

NURSING HOME RESIDENTS: SHORT-CHANGED BY STAFF SHORTAGES

FORUM
BEFORE THE
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FORUM: NURSING HOME RESIDENTS: SHORT- CHANGED BY STAFF SHORTAGES

WEDNESDAY, NOVEMBER 3, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING
Washington, DC

The committee met, pursuant to notice, at 10 a.m., in room SD-106, Dirksen Senate Office Building, Hon. Charles Grassley, (chairman of the committee) presiding.

Present: Senators Grassley and Kohl

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY

The CHAIRMAN. I would like to start our meeting. The value of this meeting will be the discussion that goes on, not what I or other Members of Congress have to say. So I want to make very clear that starting on time is for the convenience of you folks and so we can get right to the heart of things.

The only interruption I know that I would make, and I would ask Dr. Harrington, our moderator, to maybe keep this in mind, just in case other Members of Congress, a member of the House of Representatives, another colleague of mine in the Senate—if they do not come when I get done, I want you to start the panel right away, but if they do come, I would like to have you interrupt the panel to hear from our colleagues when they can come because not everybody can necessarily be according to my schedule.

I want to say thank you all very much for coming. I am pleased to welcome all of you here today. And there are many of you who have traveled far to be here to share your concerns and expertise with us, and we especially thank you for taking time out of your busy schedule to travel a long distance.

For more than 2 years, you probably know that our Committee on Aging has worked to improve the quality of care in nursing homes. We have worked to change the system, we have done this through a series of hearings and forums, but we have also done it through legislative advocacy and success; for instance, securing more millions of additional dollars for the enforcement system. And when it is all said and done, and this job is not done, what we simply wanted to do and what we continue to do is to end bedsores, malnutrition and dehydration.

Until now, we focused on those who receive nursing home care, the patient. Today, we want to focus on those people who provide that care. We will hear that nursing home residents are not alone in their suffering. Nursing home staff will tell us about their own set of hardships.

Before we begin, I would like everyone in the audience to think about what they have already done today; getting up, getting ready for work. We all got out of bed, we all showered, dressed and ate breakfast. Imagine, if you would, performing the same tasks with severe physical impairment, dementia and a host of medical needs. Of course, we would need help, even for routine activity. It would take us much longer to move from bed to breakfast than for those of us who are healthy and mobile.

Keep this image in mind, and repeat it many times, and that would give you a sense of what certified nurse aides do in nursing homes each and every day. Certified nurse aides perform at least 80 percent of the care for one and three-tenths million nursing home residents in 17,000 homes. They say they have too many mouths to feed, too many bodies to bathe and too many beds to change per shift.

Under the best of conditions, their jobs are physically and emotionally demanding. They constantly must lift and turn fragile nursing home residents who may resist their efforts. At times, they may be physically abused, punched or kicked. Residents with dementia can verbally abuse their caretakers. Witnessing the incremental decline of aging patients day after day has to be tough. Compound these difficulties with very low pay. The average wage per hour for certified nurse assistants is \$6.94. Obviously, there is high turnover. In most parts of the country, turnover rates can hover around 80 to 90 percent per year. Yet there are those who endure these conditions out of pure mission, a mission to care for our elders. An aide featured in the Washington Post this week buys her patients lotion and perfume out of her salary of \$240 a week. She sticks with her work to protect the dignity of some of Washington, D.C.'s most vulnerable citizens.

How do we attract more nursing home employees to be dedicated nurse's aides? How can we determine how much staff is enough per nursing home shift? And Congress mandated a study that we are in the middle of now. How can we quantify the link between staff shortages and poor quality of care? There are proposals to address these problems. Some advocates want to see the Federal Government impose nursing home staffing ratios. A number of states have taken other approaches, some calling for direct link between staffing and reimbursement.

The success of most of these proposals is mostly undetermined. The nursing home industry, on a whole, is opposed to such strict guidance from the Government. Industry representatives say they do not have enough money to hire enough qualified staff. It is true that this is an era of extremely low unemployment; 3 percent in my State of Iowa—in fact, under 3 percent. When there is a labor shortage, employees have more opportunities for better paying jobs than nursing home work.

Does nursing home work have to pay so poorly? Most of us would think not. But I suppose before we go any further, we have a responsibility to learn about the nursing home finances. This industry will receive \$39 billion this year just from the Federal Government to care for the Nation's nursing home residents. Now, I have not done the math, but \$39 billion is a lot of money each and every

year and a growing amount of money. It seems that it should buy us adequate care from sufficient staff.

I have asked the General Accounting Office to explain how nursing home finances work. I want to know how much of that \$39 billion goes to staff, to equipment, to supplies, to administrative expenses and to the industry profit. And I go to the General Accounting Office, instead of to the industry, to answer these questions because every cent of it is taxpayers' money, \$39 billion, but also to have an impartial source of information on how much goes to each. But let the bottom line be that the taxpayers have a right to know where every penny is spent.

Problems associated with inadequate nursing home staffing are not new. It is discouraging that so little progress has been made, and I hope the money trail will lead us to finding some solutions.

Before I turn to Senator Kohl and Congressman Stark, I am pleased to introduce today's moderator, Dr. Charlene Harrington. Where is Charlene? There. Thank you. You can come up here now, if you want to, although I am not going to invite everybody up here, but let them see who is running the show today.

Now, she has been very helpful to our committee, testifying before, and she has excellent insight into this area of staffing. She is a professor in the Department of Social and Behavioral Sciences at the University of California and San Francisco. She has been involved in nursing home quality since 1975. Dr. Harrington has published extensive research in the area of nursing home quality. The Health Care Financing Administration, on several occasions, has contacted Dr. Harrington to develop, design and implement studies on behalf of HCFA.

First, Dr. Harrington will make remarks and introduce panelists, and after each witness presents 5 minutes of testimony, Dr. Harrington will lead a question-and-answer period. There are a number of key questions that we want to present to today's witnesses. And during the forum, you will have a chance to write out questions to be asked of the panel, and my staff of the Aging Committee will be picking up the question cards throughout the forum.

I guess I want to call on my colleague, Senator Kohl, to present his remarks, when he is done, then Congressman Stark. And I want to thank both Senator Kohl, who has been very much interested in the work of this committee, and I have worked with Senator Stark both when I was a member of the House of Representatives and since.

I would ask Senator Kohl, and why don't you come up here, Congressman Stark, and stand as well. And then when Congressman Stark is done, then you will proceed.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good morning. I am pleased to welcome all of you here today, especially those of you who have traveled to be here.

For more than two years, the Special Committee on Aging has worked to improve the quality of care in nursing homes. We've worked to change the system. We've had a series of hearings and forums. We've secured millions of additional dollars for the enforcement system. We simply wanted to end bedsores, malnutrition and dehydration.

Until now, we've focused on those who receive nursing home care. Today we'll focus on those who provide it.

We'll hear that nursing home residents are not alone in their suffering. Nursing home staff will tell us about their own set of hardships.

Before we begin, I'd like everyone in the audience to think about getting ready for work this morning. We all got ourselves out of bed. We showered, dressed and ate breakfast. Imagine performing the same tasks with severe physical impairments, dementia and a host of medical needs. Of course, we would need help with each routine activity. It would take us much longer to move from bed to breakfast than if we were healthy and mobile.

Keep this image in mind, and repeat it many times. That gives you a sense of what certified nurse aides do in nursing homes each day.

Certified nurse aides perform at least 80 percent of the care for 1.3 million nursing home residents. They say they have too many mouths to feed, too many bodies to bathe and too many beds to change per shift.

Under the best of conditions, their jobs are physically and emotionally demanding. They constantly must lift and turn fragile nursing home residents who may resist their efforts. At times, they are punched or kicked. Residents with dementia can verbally abuse their caretakers. Witnessing the incremental decline of aging patients day after day is tough.

Compounding these difficulties is very low pay. The average hourly wage for certified nurse aides is \$6.94. Their high turnover is well-known. In most parts of the country, the turnover rate hovers between 80 percent and 90 percent each year.

Yet there are those who endure these conditions out of a pure mission to care for our elders. An aide featured in *The Washington Post* this week buys her patients lotion and perfume out of her salary of \$240 a week. She sticks with her work to protect the dignity of some of Washington, DC., most vulnerable citizens.

How do we attract more nursing home employees like this dedicated nurse aide? How can we determine how much staff is enough per nursing home shift? How can we quantify the link between staff shortages and poor quality of care?

There are proposals to address these problems. Some advocates want to see the Federal Government impose nursing home staffing ratios. A number of states have taken other approaches, some calling for a direct link between staffing and reimbursement. The success of such proposals is mostly undetermined.

The nursing home industry on the whole is opposed to such strict guidance from the government. Industry representatives say they don't have enough money to hire enough qualified staff. It is true that this is an era of extremely low unemployment. The unemployment rate is under 3 percent in much of Iowa. When there is a labor shortage, employees have more opportunities for better-paying jobs than nursing home work.

Does nursing home work have to pay so poorly? Before we go any further, I want to learn more about the nursing home industry's finances. This industry will receive \$39 billion this year from the federal government to care for the nation's nursing home residents. I haven't done the math, but \$39 billion is a lot of money. It seems that it should buy us adequate care from sufficient staff.

I've asked the General Accounting Office to explain how nursing home finances work. I want to know how much of that \$39 billion goes to staff, to equipment and supplies, to administrative expenses and to industry profit. Every cent of that \$39 billion is taxpayers' money. The taxpayers have a right to know where every penny goes.

Problems associated with inadequate nursing home staffing are not new. It's discouraging that so little progress has been made. I hope the money trail will lead to a solution.

Before turning to Congressman Stark, I am pleased to introduce today's moderator, Dr. Charlene Harrington. She has testified before this Committee before and has excellent insight into the area of staffing. She is a Professor in the Department of Social and Behavioral Sciences at the University of California, SF. She has been involved in nursing home quality since 1975. Dr. Harrington has published extensive research in the area of nursing home quality. The Health Care Financing Administration on several occasions has contracted with Dr. Harrington to develop, design and implement studies on its behalf.

First, Dr. Harrington will make remarks and introduce the panelists. After each witness presents five minutes of testimony, Dr. Harrington will lead a question and answer period. There are a number of key questions that we want to present to today's witnesses.

Now, I am happy to turn to Congressman Stark. He has a long record of effectively working to provide improvements to nursing home quality of care and improved quality of life for nursing home residents. I am encouraged by his continued interest and dedication to this important project.

STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Well, I thank you, Mr. Chairman. I would also like to thank Senator Breaux for bringing all of us here today to talk about the critical issue of nursing home staffing.

Over 43 percent of Americans over the age of 65 will likely spend time in a nursing home. I think we all agree they deserve to be taken care of by the most competent, compassionate nursing home staff; people who understand both their health care needs and their right to respect and to dignity. All of us, the Government, nursing home operators, families and advocates share in this responsibility.

Unfortunately, we also know that there are some serious problems in nursing homes today. Nursing home complaints and short staffing citations are up. Qualified nursing home staff has been increasingly hard to find and even harder to keep, but a staff shortage means that patients wait even longer for the care they need and deserve, or worse, they receive substandard care.

As we all know, this is a national problem, and we must look at a range of solutions. I am hopeful that this forum here today will take a serious look at payment rates and mandatory staffing levels as part of the solution, but it will also highlight strategies that are already working.

Two of my Wisconsin constituents, Mary Ann Kehoe and Mary Jo Westphal, from the Good Shepherd Home in Seymour, WI, are here to share the tremendous success story of the Wellspring program. This program is working to improve the quality of nursing home care. All 11 nursing homes participating in the Wellspring initiative had perfect surveys last year, not a single citation. In fact, Good Shepherd Home has had four perfect surveys in a row.

Clearly, many people are taking this issue very seriously, thinking outside the box and implementing successful programs to improve the quality of nursing home care. We need to applaud and encourage these efforts, and I am hopeful that this forum will bring about more improvements like those created by Wellspring.

So, again, I want to thank Chairman Grassley and Senator Breaux for convening this forum. I know it will be a constructive discussion, and I am hopeful that it will serve as a catalyst for some real solutions.

Thank you.

STATEMENT OF CONGRESSMAN PETE STARK

Mr. STARK. It is always a pleasure to follow Senator Kohl. What he may not know and what many of you may not know is I just about a month ago attended my 50th high school reunion at Wauwatosa. And I want to tell you there is a class that is going to be ready for that Good Shepherd House pretty soon. [Laughter.]

But I want to also thank Senator Breaux and Senator Grassley for convening this forum and appropriate staffing standards, which are critical to quality care, as you all know. There are not any Federal standards for staffing now. Several states are way ahead of us, back here, as so often happens. Governor Davis signed into law a bill to establish minimum nurse-to-patient ratios. My mother resides in a nursing home in California, and our all-too-infrequent visits show us how critical it is that these people—you know, I often wonder how do you legislate tender loving care? I do not

know how to write that bill. I do know that at the other extreme we are going to introduce a bill or have introduced a bill that requires criminal background check for all people who not only work with the elderly, but we want to do that for people who work in child care situations; the idea that people who are fragile and people who are in the care of a care giver and unable to respond, as many of us can as adults, need some assistance and often need protection. Sometimes we have to be protected from one another and sometimes we have to be protected from society, but that's a reasonable role of the Federal Government and a reasonable role of many of you who advocate for the good care of seniors.

Florida has a comprehensive nursing home bill signed by Jeb—I've got to get that straight—Bush. Arkansas has one. And, as you know, Senator Grassley and Senator Breaux have been after the General Accounting Office to analyze what is really going on across the country, and it is not good. The standards are not uniform. In many cases they do not exist. It is interesting to note that currently we reimburse nursing homes, under the Prospective Payment System, those that get Medicare reimbursement, and the reimbursement rate presumes a high level of staffing, but there is no follow-up. There is no requirement that, once they get this set payment from Medicare, that they will have the proper quality care. And those are adjusted, I might add, so the more severe the case is the higher the payment, and that also presumes that there will be a higher level of staffing. So we are going to ask, in our bill that we have introduced, that facilities report their total nurse staffing hours in a similar manner that is done with cost reports and a host of technical issues that I think you will find interesting.

And I hope that your forum today will advise our staff, and many of the members who will be here part of the time during your meeting, about other areas in which, first of all, we can make sensible regulations: ones that now we find that many of the nursing home owners in California do not want to weaken. They say, "Look, we built up staffing. We have equipped, we have built our facilities to be earthquake proof," which is a problem we have in California. "We have increased the safety level and the sanitary level. We do not want the fly by-nights to come in and undercut us now that we have invested the money." They fought us a little bit at the beginning, but now that they have done it, they do not want cheap competition, if you will, coming in with substandard facilities and substandard service.

So thank you for taking the time out of your day to come here and help us. We are going to need your help. I am going over in a moment to the floor of the House, where we are debating, once again, the fate of the Patient Protection bill or the Patient Bill of Rights bill under managed care. That has been a long time coming, but it is here in legislation, not finished yet, but here on both sides of the Capitol because of advocacy groups, because of people all over the country who said, "There is a need for this." Well, I think you are here to tell us there is a need for legislation and regulation, and we will listen. But we need to be—we do not sit around at night and dream up regulations to make people's lives more complicated. We try to respond to reasonable requests from people across the country.

It will be your job to focus on those reasonable requests that you think the people in your profession or in your industry can live with, and it will be up to us to respond, hold our feet to the fire, and make sure that those of us who do not respond or do not pay attention or do not recognize hear from the folks at home because we all have facilities in our districts or states, and we all have horror stories and anecdotes of what can happen if we are not vigilant.

So thank you for being here to help us be vigilant, and now we can get to work.

[The prepared statement of Rep. Stark follows:]

PREPARED STATEMENT OF REPRESENTATIVE PETE STARK

Thank you, Sen. Grassley, for hosting this forum on nurse staffing. It's a vital part of our efforts to improve the quality of care that is delivered to residents of long-term care facilities that receive billions in federal funding every year.

So far, much of the action on nurse staffing issues has been at the state level. On October 10, California Governor Gray Davis signed into law a proposal that directs the health department to establish minimum licensed nurse-to-patient ratios in various kinds of hospital units. The state will begin the process of collecting the data to do this in January. In Massachusetts and Rhode Island, similar proposals have been introduced to require "sufficient staffing" in hospitals.

Elsewhere, Florida's comprehensive nursing home reform bill signed into law last summer authorizes the state health agency to require facilities that have been cited for care deficiencies for insufficient staff to increase their staffing beyond a minimum level set by regulation. And in Arkansas, legislation enacted in April mandates staffing ratios for nursing facilities by September 30, 2000. The statute also prohibits the department of human services from issuing or renewing the licenses of nursing homes that fail to meet staffing standards.

All of you in this room know what a key role staffing plays in the quality of care in our nation's nursing homes. My mother resides in a nursing home in California, and I count on the facility to provide her with all the medical care and other services that she needs. I believe her care is good—but sadly, too many nursing homes fail to provide adequate care.

For over a year now, Sen. Grassley and Sen. Breaux have harnessed the considerable resources and talents of the General Accounting Office to analyze what's really going on in nursing homes. The results of the first of these reports on California nursing homes, of which I was a co-requester, weren't pretty. GAO found that one in three nursing homes had been cited for serious quality of care violations between 1995 and 1998.

This report and others that followed demonstrate how far we have to go before the quality standards initially passed as part of 1987 nursing home reform legislation are met.

In the near future, I will introduce legislation to make Medicare-reimbursed skilled nursing facilities accountable for periodically reporting nursing staff data. I will do so because the new prospective payment system for skilled nursing facilities factors in nurse staffing needs for the case-mix of each facility. So while Medicare is now paying for adequate staffing on an acuity basis, there is no requirement for facilities to actually provide that level of staffing. In fact, facilities may be tempted to hire fewer nurses than they are being paid for—and pocket the difference.

My bill will ask facilities to periodically report their total nurse staffing hours in a similar manner as is done for cost reports. In cases where staffing levels are found to be out of step with the case-Mix of the facility's residents, then federal payments would be adjusted.

It is with pleasure that I note that HCFA Administrator Nancy-Ann Min DeParle and Deputy Administrator Michael Hash have put together a comprehensive initiative to strengthen enforcement initiatives and improve quality with "best practices" for evaluating care delivered to high-risk sit residents who suffer from pressure sores, or who have special nutritional needs.

This initiative is just now getting Off the ground. But it is in danger of falling apart if Congress unwisely carries through with a \$15 million cut in nursing home survey and certification funding that currently exists in the Labor/HHS spending bill. Any decrease in federal funding for nursing home inspections will begin to unravel HCFA's initiative. As one frustrated official told me recently: "You can't increase funding in one year to hire more inspectors, and then take it away the next and expect to make any progress."

On a broader legislative front, there is much we must do to boost quality of care and expand long-term care services for Americans who badly need them. Last summer, I introduced a bill with Congressman Ed Markey (H.R. 2691) that would begin to expand Medicare's coverage of services for chronically dependent seniors who wish to remain at home. That bill also contains a proposal requiring routine posting of nursing staff on duty relative to the number of residents for whom they are responsible.

Over the longer term, I intend to introduce more comprehensive long-term care legislation, as well as a bill to establish consumer financial protections for anyone purchasing long-term care insurance. Today, long-term care insurance policies are a poor investment for many consumers.

Clearly, there are other steps that can be taken to improve quality of care in nursing facilities. One is to pass legislation similar to H.R. 2627, the Patient Abuse Prevention Act, which Sen. Kohl and I introduced last summer. It requires all facilities to perform criminal background checks and abuse registry checks on prospective employees. I will work hard to try to move this legislation forward next year.

I am also pleased that the HHS Inspector General recently unveiled a voluntary nursing home compliance program, which aims to improve the quality of care in nursing facilities through specific procedures that guard against fraud.

In addition, the Department of Justice recently announced that U.S. Attorneys are stepping up scrutiny of nursing homes. Substandard care is clearly an area that federal and state prosecutors need to collaborate on to address, and I will be closely monitoring those efforts.

Thank you again, Sen. Grassley, for hosting this forum. I look forward to hearing from the panelists.

Doctor.

STATEMENT OF CHARLENE HARRINGTON, PROFESSOR OF NURSING AND SOCIOLOGY, UNIVERSITY OF CALIFORNIA; SAN FRANCISCO, CA

Dr. HARRINGTON. Thank you very much. My name is Charlene Harrington, and I am honored to be invited today to serve as the moderator for this forum, and I am very pleased with the agenda and our line-up of speakers.

This forum is addressing the single most important factor related to poor nursing home quality across the country; the inadequate numbers and training of registered nurses, licensed practical nurses and nursing assistants in nursing homes.

This year, the General Accounting Office and the Inspector General's Office have confirmed that many nursing homes are operating below the minimum Federal standards. The inspector general's report said that state surveyors consider nursing home staffing shortages and inadequate staff expertise to be major factors in poor quality of care. And this is confirmed by many research studies that have shown the positive relationship between higher nurse staffing levels, especially registered nurse staff, and the outcomes of nursing home care.

Lower staffing is associated with high urinary catheter use and urinary infections, low rates of skin care, high pressure-sore rates, low resident participation rates and activities, poor physical functioning, malnutrition, dehydration and, yes, even starvation. Higher ratios of RN staff to residents will reduce the likelihood of death and increase the probability that residents can be discharged to their home, and it also reduces the number of deficiencies that a facility receives.

For the past 5 years, I have been studying nursing home staffing using data from the Health Care Financing Administration for all nursing homes in the United States, and we find that the average staffing time is only 3½ hours per resident day, but this is prob-

ably overstated because these are self-reports by facilities, and the data are not audited by HCFA. In other words, we only have one RN and one LVN for every 34 residents and one nursing assistant for every 12 residents in the United States. That is only a little over an hour per shift, and that includes everything; administration, writing in the charts, as well as the direct patient care and breaks.

