the Directors-of-Nursing, was 8 (± 1) residents to one nurse aide during the day (7am to 3pm, breakfast and lunch meals, range 7 to 10) and 10 (± 2) residents to one nurse aide during the evening (3pm to 11pm, dinner meal, range 8 to 13). The average licensed staff ratios (registered nurses + licensed vocational nurses) were 16 (± 4) and 22 (± 6) during the day and evening shifts, respectively. The average number of feeding assistants who had received training was 19 (± 16) per site (range 7 to 53); and the average number of feeding assistants who were still working as PFAs at the time of the site visit was 14 (± 11) per site (range 6 to 35). Reasons for no longer working as a PFA included: working as a CNA (n = 4), quit with no reason provided (n = 1), and left the facility altogether for a variety of reasons including retirement (n=15). None of the upper level staff at the seven facilities reported dismissing a PFA for problems related to their PFA responsibilities.

Staff Interviews: Upper-level Staff

Thirty-two interviews were conducted with the Administrator, DON, Charge Nurse, Staff Developer/Trainer and other persons involved in PFA curriculum development, training, or implementation at each site (e.g., Dieticians, PFA supervisor, Unit Nurses). The interview data demonstrated that overall, upper-level staff were satisfied with the feeding assistant program in their facility. In response to the open-ended question, "Do you have any concerns about the PFA program?" the majority of respondents stated that they had no concerns. Three respondents remarked that they had initial concerns, such as CNAs taking advantage of PFAs and inappropriate resident assignment, but their concerns had been quelled through proper training and appropriate resident assignment. Two respondents remarked that they would like to see more training so that PFAs would be sure to recognize when not to feed a resident. One hundred percent of the respondents reported that "no changes" had been made to existing nurse aide or licensed nurse staffing levels following PFA program implementation, and all (100%) upper-level staff interviewed said that they planned to continue the PFA program and train additional staff.

In response to the open-ended question regarding reasons for implementing the PFA program, three primary motives were reported by upper-level staff: (1) to increase the number of available staff during meals for feeding assistance care provision and to ensure timely, "hot" meal tray delivery; (2) to increase the individual attention and socialization that residents receive during meals; and, (3) to allow nurse aides more time for other competing tasks (e.g., incontinence care, answering call lights, helping residents who eat in their rooms). Staff at one of the seven sites reported that they had already been using non-nursing staff from other

departments to assist with mealtime tasks prior to the CMS regulation; and, the regulation had simply formalized this existing care practice.

The Staff Trainers at two sites reported that they used prepared training materials available from the state; while, the remaining five sites used either American Health Care Association (AHCA), corporate or their own training materials. Training consisted of a minimum of 8 training hours and competency evaluations (i.e., written test, performance-based observation of care provision) at all seven sites. In addition, all seven (100%) of the Staff Trainer(s) added content (hand washing, food pyramid and percent consumed estimation) and/or additional training hours (up to 18 total hours) to their PFA training curriculum. DONs, Staff Trainers, and Charge Nurses at all sites reported that only residents "without complicated feeding assistance care needs" were assigned to PFA staff; yet, the criteria used to define "complications" was unclear at all sites (e.g., "based on care plan").

There was variability in the PFA recruitment process across sites. For example, five facilities trained only existing non-nursing staff as PFAs while two facilities also recruited from the communities. Four facilities recruited into the PFA program through volunteer participation. One facility required that all laundry and housekeeping staff complete PFA training and be available as needed to help feed residents. The remaining two facilities had written PFA training and participation into certain NH job descriptions (e.g., housekeeping). One site that recruited through voluntary participation offered a raise upon successful completion of the PFA training as a recruitment incentive. The frequency of use of PFAs also varied across sites. Three facilities reported using PFAs "as needed"; while, the remaining four facilities scheduled PFAs for specific meals, days and/or residents.

