An Analysis of the Shirlee Sharkey Report on Long Term Care Homes Human Resource Issues in Ontario

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Ms. Edelman was the lead attorney for a statewide class of nursing facility residents who successfully challenged the state of California's refusal to implement the federal Nursing Home Reform Law (*Valdivia v. California Department of Health Services*, Civ. No. S-90-1226 EJG (E.D. Calif. 1993). As a beneficiary representative, Ms. Edelman has testified before Congress and served on federal task forces, technical expert panels, and working groups on nursing home issues. She has spoken at national conferences sponsored by the National Citizens' Coalition for Nursing Home Reform, the Association of Health Facility Survey Agencies, the National Association for Regulatory Administration, the American Health Care Association, the American Association of Homes and Services for the Aging, and other national and state organizations. She is Vice-President of the Board of Directors of the Assisted Living Consumer Alliance.

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Dr. Harrington served on the Institute of Medicine (IOM) Committee on Nursing Home Regulation whose l986 report led to the passage of the Nursing Home Reform Act of l987, and she was elected to the IOM in 1996, where she has served on three IOM committees that examined the nursing workforce, long term care quality, and patient safety (1996, 2001, 2003). She and a team of researchers designed a model California consumer information system website for nursing homes funded by the California Health Care Foundation (launched in October 2002) that she continues to maintain and expand.

Since 1994, she has been collecting and analyzing trend data on Medicaid home and community based service programs and policies, currently funded by the Kaiser Family Foundation. In 2003, she became the principal investigator of a five-year

$4.5 million national Center for Personal Assistance Services funded by the National Institute on Disability and Rehabilitation Research, which has just been refunded for (2008-2013). She has conducted several research projects on nursing home enforcement systems and has published those in peer-reviewed journals. She has testified before the US Senate Special Committee on Aging, and has written more than 200 articles and chapters and co-edited five books while lecturing widely in the U.S. and the U.K.

The approaches recommended in the report – increasing public funding to nursing facilities and allowing each facility to establish its own staffing standards voluntarily – cannot achieve the goal of increasing staffing levels.

The tern "nurse staffing" as used in this analysis is understood to include RN, RPN and PSW daily hands-on care.

Introduction

Although *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes* (May 2008) recognizes the need to increase nurse staffing levels in Ontario's nursing facilities, the approaches recommended in the report – increasing public funding to nursing facilities and allowing each facility to establish its own staffing standards voluntarily – cannot achieve the goal. Higher levels of direct care nursing staff and better care for residents will not occur without explicit provincial legislation, and enforcement of the legislation, requiring facilities to employ staff at specified levels. The voluntary, reimbursement-based approaches recommended in the report have been in place in the United States for more than 20 years and they have not worked. Despite the increasing acuity of residents and the payment of billions of dollars, sometimes directed specifically to staffing, nurse staffing levels, reflecting the direct care nursing staff who provide daily care to residents, have remained virtually stagnant. The Report's companion recommendation to determine accountability solely through self-reported quality indicators and satisfaction surveys mirrors recommendations made by the nursing home industry in the United States. That approach is not recommended by experts and has not been accepted in the United States. It should not be used in the Province of Ontario. Nursing home quality is best determined by objective public regulatory agencies, supplemented by consideration of staffing levels and quality indicators.

The nursing home industry in the United States

In 2008, more than two-thirds (67.14%) of the nursing facilities in the United States were for-profit, one-quarter (26.46%) were not-for-profit, and 5.82% were owned by government. In 2008, more than half (53.89%) of facilities nationwide were owned by chains.

Federal regulation in the United States depends on nursing facilities' voluntary participation in one or both federal payment programs, Medicare and Medicaid. Medicare is a federal insurance program for people age 65 and older and for people with disabilities;[1] Medicare uses the term "skilled nursing facility" (SNF) to identify its certified nursing homes. Medicaid, or Medical Assistance, is a federal-state health care program for poor people, regardless of age;[2] Medicaid uses the term "nursing facility" (NF). The standards for SNFs and NFs are, with a few minor exceptions, identical.[3] Most facilities participate in one or both programs, with nearly 90% of certified facilities participating in both.[4] All nursing homes must meet state licensing requirements, whether or not they also choose federal certification.

The nursing home industry in the United States is largely a for-profit industry, increasingly dominated by multi-facility entities, known as chains. In 2008, more than two-thirds (67.14%) of the nursing facilities in the United States were for-profit, one-quarter (26.46%) were not-for-profit, and 5.82% were owned by government.[5] In 2008, more than half (53.89%) of facilities nationwide were owned by chains.[6]

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[1] Title XVIII of the Social Security Act, 42 U.S.C. §1395.
[2] Title XIX of the Social Security Act, 42 U.S.C. §1396. Medicaid is a needs-based health care program, administered jointly by the federal and state governments.
[3] 42 C.F.R. Part 483 applies to both SNFs and NFs.
[4] CMS, *Nursing Home Data Compendium* (2008 Edition) 5, Figure 1.5 (in 2007, 89.2% of facilities participated in Medicare and Medicaid; 5.3%, in Medicare only; and 5.5% in Medicaid only), http://www.cms.hhs.gov/CertificationandComplianc/Downloads/2008NursingHomeDataCompendium_508.pdf.
[5] Charlene Harrington, Helen Carrillo, Brandee Woleslagle Blank, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 Through 2008*, page 20 (Nov. 2009).
[6] *Id.* 22.