Moreover, there are very wide discrepancies between the staffing levels found in different types of facilities and in different states. Hospital-based and skilled nursing facilities that take Medicare residents only have almost twice as much staff as other kinds of residents. For-profit facilities have significantly lower staffing, as do those facilities that have higher percentages of Medicaid residents. Many facilities have dangerously low staffing. Twelve percent of the nursing homes in the United States only have 1 to 2½ hours of nursing staff per resident day and another 28 percent have very low staffing. Facilities with low staffing should be targeted for more frequent inspections and audits by nursing home surveyors, but this has not been implemented yet by HCFA.

Now, a group of experts got together in the past year, and we came up with some recommended minimum staffing levels that we think should be set by Government. And I have handouts here today, but I think we have obviously run out with such a great crowd today. If you would like copies, we will send those to you. But we are recommending 24-hour RN care in every nursing home and a minimum of 4½ hours per resident day in total time, which would be at least 1 hour more than what is being done currently. We are also recommending substantial increases in training. So we hope that HCFA will use this information and set minimum staffing standards.

Now, many states around the country have been studying staffing this year and have had legislation. The National Citizens Coalition for Nursing Home Reform has a handout today that is a report on state activities, although it has to be updated for California because the latest data are not in it for California.

Because of the poor quality of care and low staffing ratios in California nursing homes, the California legislature raised the minimum staffing levels from 2.8 hours per resident day to 3.2 hours per resident day, and they raised all of the wages for staff in nursing homes by 5 percent this year in their budget act. They appropriated \$72 million in Federal and State money that begins January of this coming year. That will mean actually hiring 5,000 new nursing home staff people for California's 1,400 nursing homes.

Now, we had hoped to get additional minimum staffing over the next 3 years, but our Governor vetoed that request because he wanted to wait to see what the impact of the current change is going to be. In any case, we are pleased with this beginning in California, and we hope that California will become a model for the Nation.

I would like to switch to another issue. During the past 5 years, my colleagues, Sara Burger and David Zimmerman, and I have been working on developing a consumer information system for nursing homes. We were very pleased when President Clinton an-

nounced that HCFA would put consumer information about nursing homes on the Internet, as we have proposed for a long time.

Since that time, we have been working with HCFA informally to help see that this happens. In September 1999, HCFA added new information to its website on facility characteristics and residents. It is called "Nursing Home Compare" website, under the Medicare section. At the last minute, however, HCFA made a decision not to include the data on nursing home staff on the website for individual facilities, saying that they were not sure the data is accurate. We were extremely disappointed with this decision which, of course, we did not find justifiable. So we hope that HCFA will move forward to begin to put this information on the website this coming spring because the public has a right to know what the staffing is in nursing homes.

In summary, nursing home staff are the key to improving the quality of nursing home care. We are pleased that the U.S. Senate Special Committee on Aging recognizes the importance of nursing care and nursing homes, as demonstrated by having this forum today. And we look forward to hearing from our panelists about the problems in nursing homes, as well as how excellent care can be provided.

I think we are all here today for the same thing, and that is to ensure that our Nation's nursing home residents have the right to high quality of care, and high quality of life and human dignity.

Thank you.

[The prepared statement of Charlene Harrington follows:]

U.S. Senate Special Committee on Aging**Senator Chuck Grassley, Iowa Chairman
Senator John Breaux, Louisiana, Ranking Member****Forum On
Nursing Home Residents: Short-Changed by Staff Shortages?****Forum Moderator****Charlene Harrington, Ph.D., R.N.
Professor, Department of Social and Behavioral Sciences
University of California, San Francisco
November 3, 1999**

My name is Charlene Harrington and I am a professor of nursing and sociology at the University of California, San Francisco. I am honored to be invited to serve as a moderator for the forum today and pleased by the agenda of speakers. This forum is addressing the single most important factor related to poor nursing home quality across the country -- the inadequate numbers and training of registered nurses, licensed practical nurses, and nursing assistants in facilities providing care to residents.

POOR QUALITY OF CARE

Recently, the US General Accounting Office found that one-third of California's nursing homes had seriously jeopardized the health and safety of residents and most other nursing facilities provided inadequate care.¹ Another GAO study of four states found that many nursing homes had caused actual or potential death or serious injury to residents and 77 percent of those facilities had the same or more serious problems in subsequent surveys conducted by state licensing and certification agencies.² This year the Inspector General also confirmed that many quality problems found in nursing homes are chronic and reoccurring.³ State surveyors report nursing home staffing shortages and inadequate staff expertise are major factors in poor quality.³

RELATIONSHIP OF STAFFING TO QUALITY

Many research studies have shown the positive relationship between higher nurse staffing levels, especially RNs staff, and the outcomes of nursing home care.^{4,5,6} Studies show lower staffing is associated with high urinary catheter use and urinary infections, low rates of skin care and high pressure sore rates, low resident participation in activities, and poor physical functioning.^{7,8,9} Other studies show that higher ratios of RNs to residents reduce the likelihood of death and increase the probability of discharge to the home.^{9,10} Less RN staff and other direct care staff are consistently related to more deficiencies.¹¹

Studies show inadequate staffing and inadequately trained staff are major contributors to poor feeding, malnutrition, dehydration, starvation and the hospitalization of nursing home residents.^{12,13,14,15,16} Other studies show that nursing assistants have inadequate time to provide individualized and high quality of care and they cut corners on providing care to manage the heavy workloads.^{17,18} Psychological and physical abuse of residents by nursing assistants is related to the stressful working conditions in nursing homes.^{18,19} In summary, the evidence is strong that RN staffing and total nurse staffing levels are important factors in ensuring high quality of care in nursing homes.²⁰

CURRENT NURSE STAFFING IN THE US

For the past five years, I have been studying nursing home staffing, using HCFA data for all US nursing homes. The average RN time (including all nurse administrators) was 42 minutes per resident day, LVN/LPN time was 42 minutes, and nursing assistant time was 126 minutes in 1997.^{21,22,23} The total average nurse staffing time was 3.5 hours per resident day, but these staffing hours are probably overstated because they are self-reported by facilities and not audited by HCFA. In other words, there is only 1 RN and 1 LVN for every 34 residents and 1 nursing assistant for every 12 residents per day in the US.^{21,22,23} It is apparent that a little over 1 hour per shift is not enough time to provide good nursing care to residents.

Wide disparities in nurse staffing levels are found in different types of facilities and across states. Hospital-based and skilled nursing facilities that take only Medicare residents have twice as much nursing staff as other facilities.^{21,22,23} For-profit facilities have significantly lower staffing as do those facilities with higher percentages of Medicaid residents. The large inequities in staffing levels across facilities is unacceptable.

Many facilities have dangerously low staffing, especially some for-profit and Medicaid only facilities. 12 percent of US nursing homes had only 1 and 2.5 hours of nursing staff per resident day, while another 28 percent had low staffing.²⁴ Facilities with low staffing levels should be targeted for more frequent inspections and audits by nursing home surveyors, but HCFA does not require or encourage states to do this.²⁴

This year, the shockingly poor quality and low staffing ratios in California nursing homes were used to argue for increases in California minimum staffing levels and increases in wages for staffing. In 1999, California legislature passed a budget act that raised the minimum nursing home staffing levels from 2.8 hours per resident day to 3.2 hours per resident day in California and raised wages by 5 percent for direct care nursing home staff. Overall, the legislature appropriated \$72 million dollars for Medicaid (half federal and state funds) beginning January 2000 for these changes in nurse staffing in nursing homes, which will result in hiring 5,000 additional nursing home staff.²⁵ Although we had hoped to further raise the minimum staffing over the next three years, the governor vetoed this request until the state assesses the effect of the 1999 staffing increases.²⁵ Overall, we are pleased with this beginning and hope that California staffing will become a model for the nation.

EXPERT PANEL RECOMMENDATIONS

What are the appropriate nurse staffing levels for nursing homes? A group of experts have developed a set of recommended minimum staffing levels that should be set by government, available as handouts here today. The experts recommend more administrative and

RN staff proportionate to the size of the facility, including 24 hour RN coverage.²⁶ (1 licensed nurse should be available to care for every 15 residents during the day shift, 1 for every 20 in the evenings, and 1 for every 30 at night at a minimum.²⁶ For direct caregivers, the experts recommend a minimum ratio of 1 caregiver to 5 residents on the day shift, 1:10 for evenings, and 1:15 for nights.) Overall, a minimum of 4.5 hours per resident day of total nursing time is needed, or one hour more than the current national average, with additional staff for residents with higher nursing care needs.²⁶ Substantial increases in the training of nurses are needed.²⁶ We hope that HCFA will use this information to establish minimum federal staffing standards for nursing homes.

ADMINISTRATIVE EXPENDITURES AND PROFITS

One way to increase staffing expenditures is to reduce expenditures on administration and profits in the nation's nursing homes. In the U.S., only 36 percent of total nursing home expenditures is expended on direct care (nursing staff and other direct care staff) in 1996.²⁷ Administrative costs are 27 percent of operating expenses and profits are high in some facilities.²⁷ Government, which currently pays 61 percent of nursing home costs, must be willing to pay for adequate staffing levels, while ensuring public accountability.²⁸

CONSUMER INFORMATION ABOUT STAFFING

For the past five years, my colleagues Sara Burger and David Zimmerman and I have been developing a consumer information system for nursing homes.²⁹ In July 1998, President Clinton announced that HCFA would put consumer information about nursing homes on the Internet, as we had long proposed. Since that time, we have been working with HCFA officials on an informal basis. In September 1999, HCFA added new information to Nursing Home Compare Web site. This includes information on individual facility characteristics and about residents, including: the percent of residents who are in restraints, with pressure sores, and with incontinence.

At the last minute, however, HCFA made a decision not to including the nurse staffing data on individual facilities, by making excuses that they were not certain the data were accurate. We were extremely disappointed in HCFA's decision that we did not find justifiable. We hope that HCFA will move forward with plans to put staffing information on the nursing home Website, so that the public will know what is going on behind the closed doors of the nation's nursing homes.

In summary, nursing home staff are the key to improving the quality of nursing home care. We are pleased that the US Senate Special Committee on Aging recognizes the importance of nursing care in nursing homes as demonstrated by this forum today. We look forward to hearing about the problems with staffing as well as how excellent nursing home care can be provided. We are all here today to ensure that our nation's nursing home residents have the right to a high quality of care and a high quality of life and human dignity.

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Now, I would like to ask our panelists to come up, and we are going to have all of the panelists come up at the same time.

I would like to introduce the first four panelists today, and then we will have you come up and speak at the podium.

The first witness on the panel is Elaine Daigle. She is the mother of a nursing home resident in Connecticut and a member of the Advocates for Loved Ones in Nursing Homes. She will discuss her experiences in dealing with the facility where her daughter resides and share her insight regarding the relationship between staffing and quality of care delivered to her daughter.

The next witness is Narcissus Jackson. Ms. Jackson lives and works in Baltimore, MD. She has worked for 10 years as a certified nursing aide in long-term care, and she currently works at the Keswick Multicare Center. Ms. Jackson is also a member of the Services Employees International Union, Local 1199E of D.C.

The third witness on the panel is Debbie Byrd. She has worked for 21 years as a certified nursing assistant at Hill View Retirement Center in Portsmouth, OH, her hometown. Her commitment to excellence is demonstrated through her credentials and awards, including a recent lifetime achievement award. Ms. Byrd has been inducted into NAGA's CNA Hall of Fame.

The fourth witness on the panel is Becky Kurtz. Since 1994, Ms. Kurtz has served as a long-term care ombudsman from the State of Georgia. In this position, she manages the statewide long-term care ombudsman network that serves as advocates for nursing home residents in Georgia. She is an effective long-term care ombudsman and a very strong advocate for residents' rights and autonomy.

So, Elaine.

STATEMENT OF ELAINE DAIGLE, YANTIC, CT

Ms. DAIGLE. Good morning. My name is Elaine Daigle. My daughter has been living in a nursing home for the past 4 years. She was born with a heart defect and had a mitral valve replacement at the age of two. This caused a stroke, leaving her left side paralyzed. She did really well until the age of 26, when she had another stroke affecting her right side and causing a complete loss of speech. Her now extensive paralysis has meant that she must live in a skilled nursing facility. However, despite her many physical problems, she is alert and able to communicate with a letter board. Her ability to communicate with me about what happens in the nursing home and my observations of her care have educated me about the crisis of short staffing in nursing homes.

Although the facility she lives in meets the state minimum staffing regulations for Connecticut, my daughter has experienced many deficiencies in care directly related to poor staffing. For example, staff are seldom available to answer her call bell. In several instances when aides have not had time to answer her call bell to assist her with using the bathroom, she has been forced to wet her bed. She is not incontinent. Other times she has been left on the bed pan for up to an hour. You can imagine her frustration and humiliation at being subjected to these situations. As these occurrences repeat themselves, her frustration and humiliation are turning into depression.

Another instance of poor care related to low staffing levels, which threatened not only my daughter's dignity, but also her life, occurred in January 1999, when my daughter had the flu. When she rang the call bell for help with vomiting, no one came, and her roommate found her choking on her own vomit. Only after her roommate screamed for help did anyone come. The result—aspiration pneumonia, which required many weeks of expensive medication.

With staffing levels as they are, other basic needs are not even monitored or attended to. Because of such a heavy workload, CNAs are not given the time to position my daughter properly in her wheelchair. Many times her roommate has rescued her from falling over. Also, whereas before my daughter was fed partially by mouth and partially through a feeding tube, low staffing levels means that my daughter is now fed exclusively through a feeding tube. Because of the amount of time given to feed each resident, my daughter's food by mouth was taken away because it takes her a longer period of time to eat.

Low staffing levels affect professional nurses in nursing homes as well. Nurses are so overworked that important issues are overlooked. For example, the overloaded nurses at my daughter's facility failed to notify the doctor that my daughter was not being fed by mouth any more and needed more calories through the feeding tube. Her daily calorie intake of 600 caused malnutrition. After this, I left my job to watch over my daughter's care. Also, the nurses do not have time to always check the position of the feeding tube or to make sure it was taped in place. My daughter has had six emergency room visits within a 6-week period because the feeding tube migrated into her stomach, causing vomiting, severe pain and more aspiration. Many expensive tests were ordered, and she was twice admitted to the hospital. The result of the tests? That the pain and vomiting were caused by the feeding tube not being taped as ordered by the doctor.

I believe that all of these incidents would have been avoided if there were more staff.

With the heat wave this summer, my daughter had chest pains and difficulty breathing. The staff were so busy no one noticed until one night in August her pulse rate became erratic, and she had severe chest pain and difficulty breathing. The nurse on duty sent her to the emergency room. The air-conditioned ambulance caused her to breathe easier and her color greatly improved. She was sent back and put in her hot room.

I am told that CNAs receive only 2 weeks of training. This is pitiful for such an important job. CNAs do not receive enough training on how to communicate with each resident and, therefore, end up treating the residents as a number and not as a person. This results in very poor quality of care.

Many good nurses and good CNAs are leaving because of burn-out. I hear the remarks of the nurses and the CNAs, frustrated and burnt out, threatening to quit. I see the stress on their faces. The quality of care for nursing home residents suffers when dedicated and caring nurses and CNAs are forced to leave their jobs because they are overworked and overwhelmed.

Before closing, I would like to give a final example of neglect caused by low staffing. At my daughter's nursing home, no one has time to clean her teeth. I asked politely for the first 6 months. I went through their chain of command, as they called it. Then, I contacted the ombudsman. They cleaned her teeth once a week. Finally, after contacting Connecticut Legal Services, my daughter's teeth are cleaned on a regular basis. Nursing homes should be staffed at levels that allow these basic needs to be taken care of routinely, without having to involve outside agencies.

We must change the law and increase the level of staffing in nursing homes so our loved ones get proper care. You may be the next one to need the care of a nursing home. You do not have to be an aged senior. It could be an accident or a sudden illness that would cause you to need the care of a nursing home. As a mother, I implore you to fix this now Thank you. [Applause.]

[The prepared statement of Ms. Daigle follows:]

**Testimony before the U.S. Senate Special Committee on Aging
Forum on Nurse Staffing in Skilled Nursing Facilities
November 3, 1999
By Elaine Daigle**

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Thank you.

**STATEMENT OF NARCISSUS JACKSON, CERTIFIED NURSE
AIDE, KESWICK MULTICARE CENTER, BALTIMORE, MD**

Ms. JACKSON. Good morning. I thank you this morning for the opportunity to testify.

I do this work because I enjoy what I do, and I love taking care of the elderly. Let me explain to you what my typical day is. I work on a TCU Unit, which I care for very critical and frail residents. With being understaffed, we cannot do these things for them like their mouth care, turning and reposition. It's very hard to try to take care of residents when you are very short staffed, and it is very frustrating to us CNAs.

As you can see, as I have too much to do and too little time, I rarely take a full-length break or I have time for my own dinner. And it's not physically possible to keep up with the demands on my time. There is a name for this, and it is called short staffing, and it has a huge impact on patient care. Residents are not turned enough, unnecessary bed sores, not enough time to eat, drink, people lose weight, not enough time to change people. These residents deserve better.

Workers deserve better, too. I stick with my job because I love what I do. I do have a union to protect my rights, but I see CNAs come and go, and it is a revolving-door workforce. The biggest reason for people living is unrealistic workloads, low wages, unaffordable health care benefits, and injuries also cause people to leave. Some CNAs have to work two and three jobs because they cannot afford the health insurance for their kids and themselves.

Something must be done, and the most important thing that must be done is to require safe staffing standards. I hear people talking about a lot of different measures that would make it easy for nursing assistants to give better care. Agree that we need better training, we need more; we need a say in how decisions are made; we also need affordable health insurance, benefits, equipment to prevent injuries from lifting residents and especially wage levels that will enable us to support ourselves and our family. But without strong staffing standards, none of these other measurements will be effective in improving the quality of care or keeping CNAs from leaving their jobs.

Nursing homes are not going to improve staffing levels unless they have to. We need to change the laws so that no home can require CNAs to take care of more residents than they reasonably can. My union supports the National Coalition Staffing Standards, which calls for a minimum ratio of one to five nursing assistants on day shift, one to ten during the evening and one to fifteen during the night. It also calls for adjustments of these ratios based on actual acuity.

This is what NCCNHR standards would mean for my residents. Right now, we have two CNAs for the care of 23 residents on a TCU Unit, the ratio of one to twelve. The NCCNHR standards says that there would be a minimum of one to ten on the night shift, and it also says that for higher acuity units like mine, it should even be lower.

For me, the best situation is to have seven or eight residents. This is what we used to have in my TCU before the management changed. I used to do a real good job. Some even say I spoiled my

residents, and I do. I spoiled them all the time. But now I have 12 or more, and I am just getting by and just barely covering the basics.

We need you, our representatives in the Federal Government, to act. We need you to support the strong Federal standards that require safe staffing ratios in all nursing homes all over the country. We also need a way for people to know what the staffing levels actually are in nursing homes. Nursing homes should be required to post actual numbers of staff of residents on each shift so the family members of people looking at the facility will know what's going on. I think that is a good idea because if I had to put my family member in a nursing home, my No. 1 concern would be how many residents do an aide have.

We also need to make nursing homes more accountable for how they spend Government money. Nursing homes should be required to show that they are providing the nursing staffing for residents for which they are being reimbursed. My union supports the proposal for how to do this for Medicare. The nursing homes get paid based on how much care the very sick residents in my TCU Unit needs, but no one checks to make sure that the staffing at this level needed to provide that care.

Senators and Representative, can I have—well, everybody in here, I would like to have all of your undivided attention. I would just like everyone to close their eyes for 1 minute. Now, imagine that you are in a home, that you cannot get a drink of water on time, you cannot get someone to come into your room and talk to you, you have to wait to be fed, you have to wait to be turned, you have to wait to be changed, you are laying in urine or feces for a long length of time. With all of these things, now just imagine that in this home, this resident is you.

I thank you. [Applause.]

[The prepared statement of Ms. Jackson follows:]



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TESTIMONY OF

**Narcissus Jackson, CNA
Keswick Multicare Center, Baltimore, Maryland**

**Member, Services Employees International Union
Local 1199 E-DC**

SUBMITTED TO

**The Special Committee on Aging
United States Senate**

November 3, 1999

My name is Narcissus Jackson. I am a Certified Nurse Aide at Keswick Multicare Center in Baltimore, Maryland. I have worked as a nurse aide for over 10 years. I am also a member of the Service Employees International Union, SEIU Local 1199 E-DC. Our union represents more than 100,000 nursing home workers across the country. Chairman Grassley, and other members of this committee, thank you very much for the opportunity to testify.

There is no question in my mind that short staffing is the number one problem in nursing homes today. Nothing makes me more sad and frustrated than not having enough time to meet the needs of the residents I serve.

Let me explain to you what my typical day is like:

I work the evening shift that starts at 3pm and ends at 11pm. I usually have more than 15 residents to care for. During my eight-hour shift I have to:

- Make sure everyone gets dinner, which takes up to 2 hours because I have to get some of them transported to the dining room and back, prepare meals for people who eat in their rooms, and also feed the 2 or 3 of them who can't feed themselves.
- I also bathe and change everyone and get them ready for the bed.
- Throughout the evening I take people to the bathroom, and turn and prop the sickest ones.
- Two times per evening I drop everything and distribute nourishments - "Ensure" drinks - to about half my residents.
- I also have a list of people on the walking list. This means I have to spend 15 minutes each evening with these residents helping them to walk or do passive range of motion activities.
- Every few minutes throughout the evening I have to respond to call bells or alarms that we have on wheelchairs so people can remain restraint free.
- Finally, at the very end of the day I spend 1/2 hour doing my "bookwork." For each resident I must record how they are performing the activities of daily living or ADL's, which means tracking how much they ate, moved around, whether they had a bowel movement and other details.

As you can see, I have too much to do in too little time. I rarely take a full-length break or have time to eat my own dinner. Everyday I am frustrated because I know I should be doing more. I work as fast as I can but it is not physically possible to keep up with the demands on my time.

