

June 10, 2022

**SUBMITTED ELECTRONICALLY VIA
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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
ATTN: CMS-1765-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: (CMS-1765-P) Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels

Dear Administrator Brooks-LaSure:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on the *Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels*. The AGS is a not-for-profit organization comprised of nearly 6,000 geriatrics health professionals who are devoted to improving the health, independence, and quality of life of all older adults. Our members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician assistants, pharmacists, and internists who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons.

The AGS believes in a just society – one where we all are supported by and able to contribute to communities and where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. We advocate for policies and programs that support the health, independence, and quality of life of all of us as we age.

We appreciate your ongoing interest in improving the quality of care in nursing homes. Both nurses and direct care workers play a critical role in caring for us all as we age. We have provided feedback in response to your questions below:

- 1. Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?**

In April 2022, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a report, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families and Staff*¹ recommending increasing both the numbers and qualifications of all nursing home workers noting robust evidence that enhanced requirements positively impact the quality of care provided to nursing home residents.

A study that looked at the effects of changes in staffing characteristics on changes in quality measures found a strong relationship between registered nurse (RN) staffing levels and outcomes (restraint use, catheterization, pain management, and pressure ulcers). They also found higher licensed practical nurse (LPN) and certified nursing assistant (CNA) staffing, higher RN skill mix, lower RN and CNA turnover, and lower RN and CNA agency staff use to be associated with better outcomes.² Another study found higher RN staffing levels to be associated with better resident care quality in terms of fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADL) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates.³

2. What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?

Several factors should be considered. Higher acuity rates require higher staffing levels. Research has consistently found that as resident acuity increases in nursing homes, a greater presence of physicians, nurse practitioners or RNs results in better resident outcomes and increased satisfaction.⁴ Additional considerations include ADL and instrumental activities of daily living (IADL) needs, resident assessments and care plans,³ and demographics. For the facility, considerations should include size, ownership, accreditation, teaching status,⁵ and what the facility provides (e.g., IVs, blood transfusions).

3. Is there evidence of the actual cost of implementing recommended thresholds, that accounts for current staffing levels as well as projected savings from reduced hospitalizations and other adverse events?

No information to add.

4. Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?

¹ National Academies of Sciences, Engineering and Medicine. (2022). *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families and Staff*. Washington, DC: The National Academies Press. [doi:10.17226/26526](https://doi.org/10.17226/26526)

² Castle NG, Anderson RA. Caregiver staffing in nursing homes and their influence on quality of care: using dynamic panel estimation methods. *Med Care*. 2011;49(6):545-552. <https://www.jstor.org/stable/23053761>

³ Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health Serv Insights*. 2020;13:1-14. [doi:10.1177/1178632920934785](https://doi.org/10.1177/1178632920934785)

⁴ AHCA/NCAL, LeadingAge. Care for Our Seniors Act. <https://www.ahcancal.org/Advocacy/Documents/24-Hour-RN.pdf>.

⁵ Institute of Medicine (US) Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes; Wunderlich GS, Sloan F, Davis CK, editors. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington (DC): National Academies Press (US); 1996. 6, Staffing and Quality of Care in Nursing Homes. <https://www.ncbi.nlm.nih.gov/books/NBK232673/>.

There is evidence stating nursing homes hire cheaper staff to maintain their staffing ratios and quality ratings.⁶

5. What factors impact a facility’s capability to successfully recruit and retain nursing staff?

Existing nursing shortages plus jobs that pay low hourly rates and lack paid leave and other employment benefits make recruiting and retaining nursing home staff challenging. Additional factors include negative perceptions of direct care workers and of nursing homes, competition, limited promotion of jobs in nursing homes, and poorer pay in long-term care settings compared to acute care and ambulatory settings.⁷

6. What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?

Strategies for recruiting and retaining staff include sign-on and retention bonuses, free on the job training and oversight, making the environment less punitive and more supportive of training, and increasing salaries to attract RNs and BSNs to these settings to compete with hospital offerings. An apprenticeship or mentorship program or return of some of the Covid-19 waivers may also be helpful.⁸

7. What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers? How would CMS define and assess what constitutes a good faith effort to recruit workers? How would CMS account for job quality, pay and benefits, and labor protections in assessing whether recruitment efforts were adequate and in good faith?