Nurse staffing is critical

There is an indisputable correlation between the number of nurses (RN, RPN and PSW) who provide direct care to residents on a daily bases (high "nurse staffing" levels) and high quality of care and quality of life for residents. Numerous reports and studies confirm that nursing facilities provide better care to their residents , and residents have better outcomes, when facilities are adequately staffed. No report finds better quality with fewer staff.

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A study in California found that facilities whose nurse aide staffing levels were at the highest decile (top 10%) had better results on 13 of 16 care processes, when compared with facilities employing fewer nurse aides. Residents in the highest-staffed facilities "spent more time out of bed during the day; were engaged more frequently; received better feeding and toileting assistance; were repositioned more frequently; and showed more physical movement patterns during the day that could reflect exercise."[7]

A synthesis of 71 published reports, expert opinion, and peer-reviewed studies of nurse staffing and quality of care, all published between 2002 and 2007, reported:

Higher staffing levels and other staffing characteristics in the nation's nursing facilities, including lower rates of turnover, have been repeatedly associated with better outcomes for residents; . . . .Higher staffing levels and lower rates of staff turnover have also been associated with functional improvement measures, earlier discharges from nursing facilities, and fewer [pressure ulcers]. . . .
. . .
Qualitative studies have also established a relationship between staffing characteristics and resident outcomes. For example, inadequate staffing levels, lack of training, and a dearth of supervision of [certified nurse assistants] CNAs have been associated with poor incontinence care, inadequate repositioning, and insufficient mouth care. Inadequate staffing and poor supervision have also been related to insufficient nutritional intake and increased prevalence of malnutrition and dehydration among nursing facility residents . . . . [article citations omitted]

While acknowledging that the staffing and quality research is limited by the unreliability of self-reported staffing data, small sample size, use of diverse measures of quality, and methodological concerns, another

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[7] John E. Schnelle, Sandra F. Simmons, Charlene Harrington, Mary Cadogan, Emily Garcia, and Barbara M. Bates-Jensen, "Relationship of Nursing Home Staffing to Quality of Care," *Health Services Research* , Vol. 39, No. 2, pages 225-250 (April 2004), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361005/pdf/hesr_00225.pdf.

review of 70 studies conducted between 1991 and 2006 found that the relationship between staffing and quality was strongest in the studies that had fewer limitations.[8]

Staffing standards do not preclude a comprehensive approach

The Sharkey Report argues that staffing standards alone do not ensure high quality care.[9] While true, the argument is a red herring. No one suggests that adding staff members, by itself, is sufficient to improve quality of care for residents. Appropriate recruitment, training, and supervision of staff are necessary as well as consistent assignment of staff to residents, sufficient supplies to allow staff to do their jobs, and an appropriate mix of licensed and paraprofessional nursing staff.[10]

Research cited by the Sharkey Report fully supports the need for enforceable staffing standards as a necessary component of comprehensive reform. The Canadian Health Services Research Foundation's 2006 report *Staffing for Safety*, which describes primarily hospital-based studies and licensed nursing, identifies as "one of the most important predictors of patient well-being . . . the amount of direct nursing care patients receive per day."[11] This synthesis of the research literature reports, "Research reveals a close link between inappropriate nurse staffing levels and higher rates of unwanted outcomes for patients."[12] In addition to staffing levels, the report identifies "education, experience, skill mix, and leadership qualities" as factors affecting the quality of nursing care.[13]

Other research cited in the Sharkey Report as recommending a "broader approach" to staffing issues similarly recognizes the importance of nurse staffing levels. Greg Arling's study, the first study to measure staffing on an individual resident basis, recognized that "A certain minimum level of staffing (which most if not all facilities in our study may have met) is a necessary condition for good quality."[14] The study recognized that "after that the most important determinant may be the expertise of

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[8] Nicholas G. Castle, "Nursing Home Caregiver Staffing Levels and Quality of Care: A Literature Review," *Journal of Applied Gerontology*, Vol. 27, pages 375-405 (Aug. 2008)..

[9] *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes* 9, 18 (May 2008) [hereafter Sharkey Report].