There is a name for this. Its called short staffing and it has a huge impact on patient care. Residents often do not get turned or repositioned every two hours, which means they develop bedsores. I feel sorry for residents who are in pain because of bedsores that could be avoided if we had time to take better care of them. I also feel sorry for the residents who need help with eating and drinking. A few have family members who come into to help them but most don't. I don't have time to sit with them long enough and I worry that they are losing weight. I also feel bad that I don't have time to answer my residents call buttons right away. When I am moving or changing one resident it can take several minutes. Meanwhile someone else is waiting to go to the bathroom. Residents deserve more. It hurts their dignity to lie in their own urine and feces waiting for one of us to come change them. These residents deserve better.

Workers deserve better too. I stick with my job because I like the residents. They tell me how much they like me and give me encouragement. Because we have a union, I also get paid more than the \$6 or \$7 dollars per hour that most nurse aides earn and I have health insurance coverage, unlike most nurse aides.

Other nurse aides I know have not been willing to stick with it. I have seen dozens of the women I work with come and go. Then the residents get upset because they have particular habits and needs that new people don't understand. Several people I know have hurt their backs trying to lift residents on their own because no one was around to help them. Then they leave because they can no longer meet the physical demands of the job.

Something must be done.

I am working through my union to change the laws so we can have the staff we need to do our job right. My union supports the proposed minimum staffing standards for nursing homes proposed by the National Citizens Coalition for Nursing Home Reform. These standards call for CNA to

resident ratios of 1:5 during the day, 1:10 during the evening shift and 1:15 for the night shift, plus adjusting staffing based on resident's acuity levels.

If I had only 10 residents to care for I know I could do so much more for my residents. Right now I don't have time to answer call buttons let alone read something to someone or brush their hair the way they like it. Because I wouldn't be as stressed out and rushed like I am now, I would have time to give my residents the focus and attention they need. With these ratios in place, nurse aides wouldn't be constantly leaving this work because they get fed up.

Through my union I worked to support a bill in the Maryland legislature to institute these new staffing ratios in Maryland. The nursing home industry fought hard against our bill. Even though we had a lot of support, the opposition was too strong. What ended up passing was a compromise bill that sets up task forces to study the problem and make a recommendation to the legislature. I am serving on one of these task forces.

We also need you, our representatives in the federal government to act. This forum is a good first step but what we really need are stronger federal standards that require safe staffing ratios in all nursing homes all over the country.

We also need to make nursing homes more accountability for how they spend government money. Nursing homes should be required to show that they are providing the nurse staffing for the residents for which they are being reimbursed. Congressman Stark was referring earlier to a specific proposal supported by my union and nursing home advocates for how to do this for Medicare. We appreciate your concern about this issue and we look forward to working with you

Thank you again for the opportunity to be here today. I hope the discussion we are having today will lead to action. When I go back to work tomorrow night I want to tell my residents that legislators in Washington care about them and that my trip was worthwhile. I am happy to answer any questions you might have.

**STATEMENT OF DEBBIE TANNER-BYRD, CERTIFIED NURSE
AIDE, PORTSMOUTH, OH**

Ms. BYRD. Senator Grassley and committee members, my name is Debbie Byrd. I work as a certified nursing assistant at Hill View Retirement Center in Portsmouth, OH, a Certified Alternative Facility. Thank you for the opportunity to testify on the CNA staffing challenges facing our Nation.

Clearly, we are experiencing a crisis in elder care. I am one of more than 20,000 members of NAGNA, the National Association of Geriatric Nursing Assistants, active in 26 states. We are the professional organization for nursing assistants in this country, headquartered in Joplin, MO.

I, personally, am proud to tell you that I have been a CNA for 21 years at the same facility in Southern Ohio. As is the case with all professions, we have those among us who lack a superior commitment. Unfortunately, CNAs are too often known for these few bad apples. Consider this: If my appearance before this committee is covered by the national press, it will be one of the few times an aide is mentioned who has not committed a crime. Please know my dedication does not make me the exception among nursing assistants. I am the rule. There are thousands, and thousands and thousands of extraordinary CNAs caring for the frail elders in the United States.

This committee will hear no shortage of examples of how people feel care suffers due to a national shortage of CNAs. I find stories about poor health care are the stories most people spread. For me to recite more examples will waste my time and yours. We all know that ending the CNA shortage will be a great day for residents, their families, providers and CNAs.

We at NAGNA wish to focus for a moment on creating an adequate supply of superior caregivers. My colleagues and I have spent the last 2 years developing these solutions. It is based on a five-point plan. I have the plan with me today and have detailed the five points in my written testimony to be included in the committee's record.

To list them briefly as follows:

First, we need a national CNA recruitment campaign; second, a Government-funded CNA direct wage pass through; third, mandate no ideal staffing ratios until real existing vacant positions are filled; fourth, create a national CNA registry; fifth, create a national universal titles for CNAs.

If our solutions are supported, everyone interested will have exactly what they are seeking. Mandating staffing level is not the answer. You can pass laws, but you can't do magic. Applicants will not simply appear because a law is enacted. We ask that you help us fill our vacant CNA positions today before imposing unreal, unachievable staffing ratios. Don't be misled. The number of caregivers is not the only important issue here. The quality of the caregivers and the Nation's respect for the service should be part of your committee's focus today. We must recruit quality applicants to field current positions. Every day we waste time pointing out problems and taking no action. The shortage increases. I assure you there is no unwillingness to hire quality applicants to work in nursing homes. There is simply not enough applicants.

My colleagues and I are tired of being portrayed as abusers, neglecters, and thieves in the media. We provide a vital, tender service that is about people and meeting their intimate personal care needs. Every day CNAs around this country face the risk of taking responsibility for people's lives. We often hear them say, "You can make more money flipping hamburgers at McDonald's," but let's compare jobs. If I work at McDonald's and I drop a hamburger on the floor, the worst thing that could happen to me, I would be fired. But if I accidentally drop a resident on the floor, the worst thing that could happen to me that resident would die or suffer serious injuries, the family might suspect abuse and sue, I might be fired. And if none of that happens, I still will have the feeling of being devastated that I have accidentally injured a resident.

When looking for a job, which risk would you take for roughly the same amount of money?

But in spite of the risks and the lack of recognition by society, NAGNA's member, CNAs, are proud and determined to elevate the value and the role of the Nation's caregivers.

In closing, I would remind you that mandating staffing ratios is not the answer to improving care. Only by ending the current nursing aide shortage will there be better and more consistent surveys, fewer incidents of abuse and neglect and, most importantly, high-quality of resident care. We have had enough lawsuits, bad surveys, and finger pointing. Penalties and bad stories have not proven to be the answer; progressive, positive action is.

I urge you to look closely at the Nation's National Association of Geriatric Nursing Assistance's accomplishments and goals and pledge your support for our five-point plan.

On behalf of my association, my profession and my dear residents, I wish to thank you for this time. It has been an honor to appear before the committee. I and my colleagues welcome your questions.

Thank you. [Applause.]

[The prepared statement of Ms. Tanner-Byrd follows:]

Senator Grassley and committee members. My name is Debbie Byrd. I work as a certified nursing assistant at Hill View Retirement Center in Portsmouth, Ohio. Thank you for the opportunity to testify on the CNA staffing challenges facing our nation. Clearly, we are experiencing a crisis in elder care.

I am one of more than 20,000 CNA members of NAGNA, the National Association of Geriatric Nursing Assistants. Our members live in 26 of the 50 states and work in long term care facilities. We are the professional trade association for nursing assistants in this country, headquartered in Joplin, Missouri.

I personally am proud to tell you I have been a CNA for 21 years in the same facility in Southern Ohio. I have never before had the opportunity to meet lawmakers. Unfortunately, you may have only met nursing assistants through coverage of horrible stories in the media. I am here to tell you most of us are extraordinary individuals. Sadly, our few bad apples grab all the press.

During the past 21 years, I have told hundreds of people "I am a CNA," only to have them turn up their noses and say, "I could never do that job." I wonder, do they mean they *could* never or *would* never do my work? I was stunned in September to read the leader of the National Citizen's Coalition for Nursing Home Reform, Sarah Greene Burger, quoted in McKnight's Long Term Care Magazine as saying, "Who would do that job? I wouldn't!" Sir, with all due respect, America's elders cannot afford this attitude, expressed by advocates, regulators, reporters or anyone else. In truth, it is an honor and a privilege to care for our nation's oldest citizens, individuals who made this country what it is today. Starting today, NAGNA asks us all to begin speaking with great regard for the elderly and their caregivers. Find a nurse aide who is doing a good job and honor her or him.

I am privileged to work in a facility that pays well, has good benefits, has few welfare patients and offers a beautiful work environment. Yet, despite our every effort, there are many days we work with fewer CNAs than we are budgeted for. Our facility is not unwilling to hire CNAs; there is simply a lack of applicants. We need your help to create a line of qualified applicants at the front doors of our country's 17,000 nursing homes.

This committee will hear no shortage of examples of how people feel care suffers due to a national shortage of CNAs. I find stories about poor health care are the stories most people spread. For me to recite more examples would waste my time and yours. We all know that ending the CNA shortage will be a great day for residents, their families, providers and CNAs. We at NAGNA wish to focus for a moment on creating an adequate supply of superior caregivers.

For the past two years, my coworkers and fellow NAGNA members have been developing some solutions to this national crisis in care. I would like to present our **Five Point Plan** to you today:

1. A national caregiver recruitment campaign.
2. A Government funded "direct wage pass through" for CNAs.
3. Mandate no ideal staffing ratios until real existing vacant positions are filled.
4. Create a national CNA registry.
5. Create a national, universal title for CNAs.

Allow me to explain.

1) America must elevate and celebrate the role and value of caregivers. **We need your help in financing a national caregiver recruitment campaign:**

People point fingers and shake their heads in disgust when stories of abuse and neglect are reported in the media, but few if any go to their local nursing home and get an application or even volunteer. Public perception

of nursing homes is very poor. We aides always are asked, "Isn't it depressing? Doesn't it smell? How can you change some old woman's diapers?" Senators, I would guess you also may have wondered if not asked the same questions.

To be honest, I never thought I could work as a caregiver either! But I applied and challenged myself and learned I was a better person than I had ever given myself credit for. It is often said "it takes a special person to do that kind of work," and I will be the first to say my colleagues and I are very special, but thousands of us did not feel special until *after* we became CNAs. This noble work has brought us confidence and a sense of worth. We develop powerful, meaningful relationships with our patients and each other.

In truth, few CNAs answered a calling when they came to work in a nursing home. Many just needed a job and answered a help wanted ad, wondering if they could do the job.

CNAs aren't just born... many, many are made. Knowing this, we believe there are thousands and thousands of people who are potentially special, potential CNAs; we must find them, motivate them and educate them on how they can make a difference.

How? By launching a nationwide recruiting campaign equal to the recruitment efforts of the Armed Forces. Our careers are actually very similar: We are both asked to serve and protect, often putting the well being of others before our own. Like the military, nursing homes need a recruiting campaign, to motivate people to "be all they can be." NAGNA is prepared to lead such a campaign, provided funding is made available. Can you help us secure funds?

2) CNA wages must become attractive enough to attract applicants. **We ask you to direct the Medicaid program to create and fund a CNA minimum wage or Direct Wage Pass Through.**

Nationally, the average wage for a CNA is \$7 an hour. We know this is not a living wage, which is why most caregivers are forced to work two or more jobs.

NAGNA's goal is to see that national average CNA wage to reach \$10 - \$12 per hour. Many critics of nursing homes state the shortage in staff is caused by nursing home owners refusing to pay enough. This is simply not true. We believe if people knew how much the Medicaid program pays a nursing home for a patient's daily care, they would change their minds. I understand Medicaid pays about \$100 a day for nursing home care across the country. Sir, I am staying at the Holiday Inn while here in Washington. No one in the hotel has offered to dress me, feed me, bathe me, visit with me, do my laundry, drive me to the doctor, listen to my worries or cheer me up. Yet, the hotel is charging me \$139.00 a day. With only \$100 a day per resident to operate a nursing home, it is no surprise staff can't be paid a living wage. This situation is not the fault of management...there simply isn't enough Medicaid money to go around. And of course, this circumstance exists because few Americans plan for their old age, and end up on welfare instead.

NAGNA has found there is not a significant difference in wages between CNAs working in non-profit facilities and those working in for profit facilities: both are underpaid. Given the Medicaid rates and Medicare caps, nursing homes are basically **fixed income businesses**. Revenue is limited to the number of patients the facility is licensed to treat.

On the other hand, Wal-Mart and McDonalds, who compete with us for workers, are unlimited income businesses, which **choose to pay** their employees *only* slightly above minimum wage.

Money is not everything; I have not been a career CNA for the money. To say money alone will solve the problem is to insult the character and dedication of career CNAs. However, our work is very stressful and job burnout runs high.

We often hear people say you can make more money flipping burgers at McDonalds, but let's compare jobs. If I work at McDonalds and I accidentally drop a hamburger on the floor, the worst thing that can happen is I would be fired.

If I accidentally drop a resident on the floor, the worst thing that could happen is that resident would die, or suffer serious injury, the family might suspect abuse and sue, I might be fired and I will go home devastated because I accidentally caused injury to a resident. When looking for a job, which risk would you take for roughly the same amount of money?

3) **Staffing Ratios:** Without a national recruiting campaign and Government funded wage increases, mandating higher staffing ratios will not work. You can pass laws, but you can't do magic. **We ask you to help us fill our vacant CNA positions today, before imposing unreal and unachievable staffing ratios.**

NAGNA estimates nationwide there are an average of seven CNA openings per facility right now. There is no unwillingness to hire CNAs; we just don't have qualified applicants! Mandating ratios would only result in surveyors writing staffing deficiencies in every facility across the nation.

4) **The United States needs a national registry of CNAs. NAGNA asks you to create a national CNA registry.** Currently, criminal background checks conducted by individual states do not protect a facility from hiring a CNA who has committed resident abuse in another state. If the applicant does not list other states they are certified in, their record goes undiscovered. A national registry would allow facilities access to this information. NAGNA supports this registry and as a national association would be willing to operate the registry or assist other agencies in providing the service.

5) **National Credentials: We ask for a national, universal title for certified nursing assistants.** Several states have different titles for the position. In Ohio, where I work, a nursing assistant is called a STNA, state tested nursing assistant, and we hate it. We want our credentials back. In Michigan, my colleagues are called CENAs, competency evaluated nursing assistants, and they hate it.

To make our national recruiting campaign a success, we must have a standard universal title that means the same thing in every state. If not CNA, then perhaps we could follow Vermont's lead and adopt LNA, licensed nursing assistant, or possibly a whole new name for a new image, such as certified nurse tech. The Carmelite Sisters for the Aged and Infirm operate 23 nursing homes. Many of their homes have adopted the title Geriatric Technician. And last year, Beverly Healthcare, which employs 23,000 aides, had their associates create a new title: Care Specialist. Whatever the title, let's make it national and universal.

In closing Senator, I would ask you to take my comments under careful consideration. CNAs are the best advocates for residents. Ending the nurse aide shortage will lead to better and more consistent surveys, fewer incidents of abuse and neglect and most importantly, high quality care of residents. We've had enough lawsuits, bad surveys and finger pointing. Penalties and bad stories are not the answer, progressive positive action is. I urge you to look closely at the National Association of Geriatric Nursing Assistant's accomplishments and goals, and pledge your support for our five point plan. On behalf of my association, my profession and my dear residents, I wish to thank you for this time. It has been an honor to appear before the committee. I welcome your questions.

**STATEMENT OF BECKY KURTZ, GEORGIA STATE LONG-TERM
CARE OMBUDSMAN, ATLANTA, GA**

Ms. KURTZ. Good morning. My name is Becky Kurtz, and I am the State long-term care ombudsman for the State of Georgia.

I am honored to have the opportunity to testify before this committee and this very impressive audience. Many of us from across the country have been closely watching this committee, as it has prodded the Federal Government and, indeed, the Nation to pay attention to the conditions of our Nation's nursing homes. We appreciate the excellent work of this committee and its staff.

For a week this past summer, talk of "Cloud 9," a dog training school and kennel was all over Atlanta. A trainer at the kennel was caught on videotape choking, dragging and striking a dog that she was training. It was the leading evening news story on every television channel and the front-page story on the Atlanta Journal Constitution. My friends who use the kennel angrily informed the owner that they would never again do business there. It was the main topic of conversation that week on MARTA, which is our Metro, and at the water coolers in offices all over the city. The entire city of Atlanta was disgusted and outraged. By the end of the week, the owner of Cloud 9 had issued a public apology, and the evening news reported that Cloud 9 was out of business.

This is a tragic story, but at least it has an appropriate ending as a result of public outrage. As a pet owner, I shared that outrage. Yet as a long-term care ombudsman, I had to ask myself: Why is it that the tragedies that we see in some of our nursing homes do not get that same response? When a daughter calls me in tears because the bed sores are literally rotting away the legs and the life of her mother, because her mother was found lying in feces for many hours, because her mother is severely malnourished and dehydrated, why isn't the entire city of Atlanta or Augusta or Albany outraged and disgusted? Why doesn't the mistreatment of our parents, and our grandparents and our daughters cause the same outrage?

We do not claim that poor care is a problem in every nursing home, but it occurs far too often. And our experience as ombudsmen shows us that outrageously poor care almost always relates to inadequate staffing. Bed sores cannot be prevented unless there are adequate staff to move the residents regularly. Many residents cannot stay dry and clean unless they have staff to help them get to the bathroom. Adequate staffing is needed to respond to call lights for help and to assist residents to eat and to drink. These basic human needs can never be met without enough direct-care staff.

In Georgia, our ombudsmen receive far too many complaints related to inadequate staffing. Last year, and this is just one state in 1 year, we received 239 complaints of inadequate staff in Georgia's nursing homes and, additionally, we received 1,311 complaints related to care issues that directly related to staffing. These are complaints of residents being left hungry with no one to help them eat, left in distress or pain because no one responded to their call light, and suffering the humiliation of urinating on themselves because no one was available to help with toileting.

Families, residents, ombudsmen and other advocates are baffled. Why are there no Federal minimum staffing requirements? The Federal law requires "sufficient nursing staff to provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." This is important language, particularly the "each resident" part, but it leaves us with a standard which is nearly impossible to translate into numbers of direct-care staff, much less to objectively enforce.

A few states do require adequate minimum standards, but this is not true in every state. In Georgia, our state regulations require only two nursing staff hours per resident per day. This is not sufficient to provide care to residents, many of whom need significant assistance and supervision. By failing to require specific numbers of staff be present per shift, the Georgia standard does nothing to help residents or their families or the ombudsmen or the inspectors or even the facilities to know how many persons should be providing care to residents at any time of the day or night. By comparison, the residents of Georgia's personal care homes and assisted living facilities, who do not require as much assistance as nursing home residents, can know how many staff must be present to assist them during every shift because our state regulations do require clear minimums.

In order to provide nursing home residents with good care, we must have the political will to set minimum national standards for adequate and well-trained direct-care staff supervised by experienced and knowledge nurses, and we must have the political will to really enforce those standards.

We acknowledge the difficulty that many homes face in recruiting and retaining staff, particularly in an economy with low unemployment. We understand that hiring and training staff costs money, but we simply must make this a higher priority because the suffering of our Nation's nursing home residents is every bit as real as these workforce and economic hurdles.

Because we do not pay for adequate staff, we do pay in other ways. Nearly 50 percent of the hospitalizations for hip fractures, infections and pressure sores due to poor nursing home care in the United States could be prevented with adequate staffing. We had a wonderful example just a moment ago. That could save nearly a billion dollars a year. We could save billions more if we could prevent urinary incontinence, which we could prevent far more often with adequate staffing. We pay approximately a billion dollars per year in worker compensation costs for injured nursing home workers, many of whom must overcompensate without sufficient coworkers.

By failing to address the high human cost and the high economic cost of poor care in our Nation's nursing homes, we have seen needless suffering of far too many residents. Congress simply must address this issue. Just as we are disgusted and outraged at mistreatment of our pets, this Nation must become disgusted and outraged at the mistreatment of our parents, and our grandparents and our daughters. Our outrage must result in this tragic story having an appropriate end.

Thank you. [Applause.]

[The prepared statement of Ms. Kurtz follows:]

**TESTIMONY OF BECKY A. KURTZ
GEORGIA STATE LONG-TERM CARE OMBUDSMAN
TO
THE SENATE SPECIAL COMMITTEE ON AGING'S FORUM:
"NURSING HOME RESIDENTS; SHORT-CHANGED BY STAFF SHORTAGES?"**

NOVEMBER 3, 1999

I am honored to have the opportunity to testify before this Committee. Many of us from across the country have been closely watching this Committee, as it has prodded the federal government and the nation to pay attention the conditions of our nation's nursing homes. We appreciate the excellent work of this Committee and its staff.

For a week this summer, talk of "Cloud 9," a dog training school and kennel, was all over Atlanta. This was the story on the front page of the Atlanta Journal-Constitution: a trainer at the kennel was caught on videotape choking, dragging and striking a dog she was training. It was the leading evening news story on every television channel. Not only did my friends who used the kennel angrily inform the owner that they would never again do business there, but it was the main topic of conversation that week on MARTA and at the water coolers in offices all over the city. The entire city of Atlanta was disgusted and outraged. By the end of the week, the owner of "Cloud 9" had publicly apologized for his staff's behavior and the evening news reported that "Cloud 9" was out of business.

This is a tragic story, but at least it has an appropriate ending as a result of public outrage. As a pet owner, I shared that outrage. Yet, as an ombudsman, I had to ask myself: Why is it that the tragedies we see in some of our nursing homes don't get the same response? When a daughter calls me in tears because bed sores are literally rotting away the legs and the life of her mother; because her mother was found lying in feces for many hours; because her mother is severely malnourished and dehydrated — why isn't the entire city of Atlanta or Augusta or Albany disgusted and outraged? Why doesn't the mistreatment of our mothers and fathers cause the same outrage?