The federal government could authorize funding to incentivize workers to apply for jobs in nursing homes. This can include waivers for training; competitive opportunities for nurses; and decreasing survey fines so facilities could use money to pay staff or offer staff incentives such as daycare.

8. How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, travelling or agency) nurses?

Considering the intent to turnover will help mitigate those issues and establish staffing standards. A study found that intent to leave predicts RN turnover through job satisfaction, perceived empowerment, and education level.⁹ Another study concluded that low staffing levels correlated with turnover and high job dissatisfaction.¹⁰

⁶ Sharma H, Konetzka RT, Smieliauskas F. The Relationship Between Reported Staffing and Expenditures in Nursing Homes. *Medical Care Research and Review*. 2019;76(6):758-783. [doi:10.1177/1077558717739214](https://doi.org/10.1177/1077558717739214)

⁷ Wagner LM, Bates T, Spetz J. The Association of Race, Ethnicity, and Wages Among Registered Nurses in Long-Term Care. *Med Care*. 2021;59(10 Suppl 5):S479-S485. [doi:10.1097/MLR.0000000000001618](https://doi.org/10.1097/MLR.0000000000001618)

⁸ Franzosa Em, Mak W, Burack OR, et al. Perspectives of Certified Nursing Assistants and Administrators on Staffing the Nursing Home Frontline During the COVID-19 Pandemic [published online ahead of print, March 10, 2022]. *Health Serv Res*. 2022;1-9. [doi:10.1111.1475-6773.13954](https://doi.org/10.1111.1475-6773.13954)

⁹ Kash BA, Naufal GS, Cortés L, Johnson CE. Exploring Factors Associated With Turnover Among Registered Nurse (RN) Supervisors in Nursing Homes. *J Appl Gerontol*. 2009;29(1):107–127. [doi:10.1177/0733464809335243](https://doi.org/10.1177/0733464809335243)

¹⁰ Castle NG, Engberg J, Anderson R, Men A. Job Satisfaction of Nurse Aides in Nursing Homes: Intent to Leave and Turnover. *The Gerontologist*. 2007;47(2):193–204. [doi:10.1093/geront/47.2.193](https://doi.org/10.1093/geront/47.2.193)

Rather than use of short-term nurses, CMS should consider ways to incentivize retention of nurses, certified nursing assistants, and other direct care workers. This continues to be a major issue that needs addressing. Incentives such as reimbursement for staying a certain number of years should be considered.

9. What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?

No, they should always be separated out as their training and responsibilities differ significantly.

10. How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?

It should be separated as the administrator should have dedicated time to perform administrative tasks.

11. What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

We are supportive of a 24-hour RN presence, which was also the recommendation in the recently released nursing home quality report from NASEM.¹¹ Non-nursing requirements should also be considered as a lot of nursing time is not direct patient care (e.g., paperwork, getting orders set, dealing with families).

When minimum staffing levels are set too low, they may either have no effect or adversely, incentivize nursing homes to ‘staff down’ to the minimum. Nursing homes in states with total nursing requirements of at least 2.5 HPRD had higher total nursing staff levels than nursing homes in state with no minimum requirements.¹¹

12. How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? We currently require that facilities have “sufficient nursing staff” based on a facility assessment and patient needs, including but not limited to the number of residents, resident acuity, range of diagnoses, and the content of care plans. We welcome comments on how facilities have implemented this qualitative requirement, including both successes and challenges and if or how this standard should work concurrently with a minimum staffing requirement. We would also welcome comments on how State laws limiting or otherwise restricting overtime for health care workers would interact with minimum staffing requirements.