[10] Eric Collier and Charlene Harrington, "Staffing Characteristics, Turnover Rates, and Quality of Resident Care in Nursing Facilities," *Research in Gerontological Nursing*, Vol. 1, No. 3, pages 157-170 (2008); Nicholas G. Castle, John Engberg, "The influence of staffing characteristics on quality of care in nursing homes," *Health Services Research*, Vol. 42, No.5 (Oct. 2007),, http://findarticles.com/p/articles/mi_m4149/is_5_42/ai_n21041656/ (finding that staffing levels, turnover, staff stability, and use of agency staff influence nursing home quality). *See also* Nicholas G. Castle and John Engberg, "Further Examination of the Influence of Caregiver Staffing Levels on Nursing Home Quality," *The Gerontologist*, Vol. 48, No. 4, pages 464-476 (2008), http://gerontologist.gerontologyjournals.org/cgi/reprint/48/4/464 (asserting that "resident care is dependent not only on how much is done (represented primarily by staffing levels), but also upon consistency of care, coordination, and care practices").

[11] Canadian Health Services Research Foundation, *Staffing for Safety: A Synthesis of the Evidence on Nurse Staffing and Patient Safety*, page i (Sep. 2006), http://www.chsrf.ca/research_themes/pdf/staffing_for_safety_policy_synth_e.pdf.

[12] *Id.* iii.

[13] *Id.*

[14] Greg Arling, Robert L. Kane, Christine Mueller, Julie Bershadsky, and Howard B. Degenholtz, "Nursing Effort and Quality of Care for Nursing Home Residents," *The Gerontologist*, Vol. 47, No. 5, pages 672-682 (2007), http://gerontologist.gerontologyjournals.org/cgi/reprint/47/5/672.

direct care staff, staff morale and teamwork, facility or unit management practices, care-related technologies, and so on."[15] The findings in Christine Mueller's "Framework for Nurse Staffing in Long-Term Care Facilities" were no different. While identifying "multiple factors" at work in producing high quality care, the article cited a U.S. Senate Special Committee on Aging's 1999 hearing whose "compelling testimony" recognized that "the most important factor related to poor nursing home quality across the country is the inadequate numbers and training of nurses to provide care to residents."[16]

Factors other than numbers of staff are important for ensuring high quality of care for nursing home residents. The Sharkey Report stresses non-staffing-level factors, but does not acknowledge that sufficient numbers of staff are fundamental to quality. Without sufficient staff as a base, no amount of "staff morale and teamwork" can assure high quality of care for residents. The question is how best to ensure sufficient nursing staff.

Voluntary standards do not increase staffing levels

The Sharkey Report suggests that a multi-disciplinary team in each facility develop a staffing plan for that facility.[17] Under this approach, each would develop a staffing plan appropriate for its resident population and, presumably, follow it. Such a voluntary, facility-based approach to staffing has been used in the United States for more than two decades, without achieving increased or appropriate nurse staffing levels.

After a period of deregulation in the early 1980s, the United States enacted legislation in 1987 to revise all federal regulation of nursing facilities.[18] This legislation, called the Nursing Home Reform Law, did not establish nurse staffing ratios. Instead, using the higher staffing standard of the Medicare program for facilities participating in either Medicare or Medicaid, or both, the law required that each facility have one registered nurse (RN) for eight consecutive hours each day (essentially, an RN on the day shift), licensed nurses 24 hours each day, and otherwise, "sufficient staff" to meet residents' needs.[19] Under federal law, the determination of how many staff members are "sufficient" is left up to individual facilities. Congress also called for an independent study of nurse staffing needs.[20]

Despite the statutory mandate to determine and have "sufficient" staff to meet residents' needs and despite increased resident acuity, facilities have not significantly

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[15] *Id.*
[16] Christine Mueller, "A Framework for Nurse Staffing in Long-Term Care Facilities," *Geriatric Nursing*, Vol. 21, No. 5, pages 262-267 (2000).
[17] Sharkey Report 22, Recommendations 5, 6.
[18] The Nursing Home Reform Law was enacted as part of the Omnibus Budget Reconciliation Act of 1987, 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.
[19] 42 U.S.C. §§1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i)(1), (2).
[20] Public Law 101-508, §4801(b)(7)(e)(17)(B) (requiring the Secretary of the Department of Health and Human Services to conduct a study and report to Congress by January 1, 1992 "on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios" and to include "study recommendations regarding appropriate minimum ratios.")

changed their staffing levels since the October 1, 1990 effective date of the Reform Law.

The Congressionally-mandated study of nurse staffing needs, completed in 2001, was the most comprehensive evaluation of nursing home staffing levels ever conducted in the United States. The study found that 97% of facilities nationwide failed to meet one or more federal staffing requirements and that these failures placed residents at avoidable risk of harm.[21] The simulation component of the study calculated that 91% of facilities nationwide lacked sufficient staff to meet five key care processes required by the Reform Law (dressing/grooming, exercise, feeding assistance, changing wet clothes and repositioning, and toileting), that more than 40% of facilities nationwide would need to increase their nurse aide staffing by 50%, and that more than 10% of facilities would need to increase their nurse aide staffing by more than 100%.[22] Eleven years[23] after comprehensive federal legislation directed nursing facilities to determine, and employ, the correct number of staff members they needed to provide care to residents, most facilities did not have sufficient direct care staff. Staffing has not improved since the 2001 CMS study.[24]

