

June 10, 2022

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Baltimore, Maryland 21244-8016

Submitted electronically through [www.regulations.gov](http://www.regulations.gov)

**Re: Response to Request for Information  
CMS-17665-P**

Dear Ms. Brooks-LaSure:

Justice in Aging strongly supports the Administration's proposal to set mandatory minimum staffing levels. The research is clear: quality of care depends heavily on adequate staffing; likewise, substandard staffing often is the root cause of poor nursing facility care.

The Request for Information requests input on 17 separate questions related to minimum staffing levels.<sup>1</sup> This letter responds to each of those questions.

**Question 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?**

Evidence of Appropriate Standard

The most prominent study has been the 2001 study from Abt Associates, with recommendations of a minimum of 0.75 Registered Nurse (RN) hours per resident day (hprd), 0.55 Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN) hprd, and 2.8 (to 3.0) Certified Nursing Assistant (CNA) hprd, for a

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<sup>1</sup> 87 Fed. Reg. 22,720, 22,794-95 (April 15, 2022).

total of at least 4.1 nursing hprd to prevent resident harm and jeopardy.<sup>2</sup> These standards were confirmed in a 2004 observational study,<sup>3</sup> and then again in a simulation study that found a need for between 2.8 and 3.6 hprd for CNA hours only to ensure adequate care to residents with varying needs.<sup>4</sup> In addition, some experts have recommended a minimum of 4.55 hprd, with adjustments for resident acuity or case-mix.<sup>5</sup>

### Benefits of Adequate Staffing Levels

Many studies have found a strong relationship between nursing staffing levels and improved quality of care, based both on process and outcome measures.<sup>6</sup> In particular, studies have found strong relationships between RN staffing levels and quality measures.<sup>7</sup> Studies have shown that higher nurse staffing levels are associated with improved resident outcomes in each of the following areas:

- functional improvement;<sup>8</sup>

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<sup>2</sup> Centers for Medicare & Medicaid Services, Abt Associates Inc., *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final*, Volumes I–III, Baltimore, MD: CMS, 2001.

<sup>3</sup> Schnelle, J.F., Schroyer, L.D., Saraf, A.A., Simmons, S.F., *Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model*, *JAMDA*, 17:970-977 (2016).

<sup>4</sup> Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M., Garcia, E., Bates-Jensen, B., *Relationship of nursing home staffing to quality of care?*, *Health Serv Res.* 39 (2):225-250 (2004).

<sup>5</sup> Harrington, C, Kovner, C, Kayser-Jones, J, Berger, S, Mohler, M, Burke R. et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist*, 2000: 40 (1):1-12.

<sup>6</sup> Castle, N. (2008). Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology*, 27: 375-405; Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic\$,* 33 (2):95-108 and 116; Castle, N.G. & Anderson, R.A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6):545-552; Castle, N., & Engberg, J. (2008). Further examination of the influence of caregiver staffing levels on nursing home quality. *Gerontologist*, 48: 464-76; Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care? *Health Services Research*, 39 (2):225-250.

<sup>7</sup> Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic\$,* 33 (2):95-108 and 116.

<sup>8</sup> Horn, S.D., Sharkey, S.S., Hudak, S., Smout, R.J., Quinn, C.C., Yody, B. and Fleshner, I (2010). Beyond CMS Quality Measure Adjustments: Identifying Key Resident and Nursing Home Facility

- reduced incontinence;<sup>9</sup>
- reduced urinary tract infections and catheterizations;<sup>10</sup>
- better treatment of pain;<sup>11</sup>
- reduced incidence of pressure ulcers;<sup>12</sup>
- less incidence of weight loss and/or dehydration;<sup>13</sup>

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Factors Associated with Quality Measures. *J. American Medical Directors Association*. 11 (7):500-5; Alexander, G.L. 2008. An Analysis of Nursing Home Quality Measures and Staffing. *Quality Management in Health Care*. 17 (3):242-51; Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70.

<sup>9</sup> Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845.

<sup>10</sup> Castle, N.G. & Anderson, R.A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6):545-552; Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70; Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845; Wan, T.T.H., Zhang, N.J. & Unruh, L. (2006). Predictors of resident outcome improvement in nursing homes. *Western J. Of Nursing Research*. 28 (8):974-993.

<sup>11</sup> Castle, N.G. & Anderson, R.A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6):545-552.

<sup>12</sup> Castle, N.G. & Anderson, R.A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6):545-552; Alexander, G.L. 2008. An Analysis of Nursing Home Quality Measures and Staffing. *Quality Management in Health Care*. 17 (3):242-51; Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70; Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845; Lin, H. (2014). Revisiting the relationship between nurse staffing and quality of care in nursing homes: An instrumental variables approach. *J. of Health Economics*, 37: 13-24; Horn, S.D., Bender S.A., Ferguson, M.L., Smout, R.J. et al (2004). The national pressure ulcer long-term care study: Pressure ulcer development in long-term care residents. *J. American Geriatrics Society*, 52: 359-367.