Staff Interviews: CNAs

A total of 54 CNAs were interviewed across all sites, with an average of eight aides (range = 5 - 11) interviewed per site. Sixty-seven percent (n=36) represented the day shift (7am to 3pm), and the remaining 33% (n=18) represented the evening shift (3pm to 11pm). Eighty-three percent (n=45) reported having one or more years of NH experience. The CNAs reported a resident assignment (number of residents per aide per shift) that was consistent with the staffing information reported by the DON for both the day and evening shifts (see *Setting for Site Visits*).

Most CNAs who were interviewed reported that resident assignments for feeding assistance changed daily or weekly (80%). The CNAs reported that they were responsible for the following mealtime tasks, in addition to feeding assistance care provision: transporting residents to/from the dining room (96%); meal tray delivery, set up and pick up (99%); food and fluid intake documentation in residents' medical records (93%); retrieval of substitutions from the kitchen, if the resident does not like the served meal (93%); and, delivery of additional foods and fluids between meals (98%). A total of 96% of the CNAs reported that they considered the feeding assistants "helpful" for one or more of these mealtime tasks, in addition to feeding assistance care provision; and, 92% reported that they had "no concerns" about the PFA program within their facility.

Staff Interviews: Paid Feeding Assistants (PFAs)

A total of 39 feeding assistants were interviewed across all sites, with an average of six assistants (range = 4 – 8) interviewed per site. The majority of PFAs who were interviewed represented the day shift (85%). Ninety-five percent (n=37) reported having at least one year of NH experience, which was comparable to the NH experience reported by the indigenous CNAs. Each PFA reported that s/he helped an average of two ($\pm$ 2) residents to eat per meal (range 1 to 7). Fifty-four percent (n=21) reported that their resident assignment for feeding assistance

changed daily or weekly; whereas, the remaining 46% reported that they always provided assistance to the same residents.

Almost all (n = 37; 94%) of the PFAs reported that they had participated in a formal training program for feeding assistance care delivery. The two remaining PFAs were both certified as CNAs; one was an existing NH employee who was temporarily not serving as a CNA due to pregnancy, the second was a CNA at another NH facility. Of the staff who had received training, most (n = 31; 84%) were existing non-nursing staff from other departments within the facility including: social services, activities, dietary, administration, housekeeping, and laundry. The remaining 16% (n = 6) were divided equally between two groups: CNAs who worked full-time in other NHs (8%) and single task workers hired from the community (8%).

All (100%) of the interviewees reported that they were "comfortable" with their resident assignment for feeding assistance and able to "get help from licensed staff, when needed". Consistent with the reports of CNAs, feeding assistants also reported that they helped with the following mealtime tasks, beyond feeding assistance care: transporting residents to/from the dining room (82%); meal tray delivery, set-up and pick up (85%); food and fluid intake documentation in residents' medical records (42%); retrieval of substitutions from the kitchen (75%); and delivery of additional foods and fluids between meals (54%). Direct observations during meals substantiated these self-report data, in that observers noted that PFAs assisted residents beyond those for whom they were providing feeding assistance.

Some PFAs also reported helping existing nurse aide staff with non-meal related ADLs including: transporting residents to/from social activities (63%); helping residents get in/out of bed (8%); providing toileting assistance (5%) and walking assistance (29%) to residents. Most

of the feeding assistants who reported helping residents transfer out of bed, toilet or walk were existing non-nursing staff within the facility (92%), as opposed to a single task worker.

Mealtime Observations and Feeding Assistance Care Process Measures

A total of 243 resident-meals were observed across all sites and represented all three scheduled meals (breakfast = 30%; lunch = 40%, dinner = 30%). All observations were conducted in a common dining area because that is where the CNAs and PFAs were assigned to provide feeding assistance during meals. The average observation time per meal was 59 ($\pm$ 17) minutes. Of the 243 resident-meal observations, 42 (17%) received no assistance, 126 (52%) received assistance from nurse aide staff, 70 (29%) received assistance from PFA staff, and the remaining 5 (2%) received assistance from family. A licensed staff member was present in the dining room during 66% of the meal observations.