While nurse staffing did not increase following enactment of the 1987 Reform Law or release of the 2001 staffing study, residents' care needs did. Federal data indicate that residents' acuity levels increased between 1990 and the present, in part due to the increased availability of alternatives to nursing homes (including home care and assisted living facilities). CMS now reports that

> the proportion of residents with severe Activities of Daily Living (ADL) impairment has been increasing. Nearly half of all nursing home residents require extensive assistance with at least four of the five Activities of Daily Living (ADL) that were examined (bed mobility, transferring, dressing, eating, or toileting). In 2003, about 39 percent of residents required assistance with four or more ADLs. In 2007, about 47 percent of residents required the same level of assistance.[25]

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[21] CMS, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II*, page 1-6 (Winter 2001). *See also* Testimony of Andrew Kramer, MD, lead researcher on the CMS study, before the Senate Special Committee on Aging, *Nursing Home Residents: Short-Changed by Staff Shortages, Part II* (July 27, 2000), http://aging.senate.gov/events/hr55ak.pdf.

[22] CMS, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II*, page 1-7 (Winter 2001). *See also* Testimony of John F. Schnelle, PhD., lead researcher on the simulation component of the CMS study, before the Senate Special Committee on Aging, *Nursing Home Residents: Short-Changed by Staff Shortages, Part II* (July 27, 2000), http://aging.senate.gov/events/hr55js.pdf.

[23] The Reform Law was enacted in December 1987 and required skilled nursing and nursing facilities to meet the new standards of care on October 1, 1990. Congress gave facilities three years to prepare for the new law.

[24] Charlene Harrington, Helen Carrillo, Brandee Woleslagle Blank, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 Through 2008*, page 60 (Nov. 2009). Between 2003 and 2008, nurse staffing levels in facilities certified for Medicaid only or both Medicare and Medicaid remained virtually unchanged: RN coverage per resident per day increased from 0.50 hours to 0.55 hours; licensed practical nurse/licensed vocational nurse (LPN/LVN), from 0.70 hours to 0.78 hours; and nurse aides, from 2.20 hours to 2.33 hours. *See also* 61-63, Tables 25 and 26. In Medicare-only facilities, RN coverage per resident per day declined from 2.5 in 2003 to 2.25 in 2008; LPN coverage declined from 1.5 to 1.31; and nurse aide coverage increased from 2.7 to 2.76. *Id.* 64. *See also* 65-67, Tables 27 and 28.

[25] CMS, *Nursing Home Data Compendium* (2008 Edition), page ii, http://www.cms.hhs.gov/CertificationandComplianc/Downloads/2008NursingHomeDataCompendium_508.

Residents' increased needs for direct care have not led to increased staffing levels.

Increasing reimbursement to nursing facilities does not lead to increased staffing

The Sharkey Report recommends that the Province of Ontario provide annual funding for enhanced staffing.[26] Raising payment rates to encourage better staffing levels is ineffectual. Increasing rates, with the hope and expectation that increased staffing will follow, does not work. The United States has used this approach repeatedly, at both the federal and state levels, without success. The results of reimbursement-based approaches to staffing increases have been, at best, stagnant staffing levels, and, at worst, lower staffing. Increasing public reimbursement has simply led to more money for facility profits and administrative overhead.

In 2000, Congress increased the nursing component of the federal Medicare rate by 16.66%, effective April 1, 2001,[27] giving skilled nursing facilities approximately $1 billion in additional payments per year.[28] The federal Government Accountability Office (GAO) described the rate increase as raising "the overall SNF payment rates by 4 to 12 percent, depending on the patient's expected care needs."[29] Unfortunately, as the GAO pointed out, the federal law "did not require facilities to spend this additional money on nursing staff."[30]

Skilled nursing facilities actually used less than 20% of the new staffing dollars for nursing staff. The GAO estimated that nurse staffing would have increased by about 10 minutes per patient day "if SNFs had devoted the entire nursing component increase to more nursing time."[31] But analyzing available data from slightly more than one-third of all skilled nursing facilities nationwide,[32] the GAO found,

> in the aggregate, SNFs' nurse staffing ratios changed little after the increase in the nursing component of the Medicare payment rate took effect. Overall,

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pdf. *See also* 45, Figure 3.1, showing declining number of residents with impairments with one, two, or three ADLs and increasing number of residents with impairments in four ADLs.

[26] Sharkey Report 16, Recommendation #2.

[27] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, App. F, §312(a), 114 Stat. 2763, 2763A-498, Government Accountability Office, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, page 1, GAO-03-176 (Nov. 2002), http://www.gao.gov/new.items/d03176.pdf. BIPA also increased daily rates by 6.7% for 14 resident categories, effective April 2001, BIPA §314. In earlier legislation, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Congress raised daily rates by 20% for 15 high-cost resident categories, beginning in April 2000, Pub. L. No. 106-113, App. F, §101, 113 Stat. 1501, 1501A-324; and increased the daily rate for all facilities by 4% for fiscal years 2001and 2002. *See* GAO, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase* at 6, notes 17-19.