<sup>13</sup> Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70; Simmons, S.F., Schnelle, J.F. (2004). Individualized feeding assistance care for nursing home residents: staffing requirements to implement two interventions. *J Gerontol A Biol Sci Med Sci*. 59(9):M966-73; Simmons, S.F., Keeler, E., Zhuo, X., Hickey, K.A., Sato, H.W., Schnelle, J.F. (2008). Prevention of unintentional weight loss in nursing home residents: a controlled trial of feeding assistance. *J Am Geriatr Soc*. Aug;56(8):1466-73; Horn, S.D., Bender S.A., Ferguson, M.L., Smout, R.J. et al

- improved infection prevention and control;<sup>14</sup>
- reduced falls;<sup>15</sup>
- reduced rehospitalization and emergency department use;<sup>16</sup>
- fewer incidents of “missed” care;<sup>17</sup>
- fewer adverse outcomes;<sup>18</sup> and
- and lesser mortality rates.<sup>19</sup>

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(2004). The national pressure ulcer long-term care study: Pressure ulcer development in long-term care residents. *J. American Geriatrics Society*, 52: 359-367.

<sup>14</sup> Uchida-Nakakoji, M., Stone, P. W., Schmitt, S. K., & Phibbs, C. S. (2015). Nurse workforce characteristics and infection risk in VA Community Living Centers: A longitudinal analysis. *Medical Care*, 53, 261–267; Trivedi, T.K., DeSalvo, T., Lee, L., Palumbo, A., Moll, M., Curns, A., Hall, A.J., Patel, M., Parashar, U.D., Lopman, B.A. (2012). Hospitalizations and mortality associated with norovirus outbreaks in nursing homes, 2009-2010. *JAMA*. Oct 24;308(16):1668-75.

<sup>15</sup> Leland NE, Gozalo P, Teno J, Mor V. (2012). Falls in newly admitted nursing home residents: a national study. *J Am Geriatr Soc*. 60(5):939-45; Spector, W., Shaffer, T., Potter, D.E., Correa-de-Araujo, R., Rhona Limcangco, M. (2007). Risk factors associated with the occurrence of fractures in U.S. nursing homes: resident and facility characteristics and prescription medications. *J Am Geriatr Soc*. 55(3):327-33.

<sup>16</sup> Xing, J., Mukamel, D. B., & Temkin-Greener, H. (2013). Hospitalizations of nursing home residents in the last year of life: Nursing home characteristics and variation in potentially avoidable hospitalizations. *Journal of the American Geriatrics Society*, 61, 1900–1908; Spector, W.D., Limcangco, R., Williams, C., Rhodes, W., Hurd, D. (2013). Potentially avoidable hospitalizations for elderly long-stay residents in nursing homes. *Med Care*. 2013 Aug; 51(8):673-81; Min, A. and Hong, H.C. (2019). Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A cross-sectional study using the US nursing home compare database. *Geriatr Nurs.*, 40 (2):160-165; Konetzka, R.T., Spector, W. & Limcangco, M.R. (2007). Reducing hospitalizations from long-term care settings. *Medical Care Research & Review*, 65:40-66.

<sup>17</sup> Simmons, S.F., Durkin, D.W., Rahman, A.N., Choi, L., Beuscher, L., Schnelle, J.F. (2013). Resident characteristics related to the lack of morning care provision in long-term care. *Gerontologist*. 53(1):151-61; Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 17:970-977.

<sup>18</sup> Konetzka, R.T., Stearns, S.C., Park, J. (2008). The staffing-outcomes relationship in nursing homes. *Health Serv Res*. 43(3):1025-42.

<sup>19</sup> Trivedi, T.K., DeSalvo, T., Lee, L., Palumbo, A., Moll, M., Curns, A., Hall, A.J., Patel, M., Parashar, U.D., Lopman, B.A. (2012). Hospitalizations and mortality associated with norovirus outbreaks in nursing homes, 2009-2010. *JAMA*. Oct 24;308(16):1668-75; Tong PK. (2011). The effects of California minimum nurse staffing laws on nurse labor and patient mortality in skilled nursing facilities. *Health Econ*. 20(7):802-16.

In addition, higher staffing levels are strongly associated with fewer quality of care deficiencies.<sup>20</sup> Likewise, lower staffing levels are associated with poorer infection and control practices, which obviously is of particular concern due to the dangers presented by COVID-19.<sup>21</sup>

### Continued Relevance of “Older” Studies

There is no reason to disregard previous studies. If anything, the previous studies underestimate the necessary levels of staffing. Resident acuity has increased consistently over the past 20 years, as has the focus on care that truly is resident-centered. As a result, minimum staffing levels today likely should be even higher than the recommended staffing levels from studies performed 10 or 20 years ago.

**Question 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?**

The most important function of the minimum staffing requirement is to create a meaningful floor on staffing levels. That floor would not be dependent upon resident assessments or acuity, since the floor must be set so that the facility has adequate capacity even if (for example) a particular group of residents all have very low needs.