We do not claim that poor care is a problem in every nursing home, but it occurs far too often. And our experience in the Ombudsman Program shows us that outrageously poor care almost always relates to inadequate staffing. Bed sores cannot be prevented unless there are adequate staff to move residents regularly. Many residents cannot stay dry and clean unless they have staff help them get to the bathroom. Adequate staffing is needed to respond to call lights for help and to assist residents to eat and to drink. These basic human needs can never be met without enough direct care staff.

In Georgia, our Ombudsman Program receives far too many complaints related to inadequate staffing. Last year, we received 239 complaints of inadequate staff in nursing homes and 1,311 complaints of care issues related to staffing. (See attached table). These are complaints of residents being left hungry with no one to help them eat, left in distress or pain because no one

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November 3, 1999

responded to their call light, and suffering the humiliation of urinating on themselves because no one was available to help with toileting.

Families, residents, ombudsmen and other advocates are baffled: why are there are no federal minimum staffing requirements? The federal law requires "sufficient nursing staff to provide . . . services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." This is important language, but it leaves us with a standard which is nearly impossible to translate into numbers of direct care staff, much less to objectively enforce.

A few states require adequate minimum standards, but this is not true in every state. In Georgia, our state regulations require only 2.0 nursing staff hours per resident per day. This is not sufficient to provide care to residents, many of whom need significant assistance and supervision. By failing to require specific numbers of staff be present per shift, the Georgia standard does nothing to help residents, their families, ombudsmen, or inspectors — or even facilities — know how many persons should be providing care to residents at any time of the day or night. By comparison, the residents of Georgia's personal care homes — who don't require as much assistance as nursing home residents — can know how many staff must be present to assist them during every shift because state regulations require clear minimums.

In order to provide nursing home residents with good care, we must have the political will to:

- set national minimum standards for adequate and well-trained direct care staff supervised by experienced and knowledgeable nurses; and
- enforce these standards.

We acknowledge the difficulty that many homes face in recruiting and retaining staff, particularly in an economy with low unemployment. We understand that hiring and training staff costs money. But we simply must make this a higher priority, because the suffering of our nation's nursing home residents is every bit as real as these workforce and economic hurdles.

Because we do not pay for adequate staff, we do pay in other ways. Just a few examples:

- Nearly 50% of hospitalizations for hip fractures, infections, and pressure sores due to poor nursing home care in the United States could be prevented with adequate staffing, saving nearly \$1 billion per year. ("Nursing Home Residents Rights: Has the Administration Set a Land Mine for the Landmark OBRA 1987 Nursing Home Reform Law," Subcommittee on Aging, Senate Committee on Labor and Human Resources, 1991)

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- We could save billions more if we could prevent urinary incontinence, which we could do far more often with adequate staffing. (Id.)
- We pay approximately \$1 billion per year in worker compensation costs for injured nursing home workers, many of whom must over-compensate without sufficient co-workers. ("Establishing Safe Standards in Nursing Homes: We Can't Afford Not To," Service Employees International Union, 1997)

By failing to address the high human cost and the high economic cost of poor care in our nation's nursing homes, we have seen needless suffering of far too many residents. Congress simply must address this crisis. Just as we are disgusted and outraged at mistreatment of our pets, this nation must become disgusted and outraged at the mistreatment of our parents and grandparents. Our outrage must result in this tragic story having an appropriate end.

Prepared by:

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Nursing Home Complaints Related to Staffing

**Georgia Long-term Care Ombudsman Program
State Fiscal Year 1999**

Complaint Category	Complaints Received	% of Total NH Complaints
Shortage of Staff	239	5%
Care Issues Related to Staffing:		
Gross Neglect	86	
Accidents, Improper Handling	144	
Call Lights, Requests for Assistance	220	
Personal Hygiene -- including oral hygiene	305	
Pressure Sores	76	
Toileting	125	
Tubes -- neglect of catheter, gastric, NG tubes	24	
Inadequate Supervision of Residents	43	
Assistance in Eating or Assistive Devices	106	
Fluid Availability, Hydration	99	
Staff Unresponsive, Unavailable	83	
Total: Care Issues Related to Staffing	1,311	26%
Total of Resident Care Complaints	1,526	30%
Total All Nursing Home Complaints	5,071	

Dr. HARRINGTON. I would like to remind all of you that we are going to take some questions after our speakers finish their introductory remarks. So if you could fill out the question cards that I think may have been passed out and pass them over, we will take those after the panelists finish.

The first two witnesses on the second panel are from Good Shepherd Home in Seymour, WI. Mary Ann Kehoe is the administrator and Mary Jo Westphal is a certified nurse aide. They will talk about their strategies that their facility employs to ensure that residents receive appropriate levels of care and supervision.

Following them, we will hear from Leslie Williams, the administrator of NHC Health Care in Merritt Island, FL. Ms. Williams began working in long-term care at the age of 16, and she quickly rose to the position of administrator. Today, she will talk about the methods that her facility uses to ensure that residents receive appropriate levels of care.

Last, we will hear from Judith Ryan, who is the president and chief executive officer for the Evangelical Lutheran Good Samaritan Society, which is one of the largest long-term care organizations in the Nation. Ms. Ryan is also a registered nurse and a former executive director of the American Nurses' Association. She will talk about the strategies that her organization employs to ensure that facilities are adequately staffed.

Mary Ann.

**STATEMENT OF MARY ANN KEHOE, EXECUTIVE DIRECTOR,
GOOD SHEPHERD SERVICES, LTD., SEYMOUR, WISCONSIN,
ON BEHALF OF AMERICAN ASSOCIATION OF HOMES AND
SERVICES FOR THE AGING**

Ms. KEHOE. Good morning, Mr. Chairman, committee members. Thank you for the opportunity to address you and share some positive things that are going on in long-term care. My name is Mary Ann Kehoe, and I am the executive director at Good Shepherd Services in Seymour, WI. Good Shepherd is a not-for-profit organization that offers an array of health and community services ranging from a nursing home to a child daycare center.

I am also speaking on behalf of the American Association for Homes and Services for the Aging, which represents over 6,000 not-for-profit providers. We are proud to report that quality of care is alive in this Nation. Staffing issues are diverse and complex. I have devoted my life and my career to improving the care of the elderly in this country and in our facility. But both personally and professionally, I don't feel that mandating staffing ratios is the direction we should be taking. Staffing mandates, despite the very best of intentions, are not a magic bullet. The lack of qualified applicants, reimbursement issues and negative press about life in nursing homes are just some of the multiple causes. Mandating unavailable resources will not get us the desired results.

Furthermore, both the provider and consumer communities have long supported the shift from process to outcomes as a measure of assessing quality of care in our nursing homes. Any attempt to assure the provision of optimal care based on mandated staffing ratios would defeat the efforts that have been made within both the legislative and regulatory arenas toward this goal.

Current regulations already mandate that facilities provide sufficient staff to meet resident needs. The regulations place a clear responsibility on facilities not just to maintain the status quo, but to act aggressively to improve the quality of life by providing adequate staff.

Since July, quality indicators have been incorporated into the survey process. As a result, feedback reports are available that provide facility-specific comparative data on the quality status of every resident. The critical question becomes: How do we use this data? Quality cannot be guaranteed simply by having staff present. Rather, the keys to quality lie with having adequate staff who work in an environment where they are provided the necessary tools to do their jobs and, like our residents, they are treated with dignity and respect.

Today, I do not come before you to bemoan the questions that are going on in our homes, but rather I am proud and very excited to tell you about a potential solution. This solution has been effective in 11 organizations in Wisconsin that care for over 1,600 residents. The initiative is called Wellspring Innovative Solutions for Integrated Services. Wellspring facilities are located in rural and urban areas across our state and offer an array of services to our elderly.

Wellspring facilities are characterized by an entrepreneurial spirit and a zeal for improving the life and care of residents by totally cooperating and collaborating with one another. Wellspring has integrated the quality indicators, best practices and a new management paradigm to dramatically improve resident outcomes and cost efficiency.

Fundamental to the Wellspring program is the concept that the definition of quality care is created by top management, but that the best decisions about how care is delivered to each and every resident are made by the front-line staff who know those residents the best. This empowerment is achieved through extensive staff education in the form of care resource teams, through shared decisionmaking and enhancing critical thinking skills of all staff. All staff of Wellspring facilities have a responsibility to ensure quality resident care. Quality is not just a Nursing Department function, and I am a nurse.

The Wellspring education component is led by a geriatric nurse consultant who utilizes other clinical experts for teaching best practices. Best practices are taught in seven clinical modules, including physical assessment, elimination continence, skin care, behavior management, falls prevention, restorative care and nutrition. These modules are taught to staff over a 2-year period.

The educational components mirror the quality indicators. While the quality indicator reports are a step in the right direction, two main problems still exist. The reports merely indicate that a problem may exist. The facility must determine whether there truly is a problem with quality and then, more importantly, what to do about the problems. Wellspring provides tools in both of these areas.

Quality indicator investigation, combined with group process and what I call simply "Golden Rule" management are central to Wellspring. The shift from traditional autocratic management structure to staff empowerment has made the difference with

Wellspring's approach. Each Wellspring organization is responsible for data collection, and each of us is held accountable to the others to improve resident outcomes on an ongoing basis. We have created a network of staff in 11 different organizations who work together to solve problems for one another. The collaboration and mutual accountability for improving outcomes is what ensures quality over time, despite market conditions.

As a result of this new paradigm, Good Shepherd has consistently achieved a 98-percent resident and family satisfaction rate. Despite very low unemployment in Wisconsin, our CNA turnover went from 105 percent to less than 30 percent in the last 5 years since implementation of Wellspring. Many staff drive 20 miles to our rural facility, just to work in our facility. And during the past 3 years, there have been many times when we have had waiting lists of staff wanting to work in our organization. Staff retention has remained consistently high over the past 4 years. Our organization accomplished over 900 days without a work-time loss to accident, and we're up over 100 again.

While the impact on staff is remarkable, residents are the prime beneficiaries. Through the implementation of just one Wellspring module, the residents at Good Shepherd experienced 23,000 less incontinent episodes last year. For Good Shepherd, by simply reducing incontinence, we were able to save over 4,000 hours or 2½ full-time equivalence of nurse aide time. This saved time is used to improve quality of life, as well as quality of care. Further, if you significantly eliminate one of the most difficult parts of the nursing assistant job, it is easier to recruit and to retain staff.

In conclusion, quality care can and is being sustained in nursing homes across the Nation. We are replicating the Wellspring model. Proscriptive staff mandates carry no guarantees. There are effective alternatives that result from current staffing levels enhanced by creativity and empowerment.

I sincerely thank you for this opportunity. [Applause.]

[The prepared statement of Ms. Kehoe follows:]

STATEMENT OF
AMERICAN ASSOCIATION OF HOMES AND SERVICES
FOR THE AGING



BEFORE THE:
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

A FORUM ON
NURSING HOME RESIDENTS: SHORT-CHANGED
BY STAFF SHORTAGES?

NOVEMBER 3, 1999

Mr. Chairman and members of the Committee, I am Mary Ann Kehoe, Executive Director of Good Shepherd Services, Ltd., Seymour WI. Good Shepard is a not-for-profit facility that has 92 nursing care beds and also provides a range of community-based services, including case management, hospice care, and home-delivered meals.

I am here today as a member of the American Association of Homes and Services for the Aging (AAHSA). The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit written testimony to the United States Senate Special Committee on Aging. We consider the issue of staffing in long term care facilities, and its impact on quality of care to residents, to be one of critical importance.

AAHSA is a national nonprofit organization representing almost 6,000 not-for-profit providers of health care, housing, long-term care, and community services to almost 1,000,000 individuals daily. Approximately seventy-five percent of AAHSA members are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, and community groups. Our members include not only nursing facilities, but also independent senior housing, continuing care retirement communities, and providers of home health care, adult day care, respite care, meals on wheels, and other services. With strong community involvement and long-standing community ties, AAHSA and its members have long been committed to providing quality care to the people we serve and to meeting the needs of these individuals in a manner that enhances their sense of self-worth and dignity, and that allows them to function at their highest levels of independence. Although AAHSA's membership spans the continuum of long term care, the majority of our members continue to provide nursing facility (NF) and skilled nursing facility (SNF) care, either alone or in combination with other services.

Quality of Care in Nursing Facilities

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. One of the most significant transformations resulting from the passage of OBRA '87 was the shift in focus of regulatory oversight from facilities' capacity to provide care, "paper compliance" with requirements, to one on resident outcomes, that is, the actual care provided.

Several of the nursing home quality reform provisions have facilitated this change in approach and have worked to improve the quality of care and assure better resident outcomes.

1. Standardized Resident Assessment (RAI/MDS)

Central to the OBRA '87 change from process to outcomes is the mandate that every facility conduct, "initially and periodically, a comprehensive, accurate, standardized,

reproducible assessment of each resident's functional capacity." These assessments are to be interdisciplinary in nature, to be conducted at least annually, reviewed quarterly, and revised in the event of a significant change in status. The resident assessment instrument and minimum data set (RAI/MDS) developed under the auspices of the Health Care Financing Administration (HCFA) as a result of OBRA '87 has been successfully implemented on a national basis.

As a refinement to the process, the federal government has now developed a national system for computerization and transmission of the RAI/MDS data from each resident to a national database. Effective June 22, 1998, all participating facilities are required to electronically transmit MDS data. The data goes first to the states, and then to HCFA for inclusion in the national database. Theoretically, this will permit the government to compile individual resident profiles, to link individual assessments longitudinally, and to monitor outcomes for both improvement and decline. Over time, the MDS data can also be used to develop performance standard norms. The ability to track individual and collective resident outcomes on a longitudinal basis will allow targeting of oversight resources on facilities providing less than optimal care. The RAI system with its "feedback loop" to providers, can also serve as one piece of an effective internal quality assurance program.

Implementation and computerization of the RAI/MDS must be considered a major step forward in assuring accurate and individualized assessment and care planning for all nursing facility residents. However, the current process is not yet perfect, with some MDS items requiring further refinement. In practice, despite a voluminous instruction manual, there are problems with inter-rater reliability and/or variability in how individual facilities interpret the MDS questions. HCFA has always characterized the RAI/MDS as evolutionary in nature and has continued to work toward the accomplishment of these and other refinements.

2. Highest Practicable Physical, Mental, and Psychosocial Well-being

OBRA '87 also placed nursing facilities in the unique position of the being the only health care provider to be mandated to guarantee specific resident or patient outcomes. Under requirements for both Resident Assessment (CFR 483.20) and Quality of Care (CFR 483.25), nursing facilities must "provide and assure that each resident receives the necessary care and services to attain and maintain [his/her] highest practicable physical, mental, and psychosocial well-being." The interpretive guidelines for these requirements (State Operations Manual Transmittals #10,) state that "Facilities must ensure that each resident obtains optimal improvement or does not deteriorate [within the limits of the resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process]."

This language not only assures that resident outcomes will be stressed as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status.

The focus on outcomes contained in the OBRA '87 nursing facility reform provisions has proved consistent with the increased emphasis on outcomes as a quality measure across provider types and health care settings. In this rising environment of managed care, the general trend for insurers and payers to want to know what they are getting for their dollars is one that has actually been written into statute for nursing facilities in the OBRA mandate for attainment of highest practicable well-being.

3. Incorporation of QIs into the Survey Process

Effective as of July 1999, HCFA has incorporated the use of eleven quality indicator (QI) domains into the long-term care oversight process. These QI domains are comprised of twenty-four indicators falling under the headings of accidents, behavior/emotional patterns, clinical management, cognitive patterns, elimination/incontinence, infection control, nutrition/eating, physical functioning, psychotropic drug use, quality of life, and skin care, and are currently being used to focus nursing facility surveys. The QIs were developed by the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin under contract with the Health Care Financing Administration (HCFA) and are based on the MDS 2.0.

4. Elimination of SNF/ICF Distinction

OBRA '87 eliminated staffing distinctions that existed between intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). This means that all nursing facilities are now required to have twenty-four hour licensed nursing staff. Facilities are also required to have a registered nurse on duty for at least eight hours a day, seven days a week.

In keeping with the statutory intent to focus on outcomes rather than process, the current Requirements for Participation for Long Term Care Facilities, promulgated as a result of OBRA '87, mandate that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident..."

When raising the staffing standards for all facilities to meet SNF requirements, one concern of Congress was that the result would be an inadequate supply of nursing personnel. In an effort to avoid imposing an unfair burden on nursing facilities, a provision for a waiver was included in the statute. However, in the interests of resident safety and welfare, certain qualifying criteria were also included. Under current regulations, requirements for licensed nursing may be waived under seven conditions: Among these seven are: (1) "the facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, to recruit appropriate personnel"; (2) "the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility"; and (3) "the State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility."

While there was some initial concern that numerous requests from nursing facilities for staffing waivers would be forthcoming, this situation has not materialized, and few, if any, waivers have in fact been granted. The future of this status cannot be assured, however, and facilities may find themselves in the position of being forced to make these requests. Today, at least the state of Wisconsin is experiencing an acute shortage of professional nurses. Despite the fact that Good Shepherd's documentation system is completely automated and efficient, in the last six months, several of our nurses have left long term care because of the stress related to excess paperwork and low industry wages.

5. Nurse Aide Training

In developing the nursing home quality of care provisions, Congress also recognized the magnitude of care provided by nurse aides. Nurse aides employed by nursing facilities are required to meet minimum training and competency evaluation requirements that do not apply to other health care settings. Facilities are prohibited from using any individual as a nurse aide for more than four months on a full-time basis, unless that individual has successfully completed at least a 75-hour training and competency evaluation program, or a competency evaluation program, approved by the State. HCFA's final rule on nurse aide training, published in the Federal Register on September 26, 1991, included a core curriculum with required training in such areas as: infection control; communication and interpersonal skills; safety and emergency procedures; promoting resident independence and respecting resident rights; basic nursing skills; caring for the resident's environment; and personal care skills.

Impact of OBRA '87

Since the implementation of OBRA '87 and the resulting federal regulations, several studies have found significant improvements in quality of care and resident outcomes in nursing facilities, including reductions in the use of psychotropic drugs and physical restraints. A 1995 study funded by the Health Care Financing Administration found significant reductions in decline [and need for assistance] among residents in such areas as activities of daily living, bathing dressing, locomotion, toileting, transferring, and eating. The study also found a 26% decrease in hospitalizations among nursing home residents. This reduction reflects not only increased resident well-being, but also a positive impact on Medicare expenditures, yielding an estimated savings to the Medicare program in hospital costs alone of more than \$2 billion per year in 1992 dollars.

AAHSA supported the passage and implementation of OBRA. We were one of the initial members of the Campaign for Quality Care, the coalition of organizations coordinated by the National Citizens' Coalition for Nursing Home Reform, that worked to reach consensus on twelve key areas of nursing home reform. Throughout the phase-in of nursing home reform, AAHSA has continued to serve on various committees and workgroups convened by the Health Care Financing Administration to work toward a reasonable and equitable implementation of the regulations and

interpretive guidance resulting from the OBRA requirements. As a national association we have remained an advocate for the presence of these federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of their existence.

Outcomes vs. Staffing Ratios

Both the provider and consumer communities have long supported the shift from process to outcomes as a means of assessing quality of care. Any attempt to assure the provision of optimal care based on mandated nurse staffing ratios would defeat all of the efforts that have been made within both the legislative and regulatory arenas to achieve this goal. Additionally, any assumptions of quality based on numbers of nursing staff and nursing hours rather than on efficient use of nursing staff and resident outcomes is simplistic and potentially deceptive.

First, while too little staffing is certainly likely to lead to poor outcomes, there has never been any proven correlation between higher staffing levels and the guarantee of positive outcomes. Second, inherent in any mandate for staffing ratios is the danger that the minimum will become the maximum. This scenario is even more likely in the managed care environment and the accompanying climate of cost containment.

Finally, a mandate for nurse staffing ratios discounts the growing role of technology in nursing facilities. One example that can be cited from the past is the mechanical lift. Prior to its implementation, two nurses or nurse aides were required to lift one resident. With the new lifts available today, one nurse or aide can perform the task, cutting the number of required staff by half. This raises the question of whether staffing ratios would have to be recalculated every time a new mode of technology is developed that can substitute for, and possibly perform better than, human intervention.

OBRA '87 and the Federal regulatory system already assure adequate protection for residents through requirements that facilities "have sufficient nursing staff...." as noted above. Failure to comply with these requirements subjects nursing facilities to State and Federal enforcement actions. Any further specification of staffing numbers or ratios is excessive and undermines the focus on resident outcomes as an effective barometer of care.

The Changing Environment of Nursing Facilities

The OBRA '87 nursing facility reform amendments were primarily designed to ensure the provision of quality care to the chronically ill, elderly "long-stay" resident such as those individuals with Alzheimer's disease and related dementias. While the need to assure optimal care to these residents certainly remains, the years since the passage of OBRA '87 have seen significant change in the residents served in our organizations. Today, nursing home providers also serve a new "constituency". These are individuals who are patients, not residents, who are younger, and who are admitted for short-stay or transitional services such as post-acute or sub-acute care, intensive rehabilitation

services, hospice, and respite care. This population shift has dramatically affected the operations of many of our homes. The length of stay for individuals has dramatically declined, but the paperwork and staff time required by the Medicare PPS (prospective payment system) system has multiplied. In the first six months of 1998, prior to implementation of PPS, the staff at Good Shepherd conducted 46 MDS assessments on our Medicare population. During the same time period this year with PPS, our staff completed 124 assessments. The average RAI assessment takes approximately four hours to complete.