[28] Government Accountability Office, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, page 6, GAO-03-176 (Nov. 2002), http://www.gao.gov/new.items/d03176.pdf

[29] *Id.* 1-2.

[30] *Id.* 2.

[31] *Id.* 10.

[32] The GAO found that these 6500 facilities and the total of 13,454 facilities were not statistically different "in terms of type of facility, size, ownership, and the share of SNF patients paid for by Medicare." *Id.* 2.

> SNFs' average nursing time increased by 1.9 minutes per patient day, relative to their average in 2000 of about 3 and one-half hours of nursing time per patient day.[33]

In contrast to virtually stagnant staffing levels in most states, the GAO found that nursing facilities in four states, which it did not identify, "increased their staffing by 15 or more minutes per patient day."[34] Three of these four states implemented "payment or policy changes . . . aimed at increasing or maintaining SNF nursing staff."[35] In short, the GAO found that reimbursing facilities at higher rates, in hopes that they would use the money to increase staffing, did not work. It concluded, "increasing the Medicare payment rate was not effective in raising nurse staffing."[36] The most effective way to increase staffing is to **require** increased staffing.

States that have raised their Medicaid rates in hopes of increasing nurse staffing levels have been similarly ineffectual in achieving their goal.

Beginning in 2000, the state of Florida began to use a variety of methods to improve nurse staffing in nursing facilities.[37] An analysis of nurse staffing in Florida nursing facilities by the University of South Florida found that "staffing as measured by [hours per resident day] hprd increases when legislatively required, not with financial incentives."[38]

In 2000, Florida authorized $40 million in financial incentives for direct care, using the same approach that Congress would later attempt with Medicare reimbursement in 2000. Nurse staffing levels did not increase; they actually *decreased*.[39]

In 2002, the Legislature amended the state law to mandate specific nurse staffing ratios, phased in over several years. The new law led to increased staffing between 2002 and 2008. Then, in July 2008, faced with fiscal crises, the state Legislature prohibited the state from imposing sanctions against nursing facilities that did not meet the final, highest state staffing standard. Following the Legislature's action, staffing declined below the highest mandated level.[40]

Researchers with the University of South Florida report:

> [W]hen providers are allowed to spend reimbursement as they deem appropriate, direct care hours per resident day decrease. The trend line of

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[33] *Id.* 3.
[34] *Id.* 9.
[35] *Id.* 9.
[36] *Id.* 4.
[37] University of South Florida, *Preliminary Analyses on Outcomes of Increased Nurse Staffing Policies in Florida Nursing Homes: Staffing Levels, Quality and Costs (2002-2007)*, pages 5-6 (Feb. 2009), http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/pdfs/preliminary_nursing_home_staffing_analyses_usf_final_031109.pdf.
[38] *Id.* 12-13.
[39] *Id.* 13, Figure 1-3.
[40] *Id.* 13.

> average staffing per resident day suggests that only when minimum standards are established and enforced do hours of per resident care increase.[41]

The researchers also found that housekeeping and activity staff, whose ratios are not mandated by state law, declined between 1999 and 2004.[42]

In 2004, the state of California made similar efforts to improve nurse staffing levels by raising Medicaid reimbursement rates. Beginning in 2006, California raised Medicaid rates by $590 million. When all funding sources were considered, rates increased by $1.1 billion. The reimbursement-based effort to raise staffing levels was, like Congress' and Florida's efforts, ineffective.[43]

Researchers with the University of California, San Francisco who analyzed the impact of the rate increases found small increases in the numbers of registered nurses and certified nurse assistants.[44] Within the category of wages and benefits, the highest increases went to administrators, compared to licensed nurses and nursing assistants.[45]

Facilities spent their increased reimbursement on expenses other than nursing staff. Between 2004 and 2006, total spending in administration increased 36.75% while total spending in direct care costs, including staff, declined by 3.7%.[46] Facilities in California also became considerably more profitable after the rate increases went into effect. Net income increased 129% between 2001 and 2006 and 233% between 2004 and 2006.[47]

The California researchers concluded:

> At this point, there is no evidence that the new Medi-Cal[48] reimbursement incentives are sufficient to encourage increases in nursing staffing and increased wages and benefits, which are necessary to improve the quality of nursing home care and reduce staff turnover rates. Without attaching more specific minimum requirements for staffing levels and