Table 2 shows the results for the five feeding assistance care process measures (see *Methods, mealtime observational protocol*) compared between CNAs (126 resident-meals) and PFAs (70 resident-meals) using chi-square analyses (proportion who met the criteria for each measure). There were few to no significant differences in the adequacy and quality of assistance provided by regular NH staff (CNAs) versus PFAs. Feeding assistants spent significantly more time providing help to residents to eat compared to nurse aides (17 $\pm$ 14 versus 11 $\pm$ 12 minutes per resident per meal; $t = -2.81$, $p < .01$). In addition, a significantly higher proportion of residents ate less than half of the served meal and received less than one minute of assistance from CNAs compared to PFAs (Table 2. care process measure 1. 9% versus 1%, chi-square = 4.17, $p < .05$). Although, the proportion of residents who ate less than half of the served meal was comparable between those helped by CNAs versus PFAs (41% versus 33%, respectively). The two groups of staff also were comparable on all other care process measures shown in Table

2 (measures 2-5). Both groups of staff failed to offer the resident a substitution when s/he ate less than half of the served meal during approximately one-third of the observations (Table 2. measure 2). Oral liquid nutritional supplements were rarely provided to residents during meals, regardless of oral intake and/or which type of staff provided assistance (Table 2. measure 3). Both groups of staff provided physical assistance even when the resident was capable of eating independently during 24% (CNAs) to 29% (PFAs) of the observations (Table 2. measure 4); but, it was rare for either type of staff to provide physical assistance without also providing at least one episode of verbal cueing (Table 2. measure 5). In addition, both groups of staff were observed to help residents to eat who had modified texture diets (i.e., ground, mechanical soft, or pureed texture), which suggests swallowing difficulties (51% versus 57% for CNAs and PFAs, respectively).

DISCUSSION

This CMS- and AHRQ-sponsored preliminary evaluation study conducted in a convenience sample of seven NHs in three states showed that the quality of feeding assistance care provided by staff trained as feeding assistants was comparable to that provided by indigenous nurse aide staff according to five care process measures. In addition, the majority of PFAs were non-nursing staff within the facility (84%) or CNAs who worked in other NHs (8%), as opposed to single task workers hired from the community (8%); and, the NH experience of these workers was comparable to that of the indigenous CNAs. Moreover, there were no reported changes in existing staffing levels due to PFA program implementation. These preliminary results suggest that single task workers were not being used to replace existing nurse aide staff in this small sample of facilities.

Related to the adequacy of staff training, almost all staff providing feeding assistance had received at least eight hours of formal training specifically focused on feeding assistance, which included both written and performance-based competency evaluations. In comparison, while 60 total hours of training are required for CNAs, only nine of these hours typically are focused on nutritional care. Thus, PFAs and CNAs actually received comparable training relative to this specific care process. Although, CNAs themselves may lack adequate training and supervision related to mealtime care (Amella, 2004; Kayser-Jones, 1996; Kayser-Jones & Schell, 1997; Mondoux, 1998; Pelletier, 2004).

Related to supervision, licensed nurses were not always present in the dining room, regardless of who was providing care (PFAs versus CNAs). This finding is consistent with the results of other studies, which have suggested that licensed nurse supervision needs to be increased for direct care staff during mealtime care, in particular to oversee the feeding of residents with complicated needs (Kayser-Jones & Schnell, 1997; Mondoux, 1998). While it was reported during the site visits that only residents without complicated feeding needs were assigned to feeding assistants, PFAs 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 difficulties and/or other physical impairments that placed them at risk for feeding complications. In addition, a minority of PFAs reported via interview that they helped residents with other ADLs beyond feeding and for which they had not received additional training (e.g., transfer out of bed, toileting and walking assistance). The collection of resident-level data related to medical (e.g., diagnosis of Dysphagia, history of aspiration), nutritional status (e.g., body weight, history of loss) and

physical impairment (e.g., eating dependency, ambulation, fall risk) would determine to what extent these care activities pose a threat to resident safety, and such data were not collected as part of this study.