We understand that some considerations are potentially in conflict here. On one hand, a minimum standard that varied with resident acuity might better maintain adequate staffing levels. On the other hand, however, calculation of a variable

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<sup>20</sup> Harrington C., Zimmerman D., Karon S.L., Robinson J., Beutel P. (2000). Nursing Home Staffing and Its Relationship to Deficiencies. *Journal of Gerontology Series B: Psychological Science and Social Science*. 55(5): S278-87; Castle, N.G., Wagner, L.M., Ferguson, J.C. & Handler, S.M.. (2011). Nursing home deficiency citations for safety. *J. Aging and Social Policy*, 23 (1):34-57; Kim, H., Harrington, C. & Greene, W. (2009). Registered nurse staffing mix and quality of care in nursing homes: A longitudinal analysis. *Gerontologist*, 49 (1):81-90.

<sup>21</sup> Rau, J. *Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses*, Kaiser Health News (Mar. 4, 2020), <https://khn.org/news/coronavirus-preparedness-infection-control-lapses-at-top-rated-nursing-homes/>.

minimum might lead the regulations to set an unduly low level for some facilities, and also lead to game-playing by facilities in reporting resident acuity.

Any minimum should be set with the expectation that CNAs be available in adequate numbers to provide care that truly is resident-centered, and to provide the care necessary to assist residents in reaching the highest practicable level of functioning. From a facility's operational perspective, the facility will want to adjust CNA levels based on acuity. As cited earlier in these comments, a recent study found a need for minimum CNA staffing that varies from 2.8 hprd to 3.6 hprd, depending on resident acuity.<sup>22</sup> Medicare and Medicaid payment rates often vary with resident acuity.<sup>23</sup> And, of course, facilities must perform assessments to determine staffing levels and make other facility-level decisions.<sup>24</sup>

All that being said, federal staffing minimums are better off if they service to set a robust floor. Acuity-based minimums will likely set a weaker floor, and also be more susceptible to complications and game-playing.

**Question 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?**

A 2022 study compared actual nursing facility staffing with the staffing recommended in the 2001 Abt Associates report. The study found that 95 percent of facilities failed to meet the recommended minimum staffing levels (4.10 hprd), and estimated that the overall cost to meet the staffing minimums would be \$7.25 billion, equivalent to a 4.2 percent increase in overall nursing facility expenditures.<sup>25</sup>

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<sup>22</sup> Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 17:970-977.

<sup>23</sup> Medicare Payment Advisory Commission (MEDPAC). Report to the Congress: Medicare Payment Policy. Chapter 7. Washington, D.C. March 2022; Medicaid and CHIP Payment and Access Commission (MACPAC). State's Medicaid fee-for-services nursing facilities payment policies. 2021. Washington, DC: MACPAC.

<sup>24</sup> 42 C.F.R. § 483.70(e).

<sup>25</sup> Hawk T, White EM, Bishnoi C, Schwartz LB, Baier RR, Gifford DR. Facility characteristics and costs associated with meeting proposed minimum staffing levels in skilled nursing facilities. *J Am Geriatr Soc*. 2022; 1-10. doi:10.1111/jgs.17678.

Another study, using data from the 1995/97 Staff Time Measurement (STM) studies as a benchmark for minimum staffing, found that 60 percent of facilities did not meet the minimum for total nursing staff, and estimated the costs of meeting staffing minimums would be \$500,000 on average for those not meeting the standard, or a total of \$4.9 billion annually.<sup>26</sup>

We note that some of these studies conclude that Medicaid rates are insufficient but, on the other hand, determining profitability is compromised by the byzantine corporate organization used by many or most nursing facilities.<sup>27</sup> There is, in fact, widespread evidence that most facilities have adequate resources to increase their staffing levels without additional Medicaid resources.<sup>28</sup> A recent study documented that most major publicly traded NH companies were highly profitable, even during the COVID pandemic.<sup>29</sup> Likewise, a study showed that Ensign, the second largest publicly-traded nursing home chain in the US, made

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<sup>26</sup> Bowblis, JR. The need for an economically feasible nursing home staffing regulation: evaluating an acuity-based nursing staff benchmark. *Innovation in Aging*. March, 2022. DOI.org/10.1093/geroni/igac017.

<sup>27</sup> Stevenson, D., Bramson, J.S., Grabowski, D.C. Nursing home ownership trends and their impacts on quality of care: A study using detailed ownership data from Texas. *J. of Aging & Social Policy*. 2013; 25:30-47; Harrington, C., Ross, L., Kang, T. Hidden ownership, hidden profits, and poor quality of nursing home care: A case study. *International Journal of Health Services*. 2015;45 (4): 779-800; Harrington, C., Olney, B., Carrillo, H., Kang, T. Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Serv Res*. 2012; 47(1 pt 1):106–128.