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[41] *Id.* 11.
[42] *Id.* 15, 16 (Figures 1.5a and 1.5b).
[43] Charlene Harrington, *Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs* (2008), http://www.medicareadvocacy.org/SNF_CHCFNHReimbursementPaper.pdf. *See also* Charlene Harrington, James H. Swan, and Helen Carrillo, "Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities," *Health Serv. Res.*, Vol. 42 (3 Pt 1), pages 1105-1129 (June 2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955251/ (concluding that while raising Medicaid rates leads to some increases in nurse staffing, a more effective way to increase staffing is to mandate it explicitly.)
[44] Charlene Harrington, *Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs*, pages 22-23 (2008), http://www.medicareadvocacy.org/SNF_CHCFNHReimbursementPaper.pdf. Total nursing staff increased by 3% between 2004 and 2006. RN hours decreased by 8% between 2001 and 2006, increasing by 1.4% between 2004 and 2006. The largest increase in nurse staffing occurred in licensed vocational nurse hours; LVN hours increased by 20% between 2001 and 2006, including 9% between 2004 and 2006. *Id.*
[45] *Id.* 31, Table 6.
[46] *Id.* 29, Table 5.
[47] *Id.* 31.
[48] California's name for the Medicaid program is Medi-Cal.

penalties for poor quality of care, the new payment system appears unlikely to achieve its goals. Florida's experience with financial incentives did not show benefits until higher staffing standards were adopted.[49]

[49] Charlene Harrington, *Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs*, page 62 (2008), *http://www.medicareadvocacy.org/SNF_CHCFNHReimbursementPaper.pdf*.

Resident assessment, by itself, does not lead to better staffing

Although assessments identify residents' needs for services and these needs are incorporated into residents' individual care plans, assessments and care plans, by themselves, do not lead to increase nurse staffing levels.

Since the Nursing Home Reform Law went into effect in October 1990, all nursing facilities in the United States that receive Medicare or Medicaid payments, or both, have been required to conduct resident assessments using a uniform resident assessment instrument, called the Minimum Data Set.[50] The Province of Ontario has adapted the same assessment instrument. Although assessments identify residents' needs for services and these needs are incorporated into residents' individual care plans, assessments and care plans, by themselves, do not lead to increased nurse staffing levels. Assessments and care plans work only if they are implemented. Too often, care plans are implemented only in part or not at all when facilities lack sufficient numbers of staff to perform labor-intensive tasks.[51]

A care plan may document that a resident needs assistance with eating. The lack of sufficient staff may result in the assignment of a single staff member to feed multiple residents simultaneously in a short amount of time. The staff member may provide insufficient assistance to ensure that each resident actually eats the meal or may not feed some residents at all. A nursing facility may determine that a particular resident needs two aides for transfers and the care plan may require that two aides perform all transfers. But, in the absence of sufficient staff, one aide may attempt to transfer a resident alone. The result may be that the resident falls and is injured.[52]

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[50] 42 U.S.C. §§1395i-3(b)(3), 1396r(b)(3); 42 C.F.R. §483.20.

[51] Greg Arling, Robert L. Kane, Christine Mueller, Julie Bershadsky, and Howard B. Degenholtz, "Nursing Effort and Quality of Care for Nursing Home Residents," *The Gerontologist*, Vol. 74, No. 5, pages 672-682 (2007), http://gerontologist.gerontologyjournals.org/cgi/reprint/47/5/672 (finding "Nurse aide time was significantly higher for residents who were physically restrained, participating in a toileting program, or received range of motion or ADL training.").

[52] A recent series in the *Minneapolis Star-Tribune* reported that more than 100 nursing home residents die in Minnesota each year in falls-related incidents. One of the common causes is transfers by one aide when the resident's assessment and care plan call for two aides. David Joles, "More than 100 Minnesotans die each year after suffering falls in nursing homes. Few deaths are fully investigated by the state, and serious penalties for violations are rare," *Minneapolis Star-Tribune* (Nov. 19, 2009), http://www.startribune.com/lifestyle/health/70132502.html?elr=KArksUUUycaEacyU.

Accountability for resident outcomes must be objectively determined

Experience in the United States demonstrates that these types of evaluations of quality, largely promoted by the nursing home industry as an alternative to the public oversight system, are subjective and inadequate.

The Sharkey Report suggests that accountability for resident outcomes should be determined through quality indicators and resident, family, and staff satisfaction surveys.[53] Experience in the United States demonstrates that these types of evaluations of quality, largely promoted by the nursing home industry as an alternative to the public oversight system, are subjective and inadequate. As recommended by experts, publicly-reported facility ratings in the United States are based on composite scores reflecting primarily survey performance, with staffing and quality indicators affecting ratings at the extreme high and low ends. Satisfaction surveys are not included at all in the federal regulatory system to determine accountability for resident outcomes.

Quality indicators

Quality indicators or performance indicators are resident-specific data that are derived from resident assessment information and are case-mix adjusted. When called quality indicators or performance indicators, they are intended to give meaningful information about quality of care provided by nursing facilities.