The need to effectively respond to the varying intensity of care required by these patients and residents through different levels of staffing has already become evident to nursing facilities. The ongoing ability for facilities to determine staffing ratios based on acuity levels and case mix will become even more pronounced as these changing populations continue to increase. The establishment of minimum staffing levels in the present environment is likely to result in maximums that will be insufficient in years to come. Additionally, since best practices for these different specializations are just emerging, particularly for the care of Alzheimer's residents, the dictating of any type of model staffing level at this point in time would be extremely premature.

Nursing Education

Traditionally, nursing students have received little training geared specifically toward the care of geriatric patients. AAHSA has long supported efforts to increase academic awareness and opportunities for nursing experience in long term care settings. We have emphasized that nursing education and training must be designed to include care of the very frail and elderly as an integral component of the curriculum.

AAHSA has encouraged our nursing home members to open their doors to nursing schools and to offer opportunities for rotation through their facilities. We have also supported the concept of career ladders for nursing assistants to enter the field of professional nursing. Since 1989 the Association has, under a grant from the Patient Care Division of Proctor and Gamble, sponsored an annual scholarship program for nursing assistants to become RNs or LPNs. In addition, we have many nursing facility members who have independently developed scholarship or tuition assistance programs to enable nurse aides under their employ to become registered (RNs) or licensed practical nurses (LPNs).

AAHSA believes that further demonstrations at the federal level should create opportunities for exposure and entry of nurses into the field of long term care. Such actions could include the initiation of long term care nursing demonstration projects under the auspices of the Public Health Service, Bureau of Health Professions, Nursing Division, to support the development of innovative curriculum for nursing students that would include rotation through facilities. Another recommendation would be that the Federal government earmark loans with forgiveness programs for nurses who enter long term care as a field of practice. Such projects would serve to increase awareness of the long term care nursing experience for both individuals and educational

institutions, motivate entry into nursing facility care as a field of practice, and ultimately enhance the quality of care being provided to the residents of these facilities.

Specialized Training

AAHSA has developed a proposal to help alleviate the problem of staff shortages, particularly, at mealtimes [See attached]. We continue to support nurse aide training and competency evaluation programs for nursing assistants. However, in the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents, either by personal choice or as an integral part of their job. Permitting these individuals to perform tasks determined to be non-nursing-related may offer some relief to the nursing assistant shortage.

Three areas of potential non-nursing employee assistance have been identified. Assistance with dining is probably the most frequently cited of these areas. The others are transporting and mobility, and activities. Examples include a dietary aide who might be permitted to help residents cut their food and eat birthday cake at a party, or office personnel and activity assistants who might assist with transferring during a special event or outing. Special outings and social events are the most commonly cited examples of need for use of non-nursing personnel contact with residents. However, if permitted, some employees or senior volunteers may also choose to use their lunch hour to help in the dining room, or housekeeping staff may respond to a resident request to push a wheelchair.

The ability for non-nursing employees to provide assistance would be based on the needs and potential risks to the individual, as identified in the comprehensive assessment and determined by the licensed nurse responsible for the resident. For example, feeding a resident with a swallowing problem would be considered nursing-related, while assisting an alert and competent resident with a paralyzed or immobilized arm would not. Personnel and volunteers performing non-nursing-related tasks would be required to complete relevant in-service training approved by the regulatory authority and demonstrate competence in the duties assigned.

WELLSPRING

Since the passage of OBRA'87, the Federal/State oversight process for nursing facilities has been moving toward greater use of data and internal quality assurance and outcome measures. The quality indicators have been incorporated into the survey process. As a result, "feedback reports" are available that provide facility specific comparative data and the QI status of every resident. The critical question becomes how to use the data. AAHSA believes that one of the most innovative CQI processes have been instituted by an alliance of facilities in Wisconsin.

Today, I would like to speak to you about the process that has been implemented at Good Shepherd through our Wellspring alliance. Wellspring was founded in 1995 and

is currently an alliance of 11 independent elder care facilities, located in eastern Wisconsin. The facilities are characterized by an entrepreneurial spirit, zeal for improving the life and care of residents, and a willingness to entirely cooperate and collaborate with each other. These facilities range in size from a 63-bed skilled nursing facility to a 415 bed long-term care home, which is part of a continuing care campus. In addition, Wellspring members offer an array of facilities and services to their respective communities.

Wellspring has integrated the federal quality indicators, best practices and a new management paradigm to dramatically improve resident outcomes and cost efficiency. Fundamental to the Wellspring program is the concept that the definition of quality care is created by top management, but that the best decisions about how the care is delivered to each resident are made by the front-line staff who know the residents best. This empowerment is achieved through extensive line staff education in the form of "care resource teams", shared decision-making and enhancing critical thinking skills of all staff. The program is lead by a geriatric nurse consultant who utilizes other clinical experts for teaching best practices.

Wellspring has integrated quality monitoring pathway tools, which are used to investigate the QI report in order to determine if there is really a problem with resident care. The current QIs are merely markers or flags that may indicate potential problems with care. The true key to providing sustainable quality care is teaching line staff critical thinking techniques which are used to investigate the reports, collect relevant data and finally implement processes that improve quality.

Group process is central to Wellspring. The shift from traditional autocratic management structure to staff empowerment where line staff have equal responsibility for resident outcomes is what has made Wellspring unique. Key components at Good Shepherd have been establishing permanent staff assignments to groups of residents and allowing staff to do their own scheduling.

As a result of this process, Good Shepherd has consistently achieved a 98% resident/family satisfaction. Despite a 2% unemployment rate in Wisconsin, our CNA turnover has been cut from 105% to less than 30% since implementation of Wellspring. Many staff have to drive 20 miles to our rural facility, but several times over the past three years, we have had a waiting list of CNA applicants. Staff retention has remained consistently high over the past four years as well. Good Shepherd completed its fourth consecutive perfect federal/state inspection in 1999.

Payment Systems

Reimbursement rates and policies for nursing facilities must also be considered in addressing the adequacy of nurse staffing and the viability of programs such as Wellspring. A 1988 report by the Commission on Nursing of the Department of Health and Human Services found that on average, registered nurses in nursing facilities earned 35 percent less than their hospital counterparts. Similar salary differentials

existed for licensed practical nurses, nurse aides, and other nursing personnel in the same area. Such disparities in salary levels for long term care staff are due, in large part, to inadequate Medicaid reimbursement rates and the Medicare cost limits that establish and restrict the amounts that can be reimbursed for the costs of nursing care.

With the positive national economy, we feel the crunch across our entire organization and not just in the nursing department. In our area, fast food restaurants have higher starting wages than many of our staff. Since as much as 70 percent of the cost of nursing facility care is attributable to staffing, such limits on reimbursable expenses continue to have a chilling effect on salaries. Nursing facilities are unable to offer wages competitive with other health care settings and the general market place.

Federal policy should assume more responsibility for assuring that State Medicaid programs be required to provide adequate payment for all costs of care to Medicaid residents, including nursing care. Consideration should also be given to increasing Medicare cost limits, specifically for nursing.

In addition, the negative public perception that is fostered through the media and sensational reports that focus only on the harmful incidents and occurrences in nursing facilities are demoralizing to front-line workers. We recognize and concur that these incidents are intolerable. However, the kind and compassionate care that is provided on a daily basis, in fact, in greater numbers than the horror stories, go without notice. Portraying the entire nursing home profession in a negative light is unfair to the many dedicated staff who work continuously to assure quality care to the residents they serve. Not only does this do a disservice to these individuals, it further and severely impedes our ability to recruit and retain competent, caring individuals. The long-range impact of "negative only publicity" on our organizations is essentially inestimable.

Conclusion

The measure of a nursing facility's ability to successfully meet its residents needs must be based on actual performance rather than on the potential capacity of the facility to provide appropriate services. AAHSA believes that the impetus provided by OBRA '87 to shift the focus from paper compliance to resident outcomes has gone a long way toward ensuring the provision of optimal quality care to all residents of skilled nursing facilities and nursing facilities.

AAHSA concurs with the efforts of both Congress to promote the attainment of positive outcomes through the study and assurance of the adequacy of nursing personnel in long-term care institutional settings. For nursing facilities, this goal can only be achieved through: (1) continued movement toward quality of care assessment based on resident outcomes rather than process; (2) ongoing efforts to define positive outcomes within the context of these populations; (3) maintenance of facilities' ability to achieve these outcomes by determining staffing needs and targeting resources based on the populations they serve; (4) the development of valid and reliable quality monitoring systems that incorporate not only clinical indicators, but also resident

perceptions and satisfaction; (5) the assurance of adequate reimbursement rates by State Medicaid programs and an increase in Medicare cost limits, specifically for staffing; and (6) by increasing academic awareness and opportunities for nursing experience in these long term care settings.

AAHSA urges the Committee to support these recommendations as a means of assuring adequate staffing and the provision of quality care to nursing facility residents. The establishment of mandated nurse staffing ratios can only serve to hinder rather than enhance the achievement of this goal.



ATTACHMENT

SPECIALIZED NURSE AIDE TRAINING FOR SPECIFIC FUNCTIONS

One of the key challenges faced by nursing facilities in assuring quality of life and care outcomes to residents is the ongoing shortage of nurse aides. Higher acuity levels among nursing facility residents as well as projected aging demographics point to a demand for paraprofessional staff in nursing facilities that will continue to escalate. Cornell University's Applied Gerontology Research reports that some 600,000 new nursing assistants will be needed within the next 10 years.

Current law defines a nurse aide as "any individual providing nursing or nursing-related services to residents in a skilled nursing facility or a nursing facility", and requires that nurse aides successfully complete a training and competency evaluation program. However, in the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents. Permitting these individuals to perform tasks determined to present little or no risk to the resident can offer some relief to the nurse aide shortage.

There are three areas where non-nursing employee assistance is most needed. These are feeding, transporting and mobility, and activities. Examples include a dietary aide who might be permitted to help residents eat birthday cake at a party, or office personnel and activity assistants who might assist with eating or transferring during a special event or outing. The ability to provide assistance would be based on the needs and potential risks to the resident, and personnel performing these tasks would be required to complete in-service training and demonstrate competence in the duties assigned.

RECOMMENDATION: Amend Sections 1819(b)(5) and 1919(b)(5) of the Act to include:

"(H) Non-Nursing Personnel Performing Limited Duties"

- (i) Nursing facilities may permit personnel other than nurse aides to perform tasks that are limited in scope and/or frequency without completing the NATCEP or CEP if they have acquired the necessary knowledge and skills through an inservice training program that has been reviewed and approved by the regulatory authority and have been found competent to perform their duties.
- (ii) The determination of ability to perform these tasks will be made by licensed nursing staff responsible for the resident based on the needs and potential risks to the resident as observed and documented in the comprehensive resident assessment.
- (iii) The facility will provide evidence that the professional nurse has assessed the resident to determine that his or her health status does not require a particular task to be performed by nursing personnel."

**STATEMENT OF MARY JO WESTPHAL, CERTIFIED NURSE AIDE,
GOOD SHEPHERD SERVICES, LTD., SEYMOUR, WI**

Ms. WESTPHAL. My name is Mary Jo Westphal. I am a certified nursing assistant, and I work at Good Shepherd Services in Seymour, WI. Thank you for the opportunity to speak before you today.

I have been a CNA for the past 16 years. I have worked at Good Shepherd for the past 5 years. As a CNA, my job is to dress and feed our residents and to ensure the best possible care for them. I have attended many seminars and have advanced training in my field. I enjoy my job very much, as well as my coworkers do. We concentrate on teamwork and team spirit. We believe in individualized care. We do for our residents what we would like to have done to ourselves. Without the elderly, we would not be here today.

With all of the negative publicity that is out there, this makes it a harder career choice for many. I would like to change that. I feel that Wellspring is a wonderful change, a change for the future, as well a change for the better. I work very hard to make a living, and I know that I can make more elsewhere, but I won't leave knowing I can make a difference in someone's life. I realize that the Government pays for care. Increasing this payment, will result in better education, wages and benefits for the workers, especially in the nonprofit facilities. We owe this to our residents in the health care field, especially nursing homes.

Here are a few differences in other homes compared to the Wellspring home:

At other homes, we were told what to do. With Wellspring, there is a team decision that are made between teams. They ask for our input about the care, and they listen to us.

At other homes, we have no part in the care planning for residents. That was the nurses' jobs. With Wellspring, we give the nurses information that is part of the care plan. We take care of our residents every day, and we know what their needs are.

At other homes, we rotated around the facility, and we didn't always know our residents very well. With Wellspring, we care for the same group of residents every day. We know them very well, and we know what their needs are almost before they do.

At other homes, the nurses and other staff were not allowed to socialize together. With Wellspring, we all have a part of a big team, and because we all work together, it makes the residents' lives better. There is no back-stabbing or gossip about one another.

At other homes, we were sometimes understaffed, and it was frustrating. With Wellspring, if someone calls in, we work together. We have a sister team that we rely on. Because we do our own scheduling, people seldom call in.

At the other home, we were told what to do; had no idea why we did it. With Wellspring, we get training. Just like the nurses in other departments, we know what to look for in our residents and what to do about it.

At other homes, we were not trusted with expensive equipment. During Wellspring, we are trained to use bladder scanners and other expensive equipment.

At the other homes, a lot of residents were incontinent. We have fewer incontinent residents, and we know what to do to prevent it.

At the other home, they didn't let friends work together. I guess they thought we'd have too much fun. Friends in Wellspring can and do work together. They know how to work well together and how to get along.

At other homes, departments didn't work together also. With Wellspring, all departments, not just nursing, are involved with Wellspring.

At the other home, we didn't have anyone to go to with questions about care and did not participate in any seminars or continuing education. With Wellspring, we can call one another at the other Wellspring facilities for help, and we also have a nurse practitioner with whom we can consult with. Staff care resource teams are made up throughout the facility and attend seminars on a regular basis.

Personally, I would like to see all nursing homes participate in Wellspring's concept, and I see what a difference nursing home life can be, not only for our staff, but for our residents.

Thank you. [Applause.]

STATEMENT OF LESLIE WILLIAMS, NURSING HOME ADMINISTRATOR, NHC HEALTHCARE OF MERRITT ISLAND, MERRITT ISLAND, FL, ON BEHALF OF THE FLORIDA HEALTH CARE ASSOCIATION

Ms. WILLIAMS. Senators, Congressmen and distinguished guests, good morning. My name is Leslie Williams. I have been a licensed nursing home administrator for 13 years. I began working in nursing homes when I was 16 years old. It was then that I knew a career in long-term care was my future. In college, I worked briefly as a nursing assistant, and I learned how hard, firsthand, this job is, both physically and emotionally.

At the age of 22, I became an administrator of my very first center, November 1987, in Winterhaven, FL. Since then, I have come to know some extraordinary people, people like Avis Gero. Let me tell you what life is like for Avis. Avis began her career in long-term care 11 years ago. As a nursing assistant, she works tirelessly, sometimes 7 days in a row, even pulling double shifts—16-hour days of caring for our patients.

Her day consists of being hit, kicked, pinched, punched, spit on, hugged, kissed and loved. She has her hands in things that are not mentionable in polite company. She puts up with administration and regulators critiquing her care, and then she comforts families as they watch their loved ones decline in health. She escorts rehabed patients to their waiting cars for the triumphant trip home.

After working this 16-hour day, she comes home to a husband who expects dinner, a grandchild who wants a playmate, and a house that must be cleaned. At midnight, she's put her family to bed, she's washed the dishes, and she sits down to watch some TV. Into her home comes the familiar face of the local attorney, "Is your loved one being abused and neglected in a nursing home?" This, all after 16 hours of devoting herself to her patients' needs.

The nurses and nursing assistants who touch these patients provide the special moments I just shared with you. These people have a heart for their job. Mandating numbers will not guarantee

hearts. You will get bodies, hands and feet, but your parents and grandparents need hearts. Assuming that a law dictating the number of bodies on my center on a daily basis will guarantee quality is a flawed concept. While it is logical that ten nursing assistants can get more done than six, give me six who love what they do, as opposed to ten who are collecting a paycheck. I'll take the six, and more importantly, so will my patients.

The nursing assistants are the backbone of our facility. They are our best recruiters. It is their testimonials that advertise our open positions. They even interview prospective employees. Who better to determine if someone has a heart for this work? You can't fool them. Best yet, these nursing assistants feel valued, appreciated and recognized for their knowledge and their talent.

When classified advertising didn't bring the hearts we needed, we decided to grow our own. My director of nursing developed a 2-week class to prepare potential nursing assistants to take the state exam. We worked with the Welfare-to-Work program in our county. Within 14 months, 78 nursing assistants passed their class and began a career in health care.

Now, to keep them once we have them, that is the next step. National Health Care Corporation has many programs that allow the corporation, the patients and their families to reward excellent patient caregivers through recognition and financial bonuses. In the first 3 years of this program, the company gave over \$12 million in additional monies to our staff. We work hard to keep the staff we have. Yet despite these efforts and more, there are not enough nursing assistants to fill our positions.

Florida has minimum staffing requirements. I meet them not because they are the law—I actually exceed them when at all possible—because those are the numbers my patients need. Each center varies in the type of patient they serve. My numbers may not work for the center in the next town. They may need more or they might need less. Florida law requires that I staff 51½ nurses and nursing assistants combined in a 24-hour period. My staffing budget calls for 66 direct caregivers, not administrative staff. Sadly, I cannot always find the 66 nursing staff we need.

Unfortunately, too often, nursing home staff are met with suspicion and disdain instead of the admiration and respect they deserve. We need to show our appreciation for people like Avis Gero. NHC HealthCare of Merritt Island appreciates Avis. We promoted her and provided her with extra training to perform her job. We have placed her in a mentoring role for new nursing assistants. She earns a little more money and has a little more status among her peers. Others can follow on this ladder, if they have the heart.

You can help me attract more like her. Set an example by demonstrating respect for her profession, the profession of long-term care. Value her work, her heart, work with us in a partnership to foster dignity, not disdain. You and I expect her to treat your parents, and grandparents and children with dignity and respect. Does she deserve any less?

Allocate additional funds for the employees of long-term care. Specify its use for salaries, not for the corporation, for the staff. Help those looking for a career aspire to serve in long-term care. Anyone can flip a burger, but it takes hearts to care for our Na-

tion's elderly. Be the leaders that change the value we place on our elders and those who care for them.

Quality, not quantity, will affect the well-being of our patients. Laws mandate bodies. Our patients deserve hearts. Providers are also patient advocates. We stand in agreement for those who desire high-quality care. We ask that those who seek higher staffing levels understand that there is more to the picture than simply hiring people. When a facility is shorthanded, this is not because the administrator or the company wants it to be that way. There must be qualified, caring people to hire. There must be money to pay for these people. Ten dollars never has and never will buy \$15 worth of groceries.

Having overseen the construction and opening of three long-term care facilities, I know firsthand that the phrase, "Build it, and they will come," does not apply in our situation. Recognize this industry and its employees for the valuable service they provide. Create a partnership with us to care. Remove the adversaries who make a living criminalizing our people.

Andy Adams, the president of NHC said it best, "You cannot punish your way to excellence." When these issues are acknowledged and changed, then and only then will the number of people required to care for you when you need a nursing home be available.

My written testimony includes specific initiatives that Governor Bush signed into law giving us real tools to better serve our patients. The point is our State is moving toward a partnership with us to make life better for our patients.

Thank you so much for the opportunity to testify at this forum. I look forward to working with you and our communities to keep staffing hearts to provide loving care for your parents and grandparents. [Applause.]

[The prepared statement of Ms. Williams follows:]

**Testimony of
Leslie Williams
on behalf of
The Florida Health Care Association
and
National Healthcare
before the
Senate Select Committee on Aging
Forum on
Nursing Home Staffing
November 3, 1999**

Senator Grassley, Senator Breaux, members and staff of the Senate Select Committee on Aging, Good morning. My name is Leslie Williams. I have been a licensed nursing home administrator for 13 years. The last 10 of those years, the staff of NHC HealthCare of Merritt Island and I have provided care for approximately 2000 patients in our Florida community.

I began working in nursing homes when I was sixteen years old. It was then that I knew a career in long-term care was my future. I initially thought about being a nurse, so I followed the 3-11 shift supervisor on rounds one night at the center where I was the evening receptionist. One round did it for me and I realized that my personality would not allow me to keep a job where I could not affect change rapidly without going through the "red tape". So with all the wisdom of a 16 year old, I decided to cut through the red tape and become the scissors - I would be the administrator.

This is where God began working an amazing plan for my life. I attended Milligan College, a small Christian liberal arts school in Johnson City, TN. My mother's parents lived there and I was fortunate to have them close through my college years. My grandparents were very special to me, and my parents placed great value on them and on all elders. My junior year of college required an internship and I shipped off to Phoenix, AZ, to work in a skilled nursing facility. That summer I rotated through all the departments of the facility, physically doing each job. I knew that I needed to have exposure to all aspects of the nursing home to be able to be a credible leader to the staff of my future center. I also worked as a Nursing Assistant to support myself financially. I made \$3.65 an hour! As it turns out, that part of my internship was the most valuable and rewarding. I returned to TN to complete my senior year and applied at a local nursing facility to work as anything. It happened to be a center owned by National HealthCare Corporation (NHC). The administrator at that center sent my application to home office and the next thing I knew, I was off to interview with the Vice Presidents for a job as an administrator in training. I was hired in September of 1986, finished school in December of 1986, became a licensed administrator in March of 1987 and received my very first center in November of 1987, in Winter Haven, FL - I was 22 years old.

I have since opened a 120 bed center in Merritt Island, opened an 85 bed unit Assisted Living Facility in Merritt Island, and added 60 beds to the original 120 in Merritt Island. All that in a total of 13 wonderful, challenging, stressful, jam-packed years. God has blessed me incredibly. That He has given me these opportunities and seen me through these years continues to humble me.