<sup>28</sup> McCarthy Z. Buying boom to continue in skilled nursing as private equity keeps ‘chasing deals.’ *Skilled Nursing News*. February 22, 2022. [https://skillednursingnews.com/2022/02/buying-boom-to-continue-in-skilled-nursing-as-private-equity-keeps-chasing-deals/?euid=eed8298f98&utm\\_source=snn-newsletter&utm\\_medium=email&utm\\_campaign=ee74e728d7?euid=0ae75c2624&utm\\_source=snn-newsletter&utm\\_medium=email&utm\\_campaign=b5189a9a03](https://skillednursingnews.com/2022/02/buying-boom-to-continue-in-skilled-nursing-as-private-equity-keeps-chasing-deals/?euid=eed8298f98&utm_source=snn-newsletter&utm_medium=email&utm_campaign=ee74e728d7?euid=0ae75c2624&utm_source=snn-newsletter&utm_medium=email&utm_campaign=b5189a9a03); Stulick A. Why institutional capital is critical for skilled nursing, despite White House rhetoric. *Skilled Nursing News*. April 3, 2022. [https://skillednursingnews.com/2022/04/why-institutional-capital-is-critical-for-skilled-nursing-despite-white-house-rhetoric/?euid=c78589db4d&utm\\_source=snn-newsletter&utm\\_medium=email&utm\\_campaign=3af919ddf6](https://skillednursingnews.com/2022/04/why-institutional-capital-is-critical-for-skilled-nursing-despite-white-house-rhetoric/?euid=c78589db4d&utm_source=snn-newsletter&utm_medium=email&utm_campaign=3af919ddf6); Zorn, A. New SNF buyers drive busy acquisition market as regulatory future remains uncertain. *Skilled Nursing News*. May 4, 2022. <https://skillednursingnews.com/2022/05/new-snf-buyers-drive-busy-acquisition-market-as-regulatory-future-remains-uncertain/>

<sup>29</sup> Kingsley, D.E. and Harrington, C. COVID-19 had little impact on publicly-traded nursing home companies. *JAGS*. 2021; 69:2099–2102.

high profits during the COVID pandemic while keeping its staffing levels low and having high levels of COVID-19 resident infections and deaths.<sup>30</sup>

**Question 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?**

Yes. For example, for-profit facilities generally provide poorer care than not-for-profit facilities.<sup>31</sup> For-profit operators are more likely to have inadequate staffing levels and to shortchange nursing staff in wages, benefits, and pensions.<sup>32</sup> One study reported an average of 16 percent fewer staff in for-profit facilities, after accounting for differences in resident needs.<sup>33</sup> High profit margins often correlate with poor care.<sup>34</sup>

For-profit chains experience more quality and compliance problems than other facilities.<sup>35</sup> The largest for-profit chains have lower RN and total nurse staffing hours, along with more deficiencies.<sup>36</sup>

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<sup>30</sup> Kingsley DE, Harrington C. Financial and quality metrics of a large, publicly traded U.S. nursing home chain in the Age of Covid-19. *International J. Health Serv.*, 2022.

[doi.org/10.1177/00207314221077649](https://doi.org/10.1177/00207314221077649)

<sup>31</sup> Comondore, V.R., P.J. Devereaux, Q. Zhou, S.B. Stone, et al.. Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal*. 2009; 339:b2732; Hillmer, M.P., Wodchis, W.P., Gill, S.S., Anderson, G.M. and Rochon, P.A. Nursing home profit status and quality of care: Is there any evidence of an association? *Medical Care Research and Review*. 2005; 62 (2):139-166.

<sup>32</sup> Harrington, C., Olney, B., Carrillo, H., Kang, T. Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Serv Res*. 2012; 47(1 pt 1):106–128.

<sup>33</sup> Rau, J. and Lucas, E. 1,400 nursing homes get lower Medicare ratings because of staffing concerns. *Kaiser Health News*. July 30, 2018. <https://khn.org/news/1400-nursing-homes-get-lower-medicare-ratings-because-of-staffing-concerns/>

<sup>34</sup> O’Neill, C., Harrington, C., Kitchener, M., Saliba, D. Quality of care in nursing homes: an analysis of the relationships among profit, quality, and ownership. *Med Care*. 2003; 41(12):1318–1330.

<sup>35</sup> Government Accountability Office. *CMS’s specific focus facility methodology should better target the most poorly performing facilities which tend to be chain affiliated and for-profit*. GAO-09-689. Washington, D.C.: GAO. August, 2009.

<sup>36</sup> Harrington, C., Olney, B., Carrillo, H., Kang, T. Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Serv Res*. 2012; 47(1 pt 1):106–128; Harrington, C., Jacobsen, F.F., Panos, J., Pollock, A., Sutaria, S., Szebehely, M.

Research on private equity ownership supports the premise that money is being diverted rather than put towards quality care. Study of private equity buyouts showed evidence of declines in resident health, less regulatory compliance, and cuts to front-line nursing staff.<sup>37</sup>

As mentioned earlier, for-profit facilities often have complicated ownership structures that obscure profitability. Ownership of property is separated from operations, for example, and separate functions (therapy, for example) are delegated to separate corporations.<sup>38</sup> A recent study of the Ensign chain found 430 corporate entities to manage only 228 facilities.<sup>39</sup>

Facilities often use related-party transactions to hide revenue and profit. For example, facilities contract out basic functions like management or rent their own building from a sister corporation. A study found that nearly three-quarters of US nursing homes (more than 11,000) used related-party business transactions. Contracts with related companies accounted for \$11 billion of nursing home spending in 2015 — a tenth of their costs — according to Medicare cost reports.<sup>40</sup>

These related-party transactions have consequences. Facilities that did business with related-party companies were found to employ eight percent fewer nurses and aides, were nine percent more likely to have hurt residents or put them in

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Marketization in long-term care: A cross-country comparison of large for-profit nursing home chains. *Health Services Insights*. 2017; 10:1-23.