Identifying four "barriers to successful performance measurement" – "complex nature of quality in nursing homes, diversity of the nursing home population, lack of knowledge about how homes, as organizations, generate quality, and validity of comparisons among homes using current quality indicators" – four leading researchers in the United States argue that current "rankings [of performance measurement] are of questionable validity."[54] While recognizing that performance measurement has become popular over the last few years, they contend that current reporting for all facilities nationwide is flawed because of the difficulties and complexities in measuring facility performance.

The *multi-dimensionality of quality* makes it difficult to summarize quality in a facility because an individual facility may perform well or poorly on different indicators and there is usually little correlation among the indicators.

The *multi-dimensionality of the nursing home population* reflects the diversity of residents and their needs.

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[53] Sharkey Report 25, Recommendations 9-11.

[54] Charles D. Phillips, Catherine Hawes, Trudy Lieberman, and Mary Jane Koren," Where should Momma go? Current nursing home performance measurement strategies and a less ambitious approach," *BMC Health Services Research*, Vol. 7, pages 93-100 (2007), http://www.biomedcentral.com/content/pdf/1472-6963-7-93.pdf.

Home-related variation in quality indicators reflects the difficulty in attributing differences in resident outcomes to nursing home characteristics.

Risk-adjustment and the validity of quality indicators reflect the concern that "current indicators poorly reflect observed care in homes."[55] The researchers expressed concern with risk adjustments that attempt to account for actual resident differences. They contend that over-adjusting makes "bad homes look mediocre, and under-adjusting may make good homes look mediocre."[56]

The researchers recommend a new, more limited approach that reports on only a small subset of facilities,[57] Since 2006, Consumer Union's Nursing Home Quality Monitor has used this approach and reported three dimensions of quality – nurse staffing levels, deficiencies in the three most recent surveys, and quality indicators – to identify only the top 10% and the bottom 10% in each state (as determined by top 10% or bottom 10% in performance in at least two of the three quality dimensions).

The federal government provides public information about quality measures for *all* nursing facilities in the country that participate in Medicare and Medicaid. The Centers for Medicare & Medicaid Services's Five-Star Quality Rating System, implemented in December 2008, uses the same three dimensions of care as the Quality Monitor.[58] Each dimension is separately rated on a five-point scale. A separate composite score combines all three dimensions, but bases the score primarily on facilities' survey performance, making adjustments at the extreme ends (one or five stars) to reflect staffing information or quality indicators or both.[59]

Research finds that public reporting of quality information is unlikely to improve nursing home quality.[60] Consumers do not use the information for many reasons, ranging from the speed and stress of placement decisions to lack of familiarity with the internet, where much of the quality information appears. Facilities are also unlikely to improve the quality of care they provide based on quality indicator scores. The research concludes that public reporting of quality information is "best

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[55] *Id.*
[56] *Id.*
[57] *Id.* The researchers base their new model on five principles:
1. A home's relative values on multiple dimensions of quality should be considered.
2. The home's performance over time should be included in the analysis.
3. How a home fared on each dimension of quality over time should be aggregated into a single summary statement about a home.
4. The results should be used only to identify facilities that score very badly or very well on multiple dimensions of quality.
5. One should place more confidence in the possibility that a home may provide poor care than that a home may provide a high quality care.

Id.
[58] CMS, "Five Star Quality Rating System," http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp.
[59] CMS, "Design for *Nursing Home Compare* Five-Star Quality Rating System: Technical Users' Guide" (Sep. 2009), http://www.cms.hhs.gov/CertificationandComplianc/Downloads/usersguide.pdf.
[60] David G. Stevenson, "Is a Public Reporting Approach Appropriate for Nursing Home Care?," *Journal of Health Politics, Policy and Law*, Vol. 31, No..4, pages 773-810 (Aug. 2006). Abstract available at http://jhppl.dukejournals.org/cgi/content/abstract/31/4/773.

viewed as complementary to existing quality assurance and improvement strategies," not as an alternative.[61]

Satisfaction surveys

The Sharkey Report recommends that the Ministry of Health and Long-Term Care support the development of standardized, province-wide tools to determine resident, family, and staff satisfaction.[62] Although understanding how residents, families, and staff view their experiences could add an important dimension to evaluating the quality of nursing facilities, satisfaction surveys, as currently used, too often provide little meaningful information. Promoted by the nursing home industry, satisfaction surveys have been used by facilities as part of their ongoing efforts to support non-regulatory approaches to evaluating facility quality.[63]

In an early evaluation of customer satisfaction surveys, the federal Department of Health and Human Services's Office of Inspector General found that health maintenance organizations (HMOs) used a variety of survey instruments and procedures, so that differences in results were difficult to compare. More than half the survey instruments "include[d] no questions about problems with or complaints about health plan services."[64] Five-point rating scales often included three positive responses, with only a single neutral response and a single negative response available;[65] almost all of the HMOs that used only "agree/disagree" statements "include[d] only positive statements for respondents to respond to."[66] Concluding that HMOs "use their survey results as much for marketing as for quality improvement,"[67] the Inspector General cautioned against using provider-generated customer satisfaction surveys because of their "lack of uniformity, limited focus on Medicare beneficiaries and technical weaknesses."[68]