The lack of resident-level data to more specifically address the impact of PFAs on resident safety and clinical outcomes (i.e., weight loss) represents one limitation of this study. A second important imitation of this study is that site visits were conducted with a small convenience sample of NHs in only three states. It is likely that these facilities reflect a biased NH sample, both in terms of overall staffing levels and the quality of nutritional care provided to all residents. In fact, both PFA and CNA staff observed in the 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). In addition, the NH sample was too small to allow comparisons to be made between NHs with different staffing levels, or between shifts within the same NH, to determine to what extent PFA staff added to total staffing resources. Furthermore, although upper-level staff reported no changes in nurse aide or licensed nurse staffing as a result of PFA program implementation, a larger sample of facilities would need to be studied over a longer time period to determine the impact of PFA programs on existing staffing levels.

Finally, work efficiency issues should be explored in future studies. There was wide variability between sites in the number of trained PFAs, the number of residents helped by an individual PFA per meal, and the extent to which PFAs assisted with other mealtime tasks for all residents (e.g., transfer to/from the dining room; meal tray delivery, set up, pick up; social interaction and verbal cueing). Other studies have shown a positive impact of the use of non-traditional staff (e.g., volunteers, social activities, student nurses) to assist in mealtime care tasks

on resident's dining experience and nutritional status, even prior to the federal regulation (Marken, 2004; Musson, et. al. 1990; Remsburg, Radu, Bennett, 2001).

In summary, the results of this preliminary evaluation study in a small sample of facilities suggest that the use of non-traditional but trained staff to provide assistance to residents during meals may pose a potential solution to concerns about both NH work force and feeding assistance care quality problems. The promising use of such workers should be further evaluated in a larger, more representative sample of NHs. If these preliminary findings are supported, efforts should be made to disseminate PFA program training and management materials to all NHs.

REFERENCES

Abbasi, A. A., & Rudman, D. (1993). Observations on the prevalence of protein-calories undernutrition in VA nursing homes. *Journal of the American Geriatric Society,* 41, 117-121.

Amella, E. J. (2004). Feeding and hydration issues for older adults with Dementia. *Nursing Clinics of North America,* 39, 607-623.

Federal Register 2003. Rule 42 CFR Parts 483 and 458, 68:55528.

Gilmore S. A., Robinson G., Posthauer M. E., Raymond J. (1995). Clinical indicators associated with unintentional weight loss and pressure ulcers in elderly residents in nursing facilities. *Journal of the American Dietetic Association,* 95(9):984-992.

Health Care Financing Administration. Minimum Data Set, Version 2: User's Manual. April, 1999. Eliot Press. Natick, MA.

Kayser-Jones, J. (1996). Mealtime in nursing homes; the importance of individualized care. *Journal of Gerontological Nursing,* 3, 26-31.

Kayser-Jones J., & Schell, E. (1997). The effect of staffing on the quality of care at mealtime. *Nursing Outlook*, 45, 64-72.

Kayser-Jones J., Schell E. S., Porter C., Barbaccia J. C., Steinbach C., Bird W. F., Redford M., Pengilly K. (1998). A prospective study of the use of liquid oral dietary supplements in nursing homes. *Journal of the American Geriatric Society* 46:1378-1386.

Keller, H. H. (1993). Malnutrition in institutionalized elderly: How and why? *Journal of the American Geriatric Society*, 41, 1212-1218.

Lange-Alberts, M. E., & Shott S. (1994). Nutritional Intake; Use of touch and verbal cuing. *Journal of Gerontological Nursing,* 2:36-40.

Mondoux, L. (1998). Testimony of the American Nurses Association before the National Academy of Sciences Institute of Medicine Committee on Improving Quality in Long Term Care, Washington, DC.

Musson, N. D., Kincaid J., Ryan P., Glussman B., Varone L., Gamarra N., Wilson R., Reefe W., & Silverman M. (1990). Nature, nurture, nutrition: Interdisciplinary programs to address the prevention of malnutrition and dehydration. *Dysphagia,* 5, 96-101.