<sup>37</sup> Gupta, A., Howell, S.T., Yannelis, C., and Gupta, A. Does private equity investment in healthcare benefit patients? Evidence from nursing Homes. Philadelphia, PA: Wharton School. February, 2020.

<sup>38</sup> Stevenson, D., Bramson, J.S., Grabowski, D.C. Nursing home ownership trends and their impacts on quality of care: A study using detailed ownership data from Texas. *J. of Aging & Social Policy*. 2013; 25:30-47; Harrington, C., Ross, L., Kang, T. Hidden ownership, hidden profits, and poor quality of nursing home care: A case study. *International Journal of Health Services*. 2015;45 (4): 779-800; Harrington, C., Olney, B., Carrillo, H., Kang, T. Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Serv Res*. 2012; 47(1 pt 1):106–128.

<sup>39</sup> Kingsley DE, Harrington C. Financial and quality metrics of a large, publicly traded U.S. nursing home chain in the Age of Covid-19. *International J. Health Serv.*, 2022. doi.org/10.1177/002073142211077649

<sup>40</sup> Rau, Jordan, Care Suffers As More Nursing Homes Feed Money Into Corporate Webs (December 31, 2017). <https://khn.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/>

immediate jeopardy, and had 53 substantiated complaints for every 1,000 beds (compared with 32 per 1,000 beds at other facilities).<sup>41</sup> Similarly, for-profit facilities with related-party transactions had 10 percent higher fines, and received 24 percent more substantiated complaints from residents.<sup>42</sup>

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

### Wages and Benefits

The most obvious factors are wages and benefits. The median wage for certified nurse aides (CNAs) in 2020 was \$14.48, resulting in a median annual income of \$24,200. A third of CNAs receive some sort of public assistance, and 41% live in low-income households.<sup>43</sup>

Nurses also have financial reasons to not work in nursing facilities, although nurse pay is obviously much higher than CNA. The primary financial factor for nurses is the opportunity to receive higher wages in another setting. For registered nurses, the median annual wage in nursing homes was found to be \$72,420, compared to \$78,070 in hospitals.<sup>44</sup>

Also, employee benefits in nursing facilities tend to be lacking. One study found that 64% of nursing home staff did not have paid leave.<sup>45</sup> Health insurance also is

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<sup>41</sup> Rau J. Care suffers as more nursing homes fed money into corporate webs. *New York Times*. January 7, 2018. <https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html>

<sup>42</sup> Rau J. Care suffers as more nursing homes fed money into corporate webs. *New York Times*. January 7, 2018. <https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html>

<sup>43</sup> <https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2>

<sup>44</sup> Bureau of Labor and Statistics, <https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-5>

<sup>45</sup> Service Employees International Union. National survey shows government, employers are failing to protect nursing home workers and residents. June 2020.

a negative factor. Only 62% of CNAs were found to have health insurance through their employer. An additional 25% had Medicaid, and 13% had no health insurance coverage at all.<sup>46</sup>

The strategy to address these problems is obvious: increase wages and benefits. This is consistent with a PHI policy paper.<sup>47</sup> A Leading Age study estimated raising CNA wages of CNAs would reduce turnover and stabilize the workforce. Costs associated with increased wages would be offset by gains in productivity.<sup>48</sup> Likewise, improved sick leave and health benefits would benefit both staff and residents. During the COVID pandemic, infections and deaths were increased by staff members working while sick.<sup>49</sup>

### Workloads

High workloads directly contribute to high staff turnover.<sup>50</sup> This is another situation that is harmful to both staff and residents. Inadequate staff leads to poor care and burned-out staff, which in turn leads to more poor care and burnout.

The strategy to address this facet of the problem is simple. Hire more staff, so staff members will not be overwhelmed by the work that must be done.

### Inadequate Training

Tailored and ongoing training programs improve job satisfaction and reduce turnover.<sup>51</sup> CNAs with higher-quality training were found to be more satisfied

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<https://www.seiu.org/2020/06/national-survey-shows-government-employers-are-failing-to-protect-nursing-home-workers-and-residents>

<sup>46</sup> <https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2>

<sup>47</sup> PHI, Caring for the Future: The Power and Potential of America's Direct Care Workforce, at 94-95 (2021).

<sup>48</sup> <https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf>

<sup>49</sup> Centers for Disease Control and Prevention. COVID-19 in a long-term care facility – King Country, Washington, February 27-March 9, 2020. Morbidity and Mortality Weekly Report. 2020: 69, March 18.