These limitations with satisfaction surveys continue in satisfaction surveys that are used in nursing facilities in the United States today. An industry-led quality improvement Campaign, *Advancing Excellence in America's Nursing Homes*, has promoted resident/family satisfaction surveys and staff satisfaction surveys as two of its eight Campaign goals, but the goals are broad and require only that facilities have a satisfaction survey and use the information in their quality improvement activities.[69]

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[61] *Id.* at 805.
[62] Sharkey Report 25, Recommendation 10.
[63] MyInnerView®, *2007 National Survey of Consumer and Workforce Satisfaction in Nursing Homes,* page 37 (May 2008), http://www.myinnerview.com/_media/doc/general/2007natrpt.pdf.
[64] Office of Inspector General, *[Health Maintenance Organization] HMO Customer Satisfaction Surveys*, page 7, OEI-02-94-00360 (March 1995), http://oig.hhs.gov/oei/reports/oei-02-94-00360.pdf.
[65] *Id.* 8.
[66] *Id.*
[67] *Id.* 9.
[68] *Id.* 10.
[69] Goal 7, Resident/Family Satisfaction, "Almost all Nursing Homes will assess resident and family experience of care and incorporate this information into their quality improvement activities," http://www.nhqualitycampaign.org/files/impguides/7_ResidentFamilySatisfaction_TAW_Guide%20FINAL%2010%205.pdf; Goal 8, Staff Satisfaction, "Almost all nursing homes will assess staff satisfaction with their work environment at least annually and upon separation and incorporate this information into their quality improvement activities,"

The Campaign has identified 13 different satisfaction survey tools that are currently offered, all but one, by proprietary companies.[70] These 13 tools cover different domains of care, are administered by mail or in-person interview, and may or may not use a cognitive screen for residents. Comparing results across facilities using different satisfaction surveys is not possible.

The most widely-used satisfaction survey for residents and families offers four choices – two positive and two negative, but no neutral middle option.[71] The survey appears skewed to find positive results. This concern is heightened by the company's two most recent annual reports, which describe general trends in resident and family satisfaction and combine the two positive scores into a single measure of satisfaction, but do not report actual survey results on each of the four survey options.[72] A focus on marketing continues. A separate survey for short-stay residents describes as "the all-important question . . . 'What is your recommendation of this facility to others?'" and reports that "word-of-mouth recommendations" can be the "most powerful forum of advertising."[73]

Even if the Sharkey Report's recommendation for uniform, independently-administered satisfaction surveys in the Province were adopted, satisfaction surveys, at best, would continue to provide information primarily about residents' subjective experiences of care. These subjective experiences generally reflect interpersonal relationships between patients and their health care providers, not technical aspects of quality of care.[74] Researchers conclude that patients' ratings do not preclude the need for objective evaluation of the technical quality of care that residents receive.[75]

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http://www.nhqualitycampaign.org/files/impguides/8_StaffSatisfaction_TAW_Guide_FINAL%20%2010%205%20.pdf.

[70] Nursing Home Satisfaction Survey Tools, http://www.nhqualitycampaign.org/files/SATISFACTION%20TOOL%20MATRIX.pdf.

[71] MyInnerView®, *2008 National Survey of Consumer and Workforce Satisfaction in Nursing Homes* 34 (May 2009), http://www.myinnerview.com/_media/doc/national_report/natrptdraft_050809.pdf (describing four-point scale -- excellent, good, fair, poor).

[72] *Compare* My InnerView®, *2008 National Survey of Consumer and Workforce Satisfaction in Nursing Homes* (May 2009), http://www.myinnerview.com/_media/doc/national_report/natrptdraft_050809.pdf?PHPSESSID=d402e5994eaee3e69cab7bc8c328a030,, and My InnerView®, *2007 National Survey of Consumer and Workforce Satisfaction in Nursing Homes* (May 2008) (providing summary information) *with* My InnerView®, *2005 National Survey of Resident and Family Satisfaction in Nursing Facilities* (June 2006) (reporting ratings in each of the four options), http://www.myinnerview.com/_media/doc/national_report/2005NatRpt_Color.pdf

[73] Brad Shiverick, My InnerView®, "The Changing Landscale from long term care to short-term stay; What are your short-stay customers saying," *Provider* (May 2008), http://www.ahcancal.org/News/publication/Provider/MyInnerview0508.pdf.

[74] John T. Chang, et al, "Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care," *Annals of Internal Medicine*, Vol. 144, pages 665-672, (2006), http://www.annals.org/content/144/9/665.full.pdf+html.

[75] *Id.*

The best way to achieve appropriate staffing levels is to require them by law and to enforce the standards.

Conclusion

Staffing levels are a fundamental component of nursing home quality. Without sufficient numbers of staff, high quality of care and quality of life for residents cannot be realized. The best way to achieve appropriate staffing levels is to require them by law and to enforce the standards.