Making life worth living for the elderly in our care is what we are about. Delivering medical care is but a part of our responsibility. To assure that the world does not pass our patients by, we attempt to bring the world to them. We have a rule in our facility, if it is not illegal, unethical, or immoral and it costs less than \$100.00, every staff member is empowered to meet the request of the patients without having to seek anyone's permission. We have purchased, clothing, radios, kiwi fruit, Burger King Whoppers, pizza and even bag balm for one lady as she was certain that would help her sore joints. It is difficult to take elderly patients on a week long cruise, so we brought the cruise to them. This complete with ports of call throughout the world returning to Miami, home of Miami Vice's Don Johnson and his pet alligator who accompanied the medication cart on rounds. (The alligator that is, not Don). All patients were armed with water pistols. Katie Lyons age 92, particularly enjoyed using hers throughout the day. Unfortunately for me, this was the day our Vice President decided to come and tour our center. It was a "cleansing" experience for all.

Can you believe that some of our patients had never experienced a s'more? I couldn't, so one July fourth, we celebrated with a bonfire (with our county fire department on standby of course). The staff's children toasted marshmallows and we served them up on Hershey bars and graham crackers. What a sight to see Marie Shelton age 91 sticky with a marshmallow and chocolate smile. Memories can still be made at 90.

This, Senators is what makes a job, a life experience. The staff is the key – and the challenge. I appreciate that the Committee is looking into problems we face with finding and keeping Nursing Assistants. This must be a partnership seeking solutions. Neither the government nor long-term care providers can solve the problems we face working independently from each other. The Committee is looking at creating national minimum staffing requirements. As you look at that alternative, I ask that you consider three things:

Quality is not Quantity

The nurses and nursing assistants who touch these patients provide the special moments I've shared with you. These people have a heart for their job. Mandating numbers will not guarantee hearts. You'll get bodies, hands and feet, but your parents and grandparents need hearts. Assuming that a law dictating the number of bodies in my center on a daily basis will guarantee quality is a flawed concept. While it is logical that 10 nursing assistants can get more done than 6, give me 6 who love what they do as opposed to 10 who are collecting a check – I'll take the 6, more importantly, so will my patients. By mandating those 10, I may have to subcontract to an agency that supplies temporary help. They don't know my patients. They don't know that Mr. Regar has to have 2 sweet and lows in his tea with dinner, or that Mrs. Whitaker prefers to use her walker to get to the bathroom, not the wheelchair.

The nursing assistants are the backbone of our facility. We utilize them to assist us with recruiting. It's their testimonials that advertise our open positions, they are the contacts to reach for more information. They even interview prospective employees. Who better to determine if someone has a heart for this work – you can't fool them. Best yet, these nursing assistants feel valued, appreciated, and recognized for their knowledge and talent.

When classified advertising didn't bring the hearts we needed, we decided to grow our own. My Director of Nursing developed a two week class to prepare potential nursing assistants to challenge the state exam. We worked with the Welfare to Work program in our county. Within 14 months 78 nursing assistants passed their class and began a career in healthcare.

Now, to keep them once we have them. That is the next step. National Healthcare Corporation has many programs to recognize and reward excellence in quality patient care. The Presidential Excellence Program encourages patients, families, and staff to recognize the special, over and above efforts of our staff. The facility rewards this recognition with monetary bonuses and public acknowledgment of their actions. The Partners in Excellence plan awards bonuses to all staff who have assisted the center in achieving goals in patient care. Twelve million dollars was given to employees in the first three years of the program. (Sadly, the Medicare Prospective Payment System has forced the company to reduce the money available for that program, however, it does still exist). The annual Partner Appreciation Banquet honors staff who are nominated by their peers for excellent service. They attend a regional banquet and enjoy a special day of awards and recognition hosted by corporate officials. We work hard to keep the staff we have. Yet despite these efforts and more, there aren't enough nursing assistants to fill our positions.

Staff to Meet the Patients Needs

FL has minimum staffing requirements. I meet them, but not because they are the law. I actually exceed them when at all possible, because those are the numbers my patients need. Each center varies in the level of care it delivers and the type of patient they serve. My numbers may not work for the center in the next town. They may need more or less. Florida law requires that I staff 51.5 nurses and nursing assistants combined in a 24 hour period. Given my patient mix right now, my staffing budget asks for 66 direct care givers – NOT administrative staff. Do I meet this budget every day, sadly no. You can help me with this, allow me to tell you how.

Respect and Professionalism

There is a shortage of people who desire to serve in long-term care. One of the major contributing factors for that is respect – rather the lack of it. Why should people chose long-term care as a career? The responses I receive when I am asked what I do for a living may give you some insight. “Oh, you work in a nursing home – I’m sorry, ‘Isn’t that depressing?”. Or the worst yet, just an immediate response with body language communicating suspicion and disdain. Can you imagine how a nursing assistant feels? Avis Gero began her career in long-term care as a housekeeper 11 years ago. She so enjoyed being with the patients, she decided to become a nursing assistant. She works tirelessly, sometimes 7 days in a row, even pulling double shifts – 16 hour days of caring for our patients. Her day consists of being hit, kicked, pinched, spit on...hugged, kissed and loved. She has her hands in things that are not mentionable in polite company. She puts up with administration and regulators critiquing her care, then comforts families as they watch their loved ones decline in health. She escorts rehabed patients to their waiting cars for the triumphant trip home. After working this 16 hour day, she comes home to a husband who expects dinner, a grandchild who wants a playmate, and a house that must be cleaned. At midnight she has put her family to bed, washed the dishes and sits down to watch some TV. Into her home comes the familiar face of the local attorney....“Is your loved one being abused or neglected in a nursing home?”.....She flips the channel to a late night news broadcast and sees our Secretary of Health and Human Services telling the nation that good or bad, all nursing homes need to be watched like a hawk. – SHE, Avis, needs to be watched like a hawk. This all after 16 hours of devoting herself to her patients needs. Why should she return to work the next morning? Would you?

NHC HealthCare of Merritt Island has made Avis a level 3 nursing assistant. She has climbed our internal career ladder. She earns a little more money and has status among her peers. We’ve given her some extra training to perform her job and have placed her in a mentoring role for new nursing assistants. Those who desire can follow on this ladder – if they have the heart. You can help keep Avis encouraged to stay in her job. You can help me attract more like her. Set an example by demonstrating respect for her profession – the profession of long-term care. Value her work, her heart. Work with us in a partnership to foster dignity, not despair. You and I expect her to treat your parents and grandparents with dignity and respect, does she deserve any less? Allocate reimbursement for the employees of long-term care – specify its use for salaries, not the corporation – for the staff. Help those looking for a career aspire to serve in long-term care. Anyone can flip a burger, it takes hearts to care for our nation’s elderly. Be the leaders that change the value we place on our elders and those who care for them.

Quality not quantity will affect the well being of our patients. Laws mandate bodies, our patients deserve hearts. Providers are also patient advocates. We stand in agreement with those who desire high quality care. We ask that those who seek higher staffing levels understand that there is more to the picture than simply hiring more people. When a facility is “shorthanded” this is not because the administrator or the company decided it should be that way. There must be qualified, caring people to hire! There must be money to pay for these people. Ten dollars never has and never will buy fifteen dollars worth of groceries. Having overseen the construction and opening of three long term care facilities, I know firsthand that the phrase, “build it and they will come” does not apply to our situation. Recognize this industry and it’s employees for the valuable service they provide. Create a partnership with us to care. Remove the adversaries who make a living criminalizing our people. Andy Adams, the president of NHC said it best, “you cannot punish your way to excellence”. When these issues are acknowledged and changed, then and only then will the number of people required to care for you when you need a nursing home be available:

I ask the Committee to look to Florida and what the legislature and our Agency for Health Care Administration are doing to improve the environment for those working and living

in nursing homes. Last May, the Governor signed a bill into law that gave us real tools to better serve our patients. It included:

- Creation of a "gold seal" program to recognize exceptional nursing homes that provide innovative care.
- Registered Nurse Monitors employed by the state to work cooperatively with nursing homes to address issues before they become problems.
- Creation of a pilot teaching nursing home project.
- Additional funding that can only be used to recruit and retain nursing staff.

There are many other parts of the law and Agency initiatives that time does not allow me to go into. The point is that our state is moving toward a partnership with us to make life better for our patients.

Thank you so much for the opportunity to testify at this forum. We face a tremendous challenge in staffing hearts to provide loving care for your parents and grandparents. I look forward to a cooperative effort with you and our communities to raise awareness of our needs. I stand ready to work with you on achieving this goal.

STATEMENT OF JUDITH A. RYAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, SIOUX FALLS, SOUTH DAKOTA, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Dr. RYAN. Good morning, Senators, Congresspersons, members of this audience, members of the panel. My name is Judy Ryan, and I am president and chief executive officer of The Evangelical Lutheran Good Samaritan Society. The Society serves in little, tiny communities in 25 states in this country and collectively cares for some 27,000 residents. So it has been almost in spite of ourselves that we have become one of the largest not-for-profit providers in the country. I speak, also, this morning on behalf of the American Health Care Association.

Over these past several months, I have spent concentrated time in more than 80 of our nursing centers, including 1 week in which I worked alongside our front-line caregivers. I would say I worked as a certified nursing assistant, except it has been almost 10 years since I have been in direct nursing practice, and I could not do it. I had to work aside our certified nursing assistants, and as we have heard today, the work of caregiving is demanding intellectually, physically and emotionally. It's also very rewarding.

The three essential issues that the long-term care community believes must be carefully considered in any policy decisions related to staffing are these: First of all, access to nursing staff; second, the major issue of funding for adequate staffing; and, third, agreement on the development of methods whereby we can staff based on resident need.

Within the Good Samaritan Society, turnover amongst our nursing assistants in 1998 was 77 percent. However, when we looked deeper into those statistics, we learned that we have a very stable core of certified nursing assistants and that many of our assistants have worked with us for 25 years, 29 years, 13 years, shift-by-shift. However, our turnover amongst our new staff was extremely high. Therefore, we have launched a series of initiatives in which we are working closely with our core front-line staff to develop strategies to recruit and retain new caregivers. We have made a tremendous investment in front-line training through technology. We have a distance learning network in which we are hooked up both by satellite, by phone and by data systems so that we can work to bring education to our caregivers on the sites in which they are delivering care.

Our senior managers are now required to spend 2 days each year to work directly with caregivers so that we better understand the nature of the role in the front lines. We are working with community advisory boards that exist in each of our facilities and with the community to help explain the story of the quality of our care and our work environment to those whom we serve.

We conduct bedside memorial services for our staff who are grappling with grief and sense of loss when they lose a resident for whom they have cared intimately for many years. We are working very directly with our certified nursing assistants in our quality assurance and quality improvement teams, respecting their knowledge of care and questions and suggestions for improvement of care. And we have also become self-insured for health benefits. We

are creating, together with our vendor partners, a lift-free environment so that there is technology there to help the caregivers. We have led in some efforts in states to suggest, and introduce and been active in the passage of pass-through legislation in the Medicaid payment systems for salaries.

We serve primarily in small deeply rural settings. The numbers of old, old—those over 85—are disproportionately high in those communities. Old women are being cared for by old women. We have CNAs still actively employed who are 79 years old, and we have volunteers in their late 80's serving in senior companion roles very commonly. In spite of all of those efforts, we do not have access to the number of front-line caregivers we need. This is problem No. 1.

Problem No. 2, closely related to problem No. 3, is the issue of payment. Nearly 80 percent of residents of nursing facilities rely on Medicaid and Medicare to pay for their care. Those payment systems fall short of the cost of care, and they are simply not sufficient to enable us to pay competitive salaries to our caregivers.

A society is judged by the way in which we care for our children and our elders. Neither the welfare system, the Medicaid system nor the Medicare system were designed to pay for long-term care. The welfare system was to be a safety net, Medicare was to pay for episodes of medical care and all of the rest of the care we are talking about here today falls between the cracks.

I would like to reference two charts, and we have tried to make them big enough so this whole audience can see. The charts are facility specific. The first is our 67-bed facility in Denton, TX. The red line at the bottom is the level at which Medicaid pays in the State of Texas. That payment is to include pass-through for staffing salaries. The black line at the top is our best attempt to take the HCFA guidelines for the RUG payments and to say that if we were looking at a severity-adjusted staffing standard, that's where we would like to pay. And the line which varies from month to month, is the direct nursing care hours that we have been able to provide in that facility.

If we were to set staffing standards, not as high, Charlene, as you even suggested, but at the level that the HCFA severity adjustment criteria would suggest, our loss in one 67-bed facility in 1 year would be \$260,000. We are trying to figure out how across the whole Society we can absorb that cost, because we are staffing at the level depicted here.

Let me show you one other case. That is a similar-size facility, 67 beds, in a different state, Tripp, SD. You will note that in South Dakota, the Medicaid payment levels are higher. What we would suggest might be the HCFA standard is the top line, and you see that our staffing levels do not approach that standard.

I wanted to show you data from this particular facility because this facility has had five deficiency-free surveys and, in fact, HCFA used its look-behind authority to come out with five top-level HCFA surveyors, who spent 5 days in this 67-bed facility, to try to see whether it was some kind of a political accident that we had repeatedly achieved deficiency-free surveys.

When they left, we had two deficiencies. One was that we were not sufficiently encouraging our residents to eat autonomously in

the dining room, and the second that one of our residents had suffered weight loss of seven pounds when going on enteral therapies. And when they left, they said, "You are one of the best facilities we have ever been in."

Tripp, SD is a small town. Our staff know the residents. We have had generations of caregivers who have served there. My point is this. An arbitrary staffing standard itself is not sufficient to assure quality.

In conclusion, it is just so important that we face these three challenges together: First, recruiting persons into these wonderful caregiver roles; second, as a society, deciding that we are going to fund long-term care, and that we have the political will to engage in that debate and the political will to sustain that dialog until we get it done this time; and, finally, that we develop methods which make sure that we are staffing to meet resident need.

I believe that all of us, providers, residents, consumer advocates, regulators and policymakers must work together toward thoughtful solutions directed explicitly to benefit those residents that we serve. The residents that we serve depend on us to cooperate in that way.

Thank you very much. [Applause.]

[The prepared statement of Ms. Ryan follows.]



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Written Statement

of

Judith A. Ryan, President and Chief Executive Officer

The Evangelical Lutheran Good Samaritan Society

on behalf of the

AMERICAN HEALTH CARE ASSOCIATION

before the

SENATE SPECIAL COMMITTEE ON AGING

Forum on Nursing Home Staffing

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November 3rd, 1999

Good morning Senators, panel members and ladies and gentlemen in the audience. My name is Judith Ryan, and I am the President and CEO of The Evangelical Lutheran Good Samaritan Society. The Society has been caring for our frail elderly and disabled citizens for more than 78 years. As a registered nurse and former Executive Director of the American Nurses Association, I know as well as anyone, the direct relationship between nursing staff and the quality of care, and I grapple everyday with what can only be characterized as a major crisis for our profession. That crisis is caused by a confluence of circumstances that have struck the nursing home community with a devastating force.

I am here today as a representative of the American Health Care Association, a federation of state associations representing over 12,000 non-profit and for-profit assisted living, nursing facility, and sub-acute providers nationally.

Over these past several months, I have spent concentrated time in more than 80 of our nursing centers, including one week working alongside our CNA's and front line staff caring for residents. I know from direct experience that the individuals we entrust to care for our parents and loved ones spend their days in what are among the hardest jobs in the American workforce. The work of caregiving is demanding both physically and emotionally. The residents in today's nursing facilities require a range of care from complex medical treatment to support with daily activities, to specialized approaches in the management of dementia. Our professional and compassionate commitment needs to remain focused on helping our residents age with optimal function and dignity.

Unfortunately, negative nursing home images created, particularly in this past year, have served to enhance society's lack of recognition for the value of our elderly's most precious resource; those who care for them. If we can agree on that, then we can begin to work together.

Together, government, advocates, and providers must recognize their individual and collective responsibility to ensure adequate numbers of qualified and competent staff to care for our residents. We must agree to stop the vilification of nursing homes, and we must agree to use the regulatory system to help caregivers find ways to improve the quality of care rather than to add non-value-added cost and the burden of fear to their already difficult work.

Care providers today

The face of nursing facilities looks very different in 1999 than it did ten years ago and promises to change even more dramatically in the future as 77 million baby boomers prepare to retire. Today, a nursing facility is no longer just a building that provides a homelike setting in which the elderly, needing assistance with their activities of daily living, reside. In 1999, nursing facilities provide a vast array of services to a very diversified population of health care clients.

Patients and residents cover the entire age spectrum from children to adults to the frail elderly. They enter the nursing facility with diagnoses, clinical conditions and care needs

which range from ventilator dependency to intensive rehabilitation post stroke to need for specialized dementia management, as well as the more traditional need for assistance with routine functions of daily living.

We should all agree that adequate staffing means being responsive to the individualized needs of residents. This need differs from resident population to resident population and from facility to facility. I have described below the three essential issues that the long term care community believes must be carefully considered in any policy decisions related to staffing: access to and availability of nursing staff, sufficient payment to support adequate staffing, and facility-specific or patient population specific staffing standards based on resident acuity or need for care.

Access and Availability of Nursing Staff

Staffing shortages are prevalent across the nation and across health care settings. Shortages exist for the registered nurse (RN), licensed practical nurse (LPN) and certified nursing assistant (CNA). For example:

Licensed Nurses- (Registered Nurses and Licensed Practical Nurses)

- The average RN is now 42 years old in the acute care setting and 45 in the nursing home setting. At the same time, nursing school enrollments decreased 17% in the past four years. As larger numbers of nurses retire, there will be fewer newcomers to take their place and the competition will be “fierce” across all levels.
- In 1999 we have seen nurses at all levels giving up their jobs in nursing facilities because of the image of nursing facilities and the implied message that they are not doing a good or important job.
- Additional health care settings are emerging to meet the needs of specialized elder care. Therefore, the demand for nursing staff continues to grow as the supply diminishes.
- Elderly patients account for more than 80 percent of health care in all settings, and nursing educational programs are not adequately preparing students for their care. 60% of the nursing programs have no full-time faculty members with ANA certification in gerontology. This discourages new nurses from being exposed to the long-term care setting and the issues we face.

Certified Nursing Assistants

Within the Good Samaritan Society, turnover among all employees was 54% in 1998. Turnover of CNA's was 77%. When we looked deeper into our statistics, we learned that we have a very stable core of Certified Nursing Assistants. Many of them have served with the Society for more than 25 years. However, our turnover among new staff was extremely high. We are, therefore, working closely with our core staff to develop strategies to recruit and retain new caregivers.

- Senior managers are required to spend two days each year working directly with caregivers, so that we better understand the work in which our staff are engaged and experience the mission of the Society in the field.
- We have enlisted the help of Resident Councils and Community Advisory Councils at each of our facilities in identifying potential sources of new staff, confident that those who know us best know about the quality of our care and work environment.
- We have made a tremendous investment in learning resources, focusing first on mandatory skills and knowledge requirements that are work related, but moving quickly into life skills development and opportunity to gain academic and professional credentials. For example, in one facility we are teaching a certified course in Women's Survival Skills, a curriculum developed by women who have moved off welfare and into the work force for those aspiring to do the same.
- We are working with our front line staff to develop orientation programs for new recruits, including mentoring programs, preceptor programs, 'buddy' systems, and staff involvement in early resident assignments of new staff.
- We are paying the full cost of certification and continuing education—in many cases, on Society time.
- The Society has taken leadership in introducing 'pass through' legislation for wages and salaries within state Medicaid payment statutes.
- We conduct bedside memorial services as one means of helping staff deal with their sense of grief and loss following the death of a resident
- We are more directly involving CNA's in our quality assurance and improvement teams, respecting their knowledge of the resident's care needs and ways in which we might improve the quality of that care
- We are providing Spanish as a Second Language courses in our facilities in which most of our residents and staff are Hispanic
- We have created a 'Fall Prevention Unit', to which residents at high risk are assigned, and on which CNA's are assigned to spend individual time with these residents, reading with them, listening to their stories, etc.
- We are supporting unique programs that address the disadvantaged population, e.g., use of the Work Opportunity Tax Credit and CNA training programs that recruit new immigrants and provide specialized educational needs.
- And, we are working to obtain adequate Medicaid reimbursement to meet the level of staffing necessary to meet the individualized needs of the residents.

The Evangelical Lutheran Good Samaritan Society serves primarily in small, deeply rural settings. The numbers of old, old are disproportionately high in these areas. Old women are being cared for by old women. We have CNA's still actively employed who are 79 years old; and volunteers in their late 80ies serving in senior companion roles are very common.

Wives in many of these rural families are working, caring for children, and caring for older parents. Children in these communities are leaving home for college and for work in urban areas. We do not have access to the numbers of front line caregivers we need.

The profound impact of the growth of the aging population, the lowest unemployment rate in 29 years, with 2 in 5 American's literacy at or below 8th grade, in which new immigrants make up 1/2 the US workforce increase, and in which 3 of 4 couples both spouses are employed, 62% of moms with kids under age 3 are employed and only 50% of men, 55-64, are still in the labor force, providers, advocates and citizens must be willing to 'think outside of the box' about staffing in nursing homes.

Perhaps the most creative things we are doing to address the access issues include:

We are working with a high school in Howard South Dakota, through a grant provided by the Annenberg Foundation to secondary education, to redesign what the rural community of the future should look like, and specifically, how such a community would envision caring for its elders.

We are partnering with community colleges and state universities to bring formal education opportunities into the rural community through distance learning

We have moved into a self-insurance program for health benefits, stressing access to primary care for children and young adults and access to employee assistance services.

Reimbursement must support adequate staffing

Medicaid is the primary source of funding for nearly 68% of all nursing facility residents. Another 9% rely on Medicare. Only 3% of nursing facility residents are covered by private insurance. Since 1989, nursing facilities share of Medicaid and Medicare dollars have been dwindling.