¹¹ Mueller C, Arling G, Kane R, Bershadsky J, Holland D, Joy A. Nursing Home Staffing Standards: Their Relationship to Nurse Staffing Levels. *The Gerontologist*. 2006;46(1):74-80. [doi:10.1093/geront/46.1.74](https://doi.org/10.1093/geront/46.1.74)

No information to add.

- 13. Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.**

State minimum staffing requirements for total nursing hours can influence nursing home skill mix. Nursing homes in states that increased the total nursing minimum requirement shifted their skill mix slightly towards using more CNAs and substituting LPNs for RNs.¹²

- 14. Are any of the existing State approaches particularly successful? Should CMS consider adopting one of the existing successful State approaches or specific parts of successful State approaches? Are there other approaches to consider in determining adequate direct care staffing? We invite information regarding research on these approaches which indicate an association of a particular approach or approaches and the quality of care and/or quality of life outcomes experienced by resident, as well as any efficiencies that might be realized through such approaches.**

Yes, Minnesota's Performance-Based Incentive Payment Program led to qualitative improvement and lasting impact on facilities by increasing their capacity to design and implement quality improvement projects but significantly on staffing levels.¹³

- 15. The IOM has recommended in several reports that we require the presence of at least one RN within every facility at all times. Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? We also invite comment on the costs and benefits of a mandatory 24-hour RN presence, including savings from improved resident outcomes, as well as any unintended consequences of implementing this requirement.**

Yes, we support a 24-hour RN presence. As noted above, the April 2022 NASEM report on nursing home quality stressed the importance of the workforce and made a recommendation to support 24/7 RN coverage at nursing homes.

- 16. Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? For example, how would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff in order to offset additions to nursing staff by reducing other categories of staff?**

Yes, the concern is the inability to get decent staff and then hiring those that may not be safe or qualified. Another concern is nursing homes being fined despite trying to get staff and the cost implications of that and what it might mean for the nursing home. Furthermore, families should not be additionally burdened in terms of costs.

¹² Bowblis JR. Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes. *Health Serv Res.* 2011;46(5):1495-1516. doi:10.1111/j.1475-6773.2011.01274.x

¹³ Arling G, Cooke V, Lewis T, Perkins A, Grabowski DC, & Abrahamson K. Minnesota's Provider-Initiated Approach Yields Care Quality Gains at Participating Nursing Homes. *Health Affairs.* 2013;32(9):1631-1638. doi:10.1377/hlthaff.2013.0294

Other unintended consequences of enforcing minimum staffing standards could be a decrease in support staff (such as housekeeping).¹⁴ We can also think about training others to do some nursing tasks such as toileting, feeding, etc.

17. Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?

Yes, it does and without additional investments these facilities will be hurt the most. We need to make investments in the community such as transportation, housing, building infrastructure, safety, etc.

18. What constitutes “an unacceptable level of risk of harm?” What outcomes and care processes should be considered in determining the level of staffing needed?

As a start point, the focus should be on getting basic care needs met and being realistic about those care needs. The ideal and the real need for so many residents is one-on-one care and in some cases two-to-one care. Unfortunately, this is not realistic and CMS should consider rewarding a team-based approach to care that is focused on meeting patient needs. We can also consider eliminating some of the less important things (e.g., less worry about the timing of a medication when it doesn't matter and focusing on taking someone for a walk instead). There is too much punitive oversight that is not really leading to good care.

We appreciate the opportunity to submit these comments. For additional information or if you have any questions, please contact Alanna Goldstein at agoldstein@americangeriatrics.org.

Sincerely,



Michael Harper, MD
President



Nancy E. Lundebjerg, MPA
Chief Executive Officer

¹⁴ Chen MM, Grabowski DC. Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes. *Health Economics*. 2015;24(7):822–839. [doi:10.1002/hec.3063](https://doi.org/10.1002/hec.3063)