<sup>50</sup> Sarah L. Krein, Molly Turnwald, Barry Anderson, Donovan T. Maust "Sometimes it's not about the money... it's the way you treat people...": A Qualitative Study of Nursing Home Staff Turnover, Journal of the American Medical Directors Association, 2022,ISSN 1525-8610,<https://doi.org/10.1016/j.jamda.2021.11.03>

<sup>51</sup> Ejaz, F., and L. Noelker. 2006. Tailored and ongoing training improve job retention. <https://phinational.org/wp-content/uploads/legacy/clearinghouse/EjazSummaryFinal.pdf>;

with their jobs.<sup>52</sup> The Institute of Medicine found the current minimum federal training requirements for CNAs to be inadequate, leading not only to poor health outcomes for residents, but also increased turnover in staff.<sup>53</sup> The recent report from the National Academies of Science, Engineering, and Medicine (NASEM) came to the same conclusion.<sup>54</sup>

The strategies here are again obvious — increase CNA training. The Institute of Medicine recommended significant increases in the training requirement to at least 120 hours.<sup>55</sup> The NASEM report concurred, recommending that state and federal governments should provide free access to entry-level and continuing education training programs, and that facilities should pay workers for attending these trainings. PHI has recommended a national standard for direct care competencies.<sup>56</sup>

### Lack of Career Advancement Opportunities

Empowerment of CNAs and greater career opportunities can reduce staff turnover and increase care quality.<sup>57</sup> The NASEM report found that increasing

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Kihye Han, et al, Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis, *International Journal of Nursing Studies*, Volume 51, Issue 8, 2014, Pages 1135-1141, ISSN 0020-7489,

<https://doi.org/10.1016/j.ijnurstu.2013.12.008>.

<sup>52</sup> Kihye Han, et al, Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis, *International Journal of Nursing Studies*, Volume 51, Issue 8, 2014, Pages 1135-1141, ISSN 0020-7489,

<sup>53</sup> IOM. 2008. *Retooling for an aging America: Building the health care workforce*. Washington, DC: The National Academies Press.

<sup>54</sup> 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. <https://doi.org/10.17226/26526>

<sup>55</sup> IOM. 2008. *Retooling for an aging America: Building the health care workforce*. Washington, DC: The National Academies Press.

<sup>56</sup> PHI, *Caring for the Future: The Power and Potential of America's Direct Care Workforce*, at 94-95 (2021).

<sup>57</sup> Stone, R. et al. *Evaluation of the Wellspring model for improving nursing home quality*. New York: Commonwealth Fund; National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to*

opportunities for CNAs could lead to a reduction in staff turnover. The report noted that federal regulations required that CNAs be part of the interdisciplinary team and involved in care planning; these regulations, however, often have not been followed.<sup>58</sup>

This problem can be addressed by providing greater career advancement opportunities. The care planning requirements should of course be honored. Also, facilities should be required to provide more career advancement opportunities through training and education. A PHI report makes three recommendations: establishing a statewide workgroup to create recommendations for advancing policies that improve direct care jobs, creating a division of paid care that supports direct care workers with accessing their employment rights and resources, and integrating direct care workers into key advisory roles and leadership positions throughout the public and private spheres.<sup>59</sup>

**Question 6: 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?**

There is no workable way to establish any so-called “good faith” exceptions. For decades facilities have short-staffed and would doubtlessly do so again if given the opportunity. To the extent that facilities encounter “workforce shortages,” this should be addressed by making CNA jobs more attractive, rather than by reducing staffing requirements. An individual surveyor should not be put in the position of considering, for example, the regional labor market, and whether a facility’s hiring activities have been in good faith. The need to improve nursing

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Residents, Families, and Staff. Washington, DC: The National Academies Press.  
<https://doi.org/10.17226/26526>

<sup>58</sup> 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. <https://doi.org/10.17226/26526>

<sup>59</sup> PHI, Caring for the Future: The Power and Potential of America’s Direct Care Workforce, at 97 (2021).

facility care demands that CMS sets meaningful standards, and does not undercut those standards by establishing exceptions.

Notably, staffing standards generally are based on a ratio between nursing staff hours and residents. If a facility claims that it cannot hire more staff members, it should suspend admissions, rather than provide care with inadequate staffing.

**Question 7: 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?**

### Turnover

It is unclear to us how turnover would be “considered” in a staffing standard. A standard is likely requiring a ratio of total staff hours to residents. Turnover rates would not be included in such a ratio, and it would be difficult to “require” a facility to keep turnover at certain levels, since a specific employee always has the right to leave a job. CMS should continue to explore ways to incentivize the reduction of turnover rates, including using facility turnover rate as a measure in the SNF Value Added Purchasing Program.

### Agency Staff

The use of agency staff has been associated with poorer health outcomes for nursing home residents.<sup>60</sup> Additionally, long-term use of agency staff may be indicative of a facility’s failure to address underlying job quality issues. That being said, agency staff may sometimes be needed, and a facility should not be prohibited from using agency staff in order to meet (or exceed) minimum staffing levels.

**Question 8: 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?**

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<sup>60</sup> Castle, N. Use of agency staff in nursing homes. *Research Gerontological Nurs.* 2009: 2 (3):192-201.

Hours from nurses and CNAs should be considered together towards a minimum staffing standard. In addition, there should be a separate standard for registered nurses, recognizing the importance of RN presence in a nursing facility (as discussed extensively above). Without a separate nurse requirement, facilities are too likely to overemphasize the lower-cost CNAs, with negative consequences for quality of care.<sup>61</sup>

Other staff — including feeding assistants, social workers, and other mental health workers — should not be considered, since they cannot replace the care provided by RNs, LPNs, and CNAs. We support the creation of standards for social workers and other mental health staff, but those standards should be separate from a direct-care minimum staffing standard.