In addition, the repeal of the Boren Amendment gives states more flexibility to reduce reimbursement rates and limit payment increases. Under Boren, state Medicaid payments to nursing facilities had to be "reasonable and adequate to meet the cost of efficiently and economically operated facilities." Since repeal, many states have sought to lower their payment rates and several have succeeded. More common still, are the lack of payment adjustments as inflation and other costs of care increase. This lack of payment guarantees will make it easier for states to reduce Medicaid reimbursement rates, which will result in limited payment for labor cost.

Simultaneously, the new Medicare PPS has been demonstrated to significantly under pay for the cost of care in several high acuity and rehabilitative categories. This reduction in Medicare revenues places additional pressure on the already under funded Medicaid program and limits a SNFs financial ability to provide necessary wage and staffing increases.

The fundamental goal of a case mix payment system is to adjust the providers' revenues to reflect the residents' changing needs for services or care. With regard to the staffing issue, it becomes critical that the fundamental goal of a sound payment system is not sacrificed by Medicare and Medicaid budgetary constraints as opposed to meeting resident needs.

There should be no discussion of mandated increases in staffing levels without simultaneous discussion of funding additional mandated staff.

Determining Staffing Levels

There is not one staffing level (or even minimum ratio) that is appropriate for all nursing facilities. But there is one level appropriate for each resident population and perhaps, facility. It is essential that any mandated staffing standards be determined based upon the needs of the residents in that particular facility during a specified time.

One way to determine the case-mix and acuity level in facilities is through use of the Minimum Data Set (MDS). The MDS has been utilized to generate Quality Indicators (QIs) which will measure outcomes and quality in nursing facilities. Hopefully, these quality indicators will provide a linkage between quality of care and adequate staffing. By tracking resident characteristics and needs through the MDS, facilities are able to anticipate staffing needs and keep them continually up to date and in line with their needs.

Examples of The Evangelical Lutheran Good Samaritan Society's process for self-regulation of staffing standards are described on the charts appended. The median total direct nursing hours are plotted against Medicaid payments for that facility's resident populations, as are those staffing levels suggested by HCFA's criteria for the RUGS. As you can see, the Society is funding levels of staff well above the Medicaid payments, which account for 62% of our residents. If arbitrary staffing standards were set at the levels HCFA criteria might suggest, one of these 67 bed facilities would have an annual funding shortfall of \$178,379; the other facility, of the same size, would lose \$260,669. We do not have the capability to sustain these costs.

But we must get serious about solving these problems at once. The current debate over minimum staffing ratios is not the answer. The single most important factor that must be considered in setting staffing levels is the clinical and personal needs of the residents. The consumer advocate's ratio argument completely disregards the needs of residents, and hence would be completely inappropriate in most facilities.

But let's assume for a minute that ratios were put in place regardless of merit. Would nursing homes be able to meet those ratios? No, they would not. A sufficient pool of qualified and employable people to meet the current need simply does not exist today.

But for the sake of argument, let's assume there is no drastic labor shortage. If there is no shortage, and we start our employees at a higher competitive wage (enough to recruit and retain against privately funded market competitors) where would this money come from? As I noted, the Government pays for nearly 80% of all nursing home residents, and only 3% are paid by private insurance. There is not room for cost shifting in the nursing home equation. Will state and Federal governments meet their responsibilities to increase payments? Not likely -- in fact the trend is the opposite. With the new PPS and the repeal of the Boren amendment, we now have fewer guarantees that payment rates will meet the cost of care. We estimate the cost of paying for the staff for even the minimum NCCNHR ratio would be over \$6 billion every year.

But let's again assume the government does live up to its responsibility to provide adequate resources, then, what is the most logical and efficient way to determine appropriate staffing levels? Is it the establishment of minimums without underlying data to tie them to need? No it is not. The most appropriate and efficient way to determine staffing levels is to staff to the level of acuity or need as determined by the clinical and psychosocial needs of the residents in each facility.

Why then, if we are not willing to address the first two barriers to solving this problem, should we move immediately to demanding an inappropriate and unreachable staffing ratio of providers? Those of us who work on the front lines of caregiving know all too well that this is not a workable solution. Fully funded staffing at the appropriate level for the acuity of the residents in each facility is the only intelligent solution. Even this will not be possible unless we address the labor shortage and payment issues.

So, as I see it, the staffing crisis must be addressed in three sequential steps. First we must find creative ways to increase the labor pool. Second we must link adequate payment to appropriate staffing. And third, we must develop appropriate and attainable staffing standards based upon the needs of the residents in each facility.

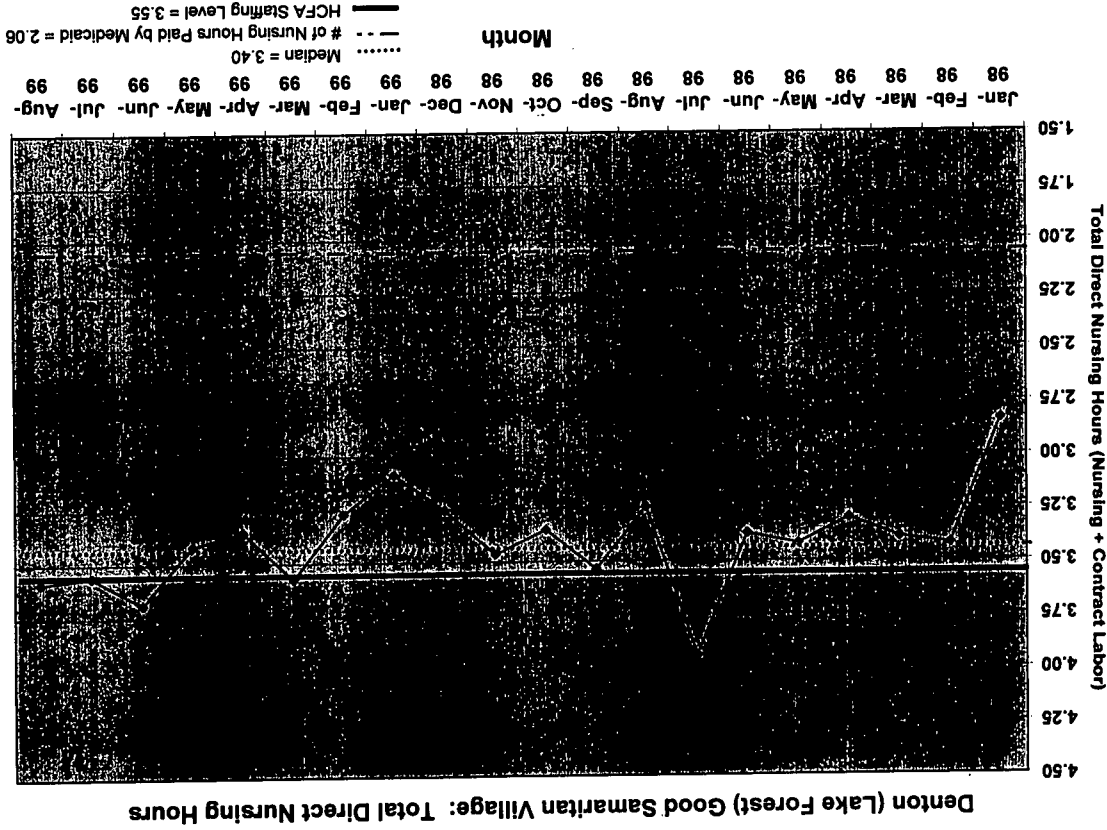
In closing, I have worked my entire life to provide care for the most needy in our society. I have never seen a staffing crisis as severe as this. It is being exacerbated by lowered payments, increased regulation and penalties, and a continued public attack on nursing facilities.

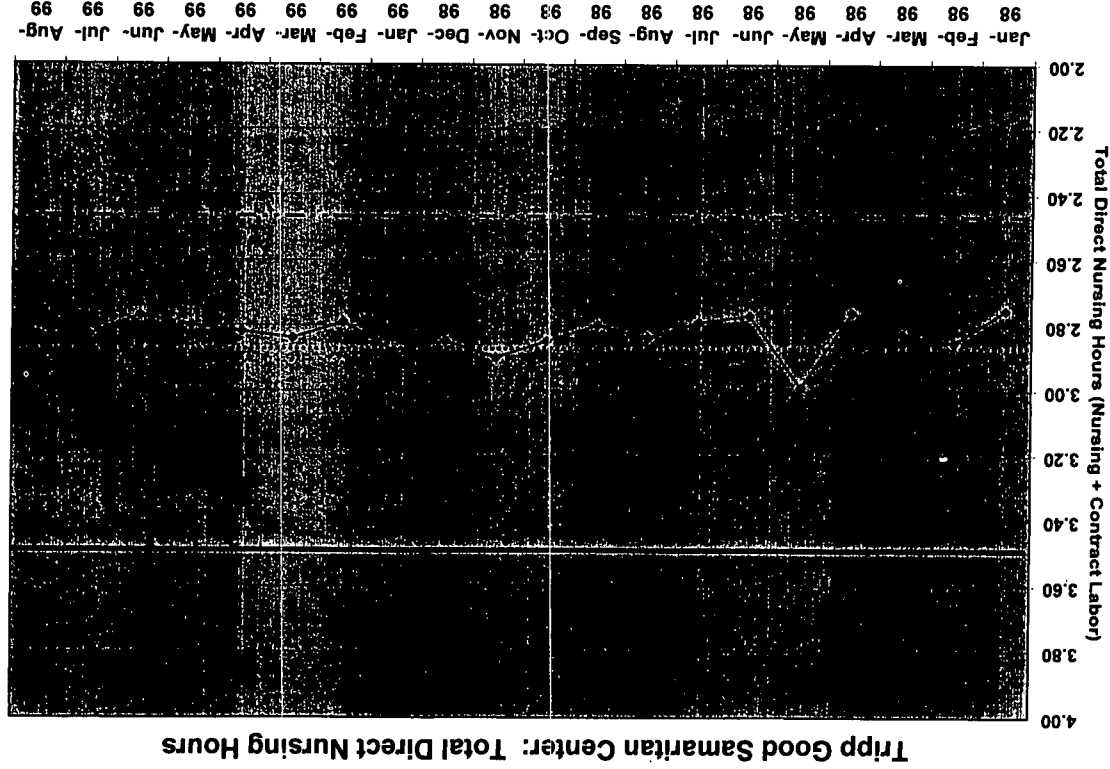
It is imperative that we face the staffing problems head-on, and that providers, residents, paid consumer advocates, regulators, and policymakers' work together toward thoughtful solutions that work explicitly to benefit the residents we serve. The residents we are caring for are depending on that cooperation.

Steps Policymakers Could Take to Help Now

Following are a few concrete steps that policymakers can take today to relieve some of the pressures causing the staffing crisis:

- Establish funding requirements that recognize the cost and importance of adequate staff.
 - Enact upward mobility scholarships to provide additional training for caregivers to receive advanced licensure and certifications.
 - Extend and improve the Work Opportunity Tax Credit (WOTC) for hiring disadvantaged workers. Enact tax credits for training workers in CNA and other career fields.
 - Cultivate careers in long term care. Work with universities to develop and promote curricula for long term care nurses. Promote long term care as an underserved career field within academic centers.
 - Develop a research agenda to support advances in caregiving, i.e. Alzheimer's care, end of life care, geriatric nutrition, and dementia.
 - The Telecommunications Act of 1996, was passed by Congress to provide funding for rural education and not-for-profit healthcare organizations to improve the communications infrastructure in their rural facilities. This act creates a universal service fund that is funded by an additional tax on telephone bills. Our concern is that long-term care is not considered a healthcare organization under the criteria for this funding. We consider this to be a critical oversight especially in light of the rural nature and enormous governmental mandate for data and information in long term care.
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Median = 2.83
of Nursing Hours Paid by Medical = 2.44
HCF A Staffing Level = 3.49

Dr. HARRINGTON. Thank you. Next, we would like to hear from Helene Fredeking, who is a Senior Advisor at the Health Care Financing Administration's Division of Outcomes and Improvement, Center for Medicaid and State Operations. Ms. Fredeking will outline the objectives of HCFA's current study on nursing home staffing and will address the Agency's role in ensuring that long-term care facilities provide adequate staffing to meet the needs of residents.

Helene.

STATEMENT OF HELENE FREDEKING, SENIOR ADVISOR, DIVISION OF OUTCOMES AND IMPROVEMENT, CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Ms. FREDEKING. Thank you, Charlene.

Chairman Grassley, Congressman Stark, Senator Kohl, thank you for inviting me to discuss HCFA's efforts to address the issue of nursing home staffing. It is indeed a pleasure for me to be here today and have the opportunity to listen to the many experiences of the other members of the panel. We certainly learn from these experiences, and it helps enrich our ability to develop policies and procedures.

We at HCFA are committed to increasing protections for vulnerable nursing home residents. That is why the President announced a major new nursing home initiative last summer. Since that time, we have worked diligently with this committee, the GAO, states, providers, advocates to buildup on these initiatives. My written testimony lists a number of the things that have been accomplished. So I will not spend any more time on that point.

We are also conducting a study and developing a report to Congress that will help to determine the appropriateness of establishing minimum nurse staff to resident ratios in nursing homes. We have been faced with many challenges in conducting the study, in part, due to the lack of data necessary for assessing resident outcomes. This has resulted in unwanted delays. However, we are now on track and expect to finish the first phase of this report in the summer of 2000.

In conducting the study with our contractor, who is Abt Associates, we expect to analyze 2 years of resident-specific data from nursing homes in three states for outcomes of care adjusted by acuity level. Then our contractor will assess whether there is a relationship between the outcomes of care and staffing levels. This analysis will be conducted by Dr. Andrew Kramer, who is a sub-contractor to Abt, and he works at the University of Colorado.

We have established a panel of technical experts to review the design and the study results at various critical phases of the study. Our experts include Dr. Barbara Bowers from the University of Wisconsin, Dr. Eric Tangelo from the Mayo Clinic, Dr. Charles Phillips from the Meyers Research Institute in Cleveland, and Dr. John Nyman from the University of Minnesota.

In addition, many other experts, as well as interest groups, have been consulted during the development of this study and will be continued to be. The Phase 1 part of the report will be completed in the summer of 2000, will answer the key study question of

whether nurse staffing ratios are appropriate and, if appropriate, what are the options for setting minimum ratios. This will primarily depend on Dr. Kramer's analyses. The Phase I report will also include other things: Literature reviews, descriptions of nurse staffing in the United States, state staffing requirements that many of you referred to and assessment of the current Federal oversight approach and Federal requirement, results of interviews and focus groups with nursing staff and providers, and an estimate of labor resources required for best-practice standards in nursing homes. The Phase I report will not include any cost analysis related to the findings or any additional qualitative analyses. We will conduct subsequent studies of these issues.

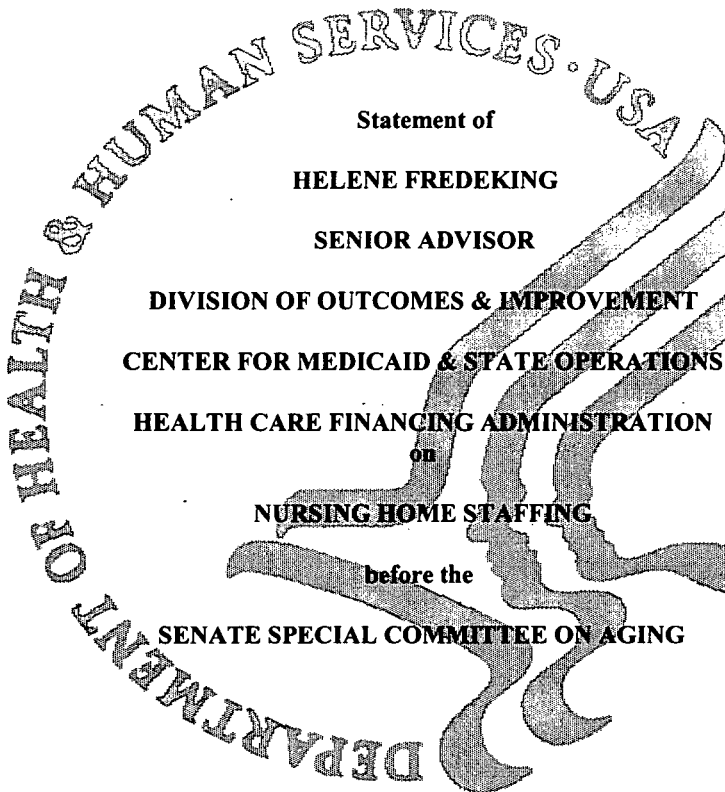
In addition to conducting the study, we are also committed to developing meaningful staffing information for our nursing home website. We have research underway to help us obtain better data. As soon as we have enough confidence in the data's accuracy at the facility level, we will post it on the Web. We want to make sure that the information would not be misleading to consumers.

Also, in July 1988, we revised the nursing home survey process to place greater focus on assessing the adequacy of nursing staff. Surveyors compare a licensed nurse on duty to the duty list, and if quality-of-care problems are identified during the survey or there are complaints from families related to staffing, surveyors have been trained to investigate staffing levels available in the facility with a new investigative protocol that includes observations and interviews, document reviews, and the interviews would be conducted with staff, including CNAs. If there is found to be inadequate staffing-to-care for residents, a deficiency should be cited. We will continue to work on the study, and we will assess the effectiveness of our new survey process.

I greatly appreciate the assistance provided by the resident advocates, labor and trade groups, other experts and the committee as we work through these issues, and we look forward to consulting further with you when our study is complete on how to interpret the findings and what to act on.

Thank you, again, for inviting me to participate today. [Applause.]

[The prepared statement of Ms. Fredeking follows:]



Statement of
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on
NURSING HOME STAFFING
before the
SENATE SPECIAL COMMITTEE ON AGING

November 3, 1999



**Statement of
HELENE FREDEKING, SENIOR ADVISOR,
DIVISION OF OUTCOMES AND IMPROVEMENT
CENTER FOR MEDICAID AND STATE OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION
before the
SENATE SPECIAL COMMITTEE ON AGING
on
NURSING HOME STAFFING
November 3, 1999**

Chairman Grassley, Senator Breaux, distinguished Committee Members, thank you for inviting me to discuss our efforts to improve quality of care for America's 1.6 million nursing home residents and to address the issue of nursing home staffing levels.

Protecting nursing home residents is a priority for this Administration and our Agency. Through the Medicare and Medicaid programs, the federal government provides funding to the States to pay for care and protect resident safety.

In 1995, the Clinton Administration began enforcing the toughest nursing home regulations ever. They have brought about measurable improvement. However, our report to Congress and GAO investigations have shown that much more needs to be done. That is why President Clinton last July announced a major new initiative to increase protections for vulnerable nursing home residents and crack down on problem providers. Since then, we have worked diligently with your Committee, States, providers, advocates, residents, and their families, to implement and build upon this initiative.

We also are conducting a comprehensive study to help determine what the appropriate level of staffing in nursing homes should be, and whether minimum nursing home staffing ratios may be in order.

This study is critical to our efforts to improve oversight and ensure safety and high quality care for vulnerable nursing home residents. We expect to have the first phase of this report completed by this coming summer.

NURSING HOME INITIATIVE PROGRESS

We have made substantial progress in implementing many facets of this nursing home initiative, announced by President Clinton in July of last year.

- We issued new protocols for conducting nursing home surveys which specifically address areas where there have been significant problems, including hydration, nutrition, and pressure sores. These protocols, released in July 1999, are vital to guiding and training State surveyors and will assure a new level of consistency of surveying among the States.
- We provided training and guidance to States on the President's nursing home initiative, including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressure sores, dehydration, weight loss, and abuse prevention.
- We required States to evaluate all complaints alleging actual harm within 10 days. Last month we issued detailed guidance on how to conduct such evaluations and prioritize complaints. Key staff from each of our regional offices will be meeting with State survey agencies to discuss these guidelines and facilitate sharing of best practices in complaint management.
- We identified facilities in each State for more frequent inspection and intense monitoring, based on results of most recent annual inspections and any substantiated complaints during the previous two years. States have begun monitoring these facilities more frequently.
- We vigorously encouraged States to impose sanctions on facilities that do not comply with health and safety regulations.
- We urged States to impose especially close scrutiny and immediate sanctions for facilities that demonstrate "yo-yo" compliance by fixing problems temporarily, only to be cited again in subsequent surveys.

- We instructed States to stagger surveys and conduct a set amount on weekends, early mornings, and evenings.
- We required States to revisit facilities in person to confirm that violations have been corrected before lifting sanctions.
- We issued regulations that enable States to impose civil money penalties for each serious incident.
- We have been working with the Department of Justice to improve referral for potential prosecution of egregious cases in which residents have been harmed.
- And we are testing an abuse intervention campaign in 10 States, with posters and other printed messages in nursing homes to inform residents and families about the signs of abuse and how to report it.

We also are taking steps to protect residents from any disruptions or dislocations in facilities that may be experiencing financial or other difficulties. We have made clear that filing for Chapter 11 bankruptcy does not diminish a facility's responsibility to provide residents with high quality care and a good quality of life. We issued monitoring protocols designed to help State surveyors and ombudsmen uncover early warning signals that might indicate the possibility that a facility in financial difficulty will fail to continue providing quality care to residents. And we developed a management contingency plan spelling out responsibilities of State and federal governments so we can respond quickly and effectively if a facility's financial situation places resident health or safety at risk.

To improve consistency in how these efforts are implemented across the country, we have established a workgroup that includes key central and regional office staff. This workgroup is promoting clear and consistent communication among all involved staff. And it is specifically addressing areas where inconsistencies have been identified.

We also continue to target our efforts toward increasing nursing home accountability by making information on each facility's care and safety record available to residents, their families, care givers, and advocates. We have launched a new Internet site, Nursing

Home Compare at www.medicare.gov, which allows consumers to compare survey results and safety records when choosing a nursing home.

STAFFING

Some evidence suggests that staffing levels and staff-to-patient ratios may be an important contributing factor to some nursing home problems. However, there is as yet little systematic evidence available to substantiate such a link for specific ratios. That is why further study is so critical.