Pelletier, C. (2004). What do Certified Nurse Assistants actually know about Dysphagia and feeding nursing home residents? *American Journal of Speech-Language Pathology,* 13:99-113.

Remsburg, R. E. (2004). Pros and cons of using paid feeding assistants in nursing homes. *Geriatric Nursing,* 25(3):176-177.

Remsburg, R. E., Radu, C., & Bennett, R. G. (2001). Impact of a buffet-style dining program on weight and biochemical indicators of nutritional status in nursing home residents: A pilot study. *Journal of the American Dietetic Association,* 101(12), 1460-1463.

Schnelle, J. F., Cretin, S., Saliba, D., & Simmons, S. F. (2000). Minimum nurse aide staffing required to implement best practice care in nursing homes. Chapter in report to congress: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*: Vol. 2. Health Care Financing Administration (pp. 14.1-14.68). Abt Associates, Inc: Cambridge, MA.

Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M. P., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care. *Health Services Research,* 39(2):225-250.

Simmons, S. F., Babinou, S., Garcia, E., & Schnelle, J. F. (2002). Quality assessment in nursing homes by systematic direct observations: Feeding assistance. *Journal of Gerontology:*

Medical Sciences, 57A(10), M665-M671.

Simmons, S. F., Garcia, E. F., Cadogan, M. P., Al-Samarrai, N. R., Levy-Storms, L. F., Osterweil, D., & Schnelle, J. F. (2003). The Minimum Data Set weight loss quality indicator: Does it reflect differences in care processes related to weight loss? *Journal of the American Geriatrics Society*, 51(10), 1410-1418.

Simmons, S. F., & Patel, A. V. (2006). Nursing home staff delivery of oral liquid nutritional supplements to residents at risk for unintentional weight loss. *Journal of the American Geriatric Society* (in press).

Simmons, S. F., & Schnelle, J. F. (2004). Individualized feeding assistance care for nursing home residents: Staffing requirements to implement two interventions. *Journal of Gerontology: MEDICAL SCIENCE*, 59A(9):966-973.

Van Ort, S., & Phillips, L. R. (1995). Nursing interventions to promote functional feeding. *Journal of Gerontological Nursing*, 10:6-14.

Table 1. Relevant items from upper-level staff interview protocols with type of employee assessed and type of question asked.

	Interview Item	Staff Assessed	Type of Question
1.	Do you have any concerns about the PFA program?"	AD, DON, ST, CN	OE
2.	Do you plan to continue using PFAs?	AD, DON, ST	Y/N
3.	Have you made any changes to your staffing levels or configuration since implement the PFA program?	AD, DON	Y/N
3a.	If yes, please explain.	AD, DON	OE
4.	What was your main reason/s for implementing the PFA program?	AD, DON, ST	OE
5.	Did you recruit trainees from the community?	AD, DON, ST	Y/N
6.	Did you recruit from current non-nursing employees?	AD, DON, ST	Y/N
7.	Did non-nursing employees volunteer or did a manager select them?	AD, DON, ST	MC
8.	How do you identify residents who are appropriate for PFA assistance?	DON, CN, ST	OE
8a.	What criteria are used?	DON, CN, ST	
9.	Are PFAs scheduled for specific meals and/or days?	DON, CN, ST	Y/N
10.	Are PFAs assigned to feed specific residents?	DON, CN, ST	Y/N
11.	Are there licensed registered nurses, other than those passing meds, who are present in the dining room during meals?	DON, CN, ST	Y/N
11a.	If an LN is present, is s/he responsible for monitoring the PFA?	DON, CN, ST	Y/N

Interview Item	Staff Assessed	Type of Question
12. How many people have been trained?	ST	SA
12b. Of those trained how many are currently working as PFAs?	ST	SA
13. How many hours over how many days in each training session conducted?	ST	SA
14. Do you use prepared materials?	ST	Y/N
14a. If yes, what materials are used (e.g., state curriculum)?	ST	SA
14b. If no, what materials do you use/how were they developed?	ST	OE
15. Do you provide PFA competency testing following training?	ST	Y/N

Note. Staff Assessed: AD = Administrator; DON = Director of Nursing; ST = Staff Trainer; CN = Charge Nurse. Type of Questions: OE = Open Ended; SA = Short Answer; MC = Multiple Choice; Y/N = Yes/No.