**Question 9: 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?**

Administrative time should not be included. Staffing standards should include only direct care to residents. Poor care is primarily related to inadequate personal attention, and that lack of personal attention is not rectified by a nurse's time with administrative tasks.<sup>62</sup> Notably, Green House facilities remove administrative responsibilities from clinical staff and report fewer hospitalizations, infections, and deaths.<sup>63</sup>

Current federal regulations allow a Director of Nursing to serve as charge nurse only if the facility has sixty or fewer occupied beds.<sup>64</sup> In accord, several states

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<sup>61</sup> Chen M.M. and Grabowski, D C. (2015) Intended and unintended consequences of minimum staffing standards for nursing homes. *Health Econ.* 24: 822-839; Hyer, K., Temple, A., and Johnson, C.D. (2009) Florida's efforts to improve quality of nursing home care through nurse staffing standards, regulation, and Medicaid reimbursement. *J. of Aging Social Policy.* 21 (4):318-37.

<sup>62</sup> Zhang, Ning Jackie; Unruh, Lynn; Wan, Thomas T H. *Nursing Economics*; Pitman Vol. 31, Iss. 6, (Nov/Dec 2013): 289-97

<https://www.proquest.com/openview/610487a33f3fe29e1111a99418315625/1?pq-origsite=gscholar&cbl=30765>

<sup>63</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5338211/>

<sup>64</sup> 42 CFR § 43.35(b)(3).

with minimum staffing standards require an additional RN if the RN on staff is subject to administrative duties.<sup>65</sup>

**Question 10: 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 1 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 acknowledge some relevant considerations. Hours per resident day is most exact, but difficult to apply or understand by individual staff, residents, or family members. Ratios of staff to residents (e.g., one CNA for each 8 residents) is more easily understood but less precise.

We recommend an hprd standard for precision, and also requiring a registered nurse to be present seven days per week. RNs should be onsite around the clock in order to maintain quality of care. Additionally, as noted in Question 1, higher levels of RN care are associated with better health outcomes for residents.<sup>66</sup> Although nurse aides provide the bulk of resident care, they need supervision and backup for many tasks.

We are unclear as to what “non-nursing duties” would entail. In general, time should only be considered if it involves caring for residents. As previously stated, minimum staffing standards should not include administrative duties.

**Question 11: How should any new quantitative direct care staffing requirement interact with existing qualitative staffing**

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<sup>65</sup> Summary Report, State Nursing Home Staffing Standards, National Consumer Voice for Quality Long-Term Care

[https://theconsumervoice.org/uploads/files/issues/CV\\_StaffingReport.pdf](https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf).

<sup>66</sup> Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic\$,* 33 (2):95-108 and 116.

**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.**

There is no conflict between a minimum “floor” and a requirement that a facility implement sufficient staffing. The minimum is just that — a minimum — and staffing beyond that minimum will be implemented by the facility as necessary. As a practical matter, the “sufficient” standard may come into play relatively frequently, to respond to a resident population with a significantly higher acuity level.<sup>67</sup> Sufficiency can be determined through review of facility records including MDS data.<sup>68</sup>

Overtime restrictions should not be considered for purposes of establishing minimum staffing standards. Facilities should recruit and train a high number of direct care workers without relying on a small number of workers with significant overtime. Overworked nursing home staff results in high rates of burnout and turnover, in addition to physical injury.<sup>69</sup> As necessary, as discussed above, facilities could use agency staff.

**Question 12: Have minimum staffing requirements been effective at the State level? What were facilities’ experiences transitioning to these requirements? We note that**

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<sup>67</sup> <https://journals.sagepub.com/doi/full/10.4137/HSI.S38994>  
[https://journals.lww.com/jncjournal/Abstract/2007/01000/Nursing\\_Staffing\\_and\\_Resident\\_Outcomes\\_in\\_Nursing.12.aspx](https://journals.lww.com/jncjournal/Abstract/2007/01000/Nursing_Staffing_and_Resident_Outcomes_in_Nursing.12.aspx)  
[https://journals.lww.com/ajnonline/Fulltext/2005/11000/RN\\_Staffing\\_Time\\_and\\_Outcomes\\_of\\_Long\\_Stay\\_Nursing.28.aspx](https://journals.lww.com/ajnonline/Fulltext/2005/11000/RN_Staffing_Time_and_Outcomes_of_Long_Stay_Nursing.28.aspx) add the actual citations here, not just the urls

<sup>68</sup> <https://journals.sagepub.com/doi/full/10.1177/1178632920934785>

<sup>69</sup> <https://onlinelibrary.wiley.com/doi/abs/10.1002/ajim.20330>

**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.**

Several studies have shown that a state's implementation of minimum staffing standards correlates to increased nursing hours, better outcomes, and reduced deficiencies.<sup>70</sup> Quality of care improves from minimum staffing requirements primarily because residents experience fewer adverse outcomes (fewer pressure sores, restraints, and deficiencies, less extensive COVID outbreaks, and less mortality overall) and experience more positive outcomes (restoration of functioning, increased nutritional intake, and increased vaccination rates).<sup>71</sup>

**Question 13: 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.**

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<sup>70</sup> Harrington, C., Swan, J.H., and Carrillo, H. Nursing Staffing and Medicaid Reimbursement Rates. *Health Services Research*, 2007: 43 (3): 1105-1129; Park, J. and Stearns S.C. (2009). Effects of state minimum staffing standards on nursing home staffing and quality of care. *Health Serv Res.* 44(1):56-78; Bowblis, J.R. (2011). Staffing ratios and quality: An analysis of minimum direct care staffing requirements for nursing homes. *Health Services Research*, 46(5): 1495-516.