We are conducting a study and developing a report to Congress that will help to determine the appropriateness of establishing minimum caregiver-to-resident ratios. We have faced challenges in conducting this study, in part due to the paucity of preexisting data on the subject. However, we are on track and expect to provide the first phase of this report to Congress in the summer of 2000.

With the assistance of our contractor, Abt Associates, we expect to analyze two years of data from nearly all nursing homes in Ohio, New York, and Texas, representing approximately 2,700 facilities that are home to over 240,000 Americans. Our study focuses on three key areas:

- Whether staffing ratios improve care;
- Whether minimum nurse staffing ratio requirements are appropriate; and
- The potential cost and budgetary implications of minimum ratio requirements.

In developing the study, we have met, and continue to meet, with a variety of individuals, including consumer groups, labor organizations, and industry representatives.

We also have established an external Technical Expert Panel to provide us with independent advice in analyzing the data. This expert panel will review our study design and provide ongoing assistance to us throughout the study process.

We were careful to select those experts who we believed could be objective and who had not publicly staked out a prior position on the appropriateness of minimum staffing ratios. While all the panelists are expert in long-term care, they represent very different disciplines that we viewed as critical to our study, including nursing and qualitative research, quality indicators, clinical expertise, and cost analysis.

Once we are confident that we have reliable and meaningful data on staffing, we will include information about staffing levels at individual nursing facilities on our Nursing Home Compare web site. We know there are concerns about the accuracy of the staffing data available to us today. We have research underway to help us get better data. And we feel it is essential to wait until we are certain the data are not flawed or misleading before they are posted.

Conclusion

We continue to move forward on both our comprehensive nursing home initiative and our study of nursing home staffing. We greatly appreciate the assistance provided to us in these efforts by resident advocates, labor and trade groups, other experts, and this Committee. And we look forward to consulting further with you when our staffing study is complete on how to interpret and act upon its findings. I thank you again for inviting us to this forum, and I am happy to answer any questions.

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Dr. HARRINGTON. Thank you to all of our panelists. We really appreciate all of your comments and insights. And now we are going to have a question and answer session, and unfortunately we do not have a lot of time. So if our panelists will keep your answers very short, we will try to get to as many of these questions as we can.

One of the first questions was about the importance of wages and benefits for certified nursing assistants, and I am wondering if some of you could talk about that, starting with some of the CNAs, about whether the wages and benefits are important and are facilities paying at the minimum wage or are some of the best practices occurring where they are paying above minimum wage.

Ms. JACKSON. Some do go by the experience of the CNA. If they are fresh out of school, they may start them off with minimum wage. If they have five or more years' experience, they may upgrade their pay from \$6 to \$8. Some facilities have a thing called a float pool, where they will not use an agency because with agency they pay more. With the float pool, they try to take their pay up to at least about \$8. If they work weekends, they may make like \$8.60 or \$8.90. So it does vary, and like I said, some CNAs or single moms may have two to three children. With the money that they are making, they may have to take another job because most of their money will go to health insurance with two or more kids. So it does vary in the pay rate.

Dr. HARRINGTON. Anyone else want to comment? What about some of the administrators?

Dr. RYAN. In most cases, we are paying well above minimum wage, but the issues of the cost of health-related benefits for single parents, particularly with family, in the health insurance and escalating health-care cost environment are huge. That is why we moved to a self-insured approach.

The other piece is the issue of compression and the fact that those certified nursing assistants who have been working in a facility for 20 to 30 years are still not making much more than that wage that the fairly new entry CNA is making. It is a huge issue. There is not sufficient pool of monies from which to put a rational compensation strategy in place.

Ms. KEHOE. Very quickly, we did some research on our profit and loss—it has been loss since 1995—and interestingly enough, our worker costs are about 80 percent of our annual budget. Since 1995, the costs for our staff RNs, LPNs, nurse aides, all staff is up 38.4 percent. The reimbursement in that same period of time has increased 7 percent. There is a dramatic discrepancy here.

Dr. HARRINGTON. This is related to Medicaid reimbursement.

Ms. KEHOE. This is right off our Medicaid cost report. This is where I am getting the information. You cannot do it.

Dr. HARRINGTON. So how do facilities afford it?

Ms. KEHOE. What happens with the not-for-profits is we do fundraising, we beg, we ask our communities to support us day-in and day-out, and you have private pay people that are supplementing what we get from the Government. It is a fact of life.

Dr. HARRINGTON. Anyone else want to comment on that? [No response.]

Another question from the audience here is we would like you to comment on the training requirements for certified nursing assistants. As everyone knows, the Federal requirements are only 75 hours of training. Is this adequate, and what should the training requirements be?

Do you want to start with any comments by CNAs?

Ms. JACKSON. You can go ahead.

Ms. WESTPHAL. I think the hours are appropriate because then not only do you get the school training, you also get to work with another CNA along with them. We do it at our home for a 2-week period at a time, and if they need more hands-on with a little CNA that has been there longer, then they can have a longer amount of time, but otherwise I think the schooling is pretty good, and then your hands on is also a lot longer.

Ms. WILLIAMS. Currently, in the State of Florida the state plan requires that the aides have 120 hours of training. That is 80 hours in the classroom and 40 hours clinical training. They graduate their students out of these approved classes through the Red Cross or our local community colleges and then they send them to take their exam.

There is a provision for nursing assistants to challenge the state exam. Anyone in the State of Florida can come in off the street and challenge the exam. If they pass, they are technically considered a certified nursing assistant. That sounds like a problem. However, it has worked to our benefit. As I mentioned in my testimony, we did decide to grow our own nursing assistants. And by using this challenging opportunity, we set up the training in our own centers. We extended that actual clinical training time in our facilities to 1 month. After the classroom time, they are sent out to the floor, they buddy up with a certified, seasoned CNA, and they work with them very, very closely to learn the ins and the outs and the real-world training of working with our patients on the floor. So this has been very successful for us. They are able to challenge the exam, successfully pass and then begin their careers.

Ms. KEHOE. Training for staff should never end. It is ongoing, day-in/day-out learning the care of those residents, and the care of our residents is a fluid thing. It changes day-in and day-out. So it should never ever stop in a good home.

Dr. RYAN. If I could just add one comment to that. Our front line staff not only need education for clinical care, they need help to learn personal life skills. Sometimes some of our new front-line caregivers have such problems trying to parent and manage their own family situation that these problems spill over into the workplace. We are doing a lot with our investment in distance learning in personal skills development. Even balancing checkbooks, trying to deal with those things that they need to hold their lives together. When I did work as a CNA last fall, we started our shift at 5:30 in the morning. At about 7 o'clock, I noticed that people were disappearing into rooms in which the telephones were. I thought, "Now, what's going on?" Staff were calling home to make sure that their own children were out of bed to go to school because there was no one home with them.

Ms. JACKSON. To add to that, I think that, like she said, CNA training should never stop. They should always be educated be-

cause it does change. You may be dealing with critical residents, some residents are mild, and you are constantly getting people that are very, very sick and fragile, and they should continue to be educated. With CNAs that have been on the job for a long time, it is a good way because, on my job, I try to give them the best way of dealing with our residents because they are very fragile, and it takes time to deal with them—if you do not have the education and the time, and a lot of it is just common sense and just having a heart and caring.

Dr. HARRINGTON. I would like to shift and ask a question of Elaine Daigle. You described a very difficult situation with the nursing home that your daughter is in. And I am wondering what kinds of things would help to give you support in having to work with the situation you are faced with for your daughter?

Ms. DAIGLE. Well, I think I bring it back to staffing again. I know many people have said raising staffing levels is not a guarantee, and it is not. But because they are so overworked where my daughter lives, the nurses do not have time to communicate with me. If I call on the phone to ask a question, it is—she rambles on so quickly I do not quite catch all of it. I have to be there and observe for myself. There is just not enough time for anyone. They are just overburdened, and the staff that have stayed many years, they are also leaving. CNAs start at about \$10 an hour where my daughter lives. So all of these things, it just does not make a difference.

Dr. HARRINGTON. Thank you.

I would like to ask a question of Becky Kurtz about the ombudsman program. You described a situation where you are getting a large number of complaints about staffing and care issues. What do you need to do a better job in terms of being an ombudsman? Do you have enough resources, enough people to respond to these complaints?

Ms. KURTZ. There are many answers to that. One thing we need is a cooperative facility that will work with us, and many facilities do work with us to solve problems. One thing we need is adequate resources so that we have enough ombudsmen to respond to the many, many complaints that are increasing every year that we do receive from family members, primarily family members, but we also receive them from CNAs who are calling us anonymously who are just overwhelmed. We need to be able to respond to the number of complaints that we have, I should say that in nursing homes and personal care homes both. In Georgia last year, we had more than 6,000 complaints. That keeps us running. We stay very busy responding and trying to support family members and residents.

And another thing that we need is strong enforcement of the standards that are there and stronger standards. [Applause.]

We can make a lot of noise, we can make a lot of our concerns known, but if the enforcement agency does not do anything about it to say, "Facility, you really must be in compliance," all of our screaming is in vain. We are not enforcers, and we need regulation. [Applause.]

Dr. HARRINGTON. All right. I would like to ask Mary Ann Kehoe a question. One of the questions is how do you change the culture of the staff working environment, and how do you get the staff to

buy in to making these kinds of cultural changes? And the other question related to that is how much staff do you have to take care of the patients and how do you actually deal with the staff shortages?

Ms. KEHOE. First of all, it is a very complex issue, and there is no real simple answer. Culture change does not happen quickly, and it is not a magic bullet. It takes time. From the start, and you are probably not going to want to hear this, but from the start of initiatives until today, it has been a 5-year process, and it starts out very, very slowly. If you have a very autocratic organization, you have to build bridges, you have to talk, you have to team build, and you spend a lot of time doing that. You have to build trust within the organization. But, again, it is really pretty simple in just Golden Rule management, you simply learn to treat one another how you would like to be treated yourself. You walk around, you are out there, you hear, you listen and you respond.

Our staffing levels fluctuate. And because the resident care needs fluctuate, it is a very fluid thing. If we mandate just one amount of staff, one level of staffing, sometimes we need one staff member per one resident. If there is a mandate to staff with a certain amount of staff numbers do not say the story.

Our staffing, in order to do Wellspring successfully, I think needs to be around 3.0 nursing hours per patient day. That translates very comfortably with Wellspring for nurse aides to be able to take care of eight residents on the day shift, around 13 per staff member on PMs and around 18 on nights. You can do it. You can do it when you utilize technology, when you streamline the job, when you get efficient with the care, when you prevent negative outcomes. There is time to do what you need to do to provide quality care, quality of life.

Dr. HARRINGTON. Thank you. I do not know if any other person on the panel wants to comment on—

Ms. JACKSON. I would just like to say that I understand that you can do a quality job with a certain amount of residents, but when you have acuity of residents that are very sick, and when they need the proper care, and they need quality when everybody is saying quality, if you have one to eight on a day shift with residents that are very, very sick, it is hard to really give that quality care. But on a long term— [Applause.]

You know, if you have one to five, I can go through and give everybody a bath, I can go through and comb the hair, I can do nails, I can do toes, I can massage bodies, and when I leave that nursing home, I know I will feel good because when I got up this morning, I did the same thing to myself. [Applause.]

Ms. KEHOE. Our last survey, the surveyors were in, and they came very early, and they stayed very late and had been doing off-time surveys in Wellspring facilities for a while. And I got back to the building on Monday morning, and I said, "Well, how did it go?"

And the surveyor said to me, "I have a little problem."

And I said, "OK. What was that?"

More residents at 5 o'clock in the morning had make-up and had jewelry on and were up and moving around the facility. They were doing much better than I can do at 5 o'clock in the morning. You

can do it with one to eight if you do it efficiently, and you do it right.

Ms. JACKSON. In the morning.

Ms. KEHOE. Because we are from a farming community, and this is the—we have residents that get up at 10 o'clock in the morning, we have others that get up at 9:30. The surveyor was there at 5 o'clock in the morning. If it is their request, if it is their request, we meet their request.

Dr. HARRINGTON. Thank you.

Now, I have a question here for Helene Fredeking. Can you give us the HCFA website for the nursing home compare?

Ms. KURTZ. www.Medicare.gov. It is a wonderful website.

Dr. HARRINGTON. It is under Medicare, which is what confuses a lot of people, and I am not sure it should be located under that, but anyway that is what you have to look under.

We have a large number of people here in the audience from the National Citizens Coalition for Nursing Home Reform. How many people are here from the conference? So I understand people have been having a wonderful conference here in Washington, and I think we have a couple of people that would like to just say a few words from the advocate's perspective. If you would come up—
[Applause.]

Ms. SPINELLA. Thank you very much for giving us that opportunity. My name is Ann Spinella, and I from Tampa, FL, and I have taken care of family members both at home and in nursing homes for the last 19 years. At the present time, I have three family members in a nursing home in Tampa, FL.

I cannot tell you about nursing homes everywhere, even though I think there maybe different scenarios here and there. But the end result is probably pretty close to the same everywhere. When you visit a nursing home to determine if it is the right place for your loved one, you are universally proudly told that they staff at more than the minimum staffing level. The reality is that most family members do not know what the minimum staffing level is or what it means in terms of 24-hour care.

If there were, in fact, adequate staffing overall in the State of Florida or if the industry could monitor itself, it would not have been necessary for Florida's Agency for Health Care, in the last approximately 3 years, to commence more than 125 administrative actions against nursing homes, issue over 80 moratoria on new admissions, institute more than 25 receiverships, closures or license revocations, impose in excess of \$2 million in state civil penalties and propose more than \$5 million in Federal civil monetary penalties.

Unacceptable conditions continue to arise and exist in Florida's nursing homes, and I believe everywhere. Florida has 700 nursing homes. Our State agency's records called "The Watch List" reflect that 228 homes were placed on conditional status or moratoria during slightly less than a 2-year period, indicative of dangerous levels of care for our elderly and our disabled loved ones. That is approximately one-third of the nursing homes in the State of Florida.

Interestingly, 102 of those nursing homes were in that status at least twice, 33 were there three times, 24 were there four times, three were there five times, five were there six times, and two were

there seven times, not including the current Watch List, which I received yesterday and which I have not yet collated.

Florida's ombudsman councils received 7,500 complaints in its last fiscal year concerning unsatisfactory conditions at nursing homes. They cited that the five most frequent complaints regarding care were shortage of staff, lack of dignity, personal hygiene, gross neglect and improper medications administration. In simple terms, there was not enough staff to do the job right.

The nursing home where my family was during a 15-day period in March 1998 the facility was short staffed 9 days. The number of hours they were short staffed was 2, 6, 10, 12, 15, 16, 19, 21 and more than 42 hours short in 1 day. That day was March the 5th. On that day, I remember it well, because the family members were doing quite a bit of work in the nursing home answering call bells and doing various services for people other than their own loved ones. That particular day, in the evening, a woman died, and nobody knew how long she had been dead. The nurse on duty sat on the floor with her back to the wall and cried because she said that she could not provide the care that the 35 residents on her wing required that night and many other nights.

The industry will tell you that they cannot get the staff, but I went to the nursing schools in our state, several of them, and talked to the teachers and the students and found that we are turning out nursing students by the caboodle, but they shortly become—and the reason that they are there is they want to make a difference in somebody's life, but after they get out and actually get in the field, they discover that most of them are simply unable to make a difference.

The nursing home industry will tell you that it does not have the money to do this. I will tell you that if you look at their 10(k) schedules that are filed with the securities and Exchange Commission, you will find examples like this.

Beverly, 1996, operating net profit, \$125 million; 1997, operating net profit, \$108 million; Genesis, \$127 million in 1996, \$185 million in 1997; IHS, \$97 million in 1996, \$146 million in 1997; Paragon, \$89 million in 1996, \$95 million in 1997; Vencor, \$83 million in 1996, \$224 million in 1997. Is that obscene? [Applause.]

I wonder how many more CNAs could have been purchased with that amount of money and still provide— [Applause.]

And still provide to those nursing home chains a reasonable amount of profit. How many folks out there feel like I do about that situation? Will you please stand up. Will you folks just stand up, just for a second, stand up. OK. Thank you. I am glad to know I am not alone.

We cannot continue to really just talk about this horrendous situation. We know that there are good CNAs, and I commend those, and we have commended those who are. We also know that they cannot do this job 24 hours a day, 7 days a week forever. They are burnt out. And when we do really have a shortage, then we are really going to know. And I ask the Congress, while they are in a position to do something about it, to do it, because when they are not in Congress, it is probably too late for them.

Thank you. [Applause.]

Ms. FERRIS. I am Beth Ferris. I am president of Texas Advocates for Nursing Home Residents. A lot of you know us by the acronym of TANHR. Lou O'Reilly and I founded this organization 10 years ago. We have worked 10 years, and the two of us, and we added eight more people on our board, and we have worked hard, but we do not see the light in sight for us to see the good care because we lack staffing.

We support—I think you saw the majority of this audience supports the comments that Senator Grassley made this morning. We support that. I do not know why the industry keeps harping on they cannot afford. I do not see why they cannot not afford to give good care, have more staff. I got a call about 2 weeks ago from an LVN, and she said, "If things do not improve here, I have to leave. I cannot, in good conscience, stay." That was a good LVN. I do not know whether she has left yet or not.

She says, "I have one nurse aide to help me at night, and we have 75 patients to look after." Those people could not—and as most of you know, the nursing home residents, this is not an assisted living home, the nursing home residents are sicker, and frailer, and more of them are bedfast. They cannot get up alone. They have to be helped, they have to be turned, they have to be fed, they have to be given drinks of water, as we heard the moving story by our wonderful speaker at the first of the week. We have to have more staff in our facilities or our people are going to suffer.

And if you have not seen some of the pictures that show the result, we talk about outcome, I am sorry, I did not have time to write because when I first got so angry sitting back there, I could write like this. After, I was so angry I started making notes, and this is the way I was writing. I am angry about how the industry has given us testimony today, and if you are not angry, go home and think about it, go home and visit a nursing home, go home and look at those people in those beds, look at how they are sitting in their wheelchairs with their—I am sorry.

Join us in seeing that we help Senator Grassley and not undermine his work. Please work as hard as you can on advocacy for nursing home residents.

Thank you very much. [Applause.]

Dr. HARRINGTON. Thank you very much. I think we are running out time. I have one last question, and then we have so many excellent questions, we are going to give these to the committee staff members, and they will ask our panelists to respond to some of these questions that we could not get answered today.

So the last question I would like to ask Helene Fredeking if she would just say a few words about what HCFA is going to do now on its surveys and the complaint process related to these issues of complaints about staffing.

Ms. FREDEKING. Yes. In July, in actually cooperation with some of the advocacy groups, we developed a new protocol for the survey process to use in looking at staffing in the survey process. Prior to that time, we had only looked at staffing if, indeed, we were doing an extended survey on a regular basis. Now, we are instructing surveyors to look at staffing if they find some negative outcomes or if there are complaints from the residents or their families that relate to staffing. And we have given them or provided for them

and trained them on a fairly extensive protocol of questions to ask, things to look at. They will interview staff, they will interview the residents and their family. So it is a more extensive look at staffing during the standard survey to help them deal with the issue of how to make the determination of what is within the current law, which is sufficient staffing, which is a difficult decision for them to make.

Dr. HARRINGTON. Thank you.

Ms. KEHOE. One final comment. I am angry too. I am angry that there are bad providers in this business, and I reach out to each and every one of you, and to the Senators and the legislature, and to all of the staff. Let us join hands and work together to make this a better world because our residents deserve it, and we want to work with you. [Applause.]

Dr. HARRINGTON. Thank you.

We have one last speaker, which I did not know about. So do you want to come forward, from NCCNHR, who wants to make another statement.

Ms. MACINNES. My name is Gail MacInnes, and I work at the National Citizens Coalition for Nursing Home Reform.

More importantly, though, to me, I am the daughter of a nursing home resident, and I wanted to just say briefly that I believe, and I think many, may consumers do, and many staff people who are doing the direct care believe that nurse staffing ratios are not sufficient to solve the problem of poor care in nursing homes, but they are necessary. I applaud the efforts that are made by providers to change the culture of nursing homes, but we must have regulations in place to ensure that basic needs are met.

My father is not in a bad home. He is in a very good home in Montgomery County, and I think it is known as one of the very best. However, I am told by the direct caregivers that take care of him that they cannot—they do not have the time to take him to the bathroom more than once per shift. It is extremely time consuming. His legs are very stiff. It takes 5 to 10 minutes just to get him onto the toilet. And with staffing levels as they are, as hard-working and as caring as they are, they just cannot do it with the other 12 residents that they have to take care of.

What would ensure the dignity that he deserves and limit the severe agitation that he experiences and the panic he experiences when he has to go to the bathroom and no one is around to take him would be if there were sufficient staff available to meet his individualized needs.

Let me say, again, that my father is in a good home. This is not a bad provider. There are a lot of very well-meaning people there. But I believe if minimum staffing ratios were put in place, it would give an opportunity for the providers and the direct caregivers to feel good about what they do.

What I hear from the staff people that I interact with is that they are getting burnt out and that they are leaving the profession because they are so overwhelmed. And I think that this is a strategy that could be used to attract people back to the profession. [Applause.]

Dr. HARRINGTON. Thank you.

I think we are going to wrap up our hearing today. I really want to thank our audience and our panelists for all of your input. I

have to say that I think everyone here has the same goal in mind, and that is to have adequate staffing, well-trained staff, and to really provide high-quality care in nursing homes.

If we took all of the energy in the room, plus the commitment from the Senators, and we all work together, I think that we can work out a solution for making sure that we have the amount of staff we need and that we are able to pay for the staff that nursing home care residents deserve.

So let us dedicate ourselves to that in the future, and thank you all for coming. [Applause.]

[Whereupon, at 12:12 p.m., the forum was adjourned.]