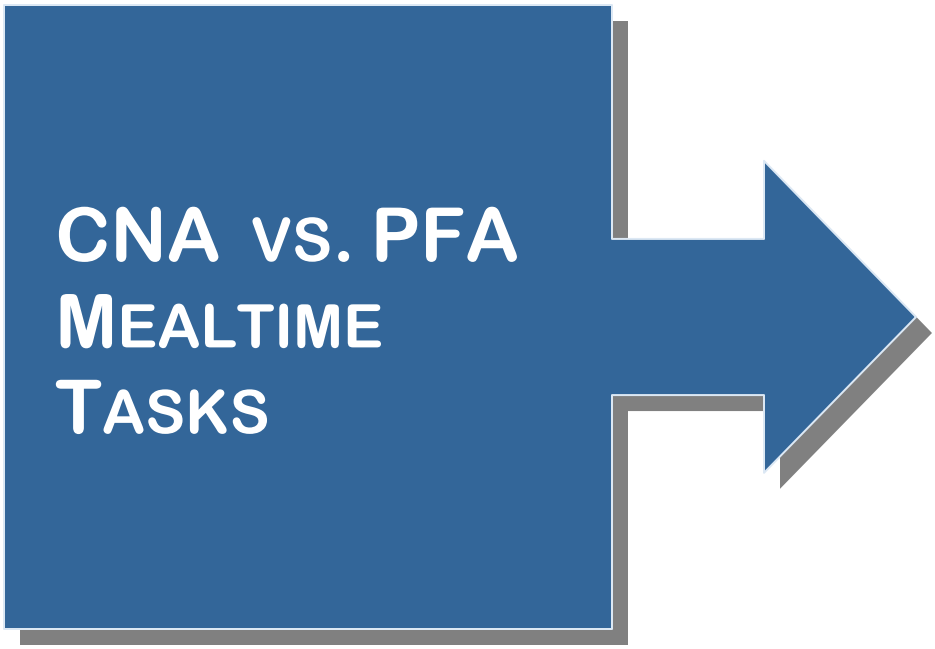
Table 2. Comparison of percentages of care process measures between Nurse Aides (CNAs) and Feeding Assistants (PFAs)

Feeding Assistance Care Process Measures	CNAs n = 126 % Resident-meals (n)	PFAs n = 70 % Resident-meals (n)
1. Resident eats < 50% and receives < 1 min of assist*	8.7 (11)	1.4 (1)
2. Resident eats < 50% and not offered a substitute	33.3 (42)	29.0 (20)
3. Resident receives < 5 min of assist and a supplement	.8 (1)	0 (0)
4. Resident independent but receives physical assist	23.8 (30)	28.6 (20)
5. Resident receives physical assist without verbal cue	3.2 (4)	1.1 (1)

*p< .05

Return to Report

CNA vs. PFA Mealtime Tasks



Appendix 9 Appendix 9

Table Comparing Involvement of Nurse Aides to Feeding Assistants on Meal-Related Tasks

	Total Number	Shift		>1 Year NH Experience	Food-related Tasks				
		Day 7am-3pm	Night 3pm-11pm		Transport	Meal Delivery/ Tray Set-up	Food/Fluid Document	Retrieve Substitutions	Serve B/T Meal Food/Fluids
CNA									
Percent		.67	.33	.83	.96	.99	.93	.93	.98
Number	54	36	18	45	52	53	50	50	53
FA									
Percent		.85	.15	.95	.82	.85	.42	.75	.54
Number	39	33	06	37	32	33	16	29	21