<sup>71</sup> Zhang, X., & Grabowski, D. C. (2004). Nursing home staffing and quality under the nursing home reform act. *The Gerontologist*, 44, 13–23. doi:10.1093/geront/44.1.13;. Bliesmer, Smayling, Kane, & Shannon (1998)

The District of Columbia has set a minimum staffing standard that meets the expert-recommended standard of 4.1 hprd.<sup>72</sup> The majority of states — 29 states — require less than 3.5 hprd, with 15 of those states falling below 2.5 hprd.<sup>73</sup> Thus, state standards generally are not appropriate models for federal regulations.

Although state standards may not be models, mistakes made by states should be taken into account by CMS. California, Ohio, and Florida, when implementing minimum standards, failed to specify minimums for each category of direct care staff (RN/LPN/CNA). As result, all three states experienced a decline in RN hours after a minimum was implemented.<sup>74</sup>

**Question 14: 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.**

We support an around-the-clock requirement for registered nurses. This is a standard supported in a several studies, in addition to the IOM.<sup>75</sup> As discussed

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<sup>72</sup> The National Consumer Voice for Quality Long Term Care. State nursing home staffing standards summary report. 2021. Washington, DC:  
[https://theconsumervoice.org/uploads/files/issues/CV\\_StaffingReport.pdf](https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf)

<sup>73</sup> The National Consumer Voice for Quality Long Term Care. State nursing home staffing standards summary report. 2021. Washington, DC:  
[https://theconsumervoice.org/uploads/files/issues/CV\\_StaffingReport.pdf](https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf)

<sup>74</sup> Chen M.M. and Grabowski, D C. (2015) Intended and unintended consequences of minimum staffing standards for nursing homes. *Health Econ.* 24: 822-839; Hyer, K., Temple, A., and Johnson, C.D. (2009) Florida's efforts to improve quality of nursing home care through nurse staffing standards, regulation, and Medicaid reimbursement. *J. of Aging Social Policy.* 21 (4):318-37.

<sup>75</sup> Harrington, C, Kovner, C, Kayser-Jones, J, Berger, S, Mohler, M, Burke R. et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist*, 2000: 40 (1):1-12; Harrington, C., Schnelle, J.F., McGregor, M., Simmons, S.F. The need for minimum staffing standards in nursing homes. *Health Serv Insights.* 2016: 9:13-19.

above in more detail, RN levels are correlated to a higher quality of care.<sup>76</sup> Furthermore, RN staffing can reduce Medicare and Medicaid expenditures by reducing hospitalizations and the need for other expensive medical interventions.<sup>77</sup>

**Question 15: 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?**

Minimum staffing requirements would not be an impediment to implementing small home models. Researchers of the Green House Model found that even though Shahbazim performed non-nursing tasks, “residents in GH [Green House] homes received approximately 0.4 more hprds (24 minutes) of direct care time from a Shahbazim than residents in traditional SNF settings.” They concluded that “[t]he GH model allows for expanded responsibilities of CNAs in indirect care activities and more time in direct care activities and engaging directly with residents.”<sup>78</sup>

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228; Wunderlich, G.S., Sloan, F.A., and Davis, C.K. Editors, Institute of Medicine. Nursing staff in hospitals and nursing homes: Is it Adequate? Washington, DC: National Academy Press, 1996.

<sup>76</sup> Dellefield, M.E., Castle, N.G., McGilton, K.S., & Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economics*, 33 (2):95-108 and 116.

<sup>77</sup> Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845. Office of Inspector General. (2013). Medicare nursing home resident hospitalization rates merit additional monitoring. November 2013 OEI-06-11-00040. Washington, DC: OIG

<sup>78</sup> Siobhan S. Sharkey, Sandra Hudak, Susan D. Horn, Bobbie James, “Frontline Caregiver Daily Practices: A Comparison Study of Traditional Nursing Homes and The Green House Project Sites,” *Journal of the American Geriatrics Society* 59:126-131, 2011,

One potential unintended consequence would be the substitution of licensed nurses for registered nurses. In Ohio and California, ratios did not distinguish licensed nurses and registered nurses; as a result, RN hours decreased, and were replaced to a certain extent by licensed nurse hours.<sup>79</sup> To prevent such unintended consequences, nurse staffing ratios must identify the different categories of nursing staff.

**Question 16: Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?**

A minimum nurse staffing standard must be met by all facilities. There is no evidence or reason to believe that residents in rural nursing facilities or underserved areas have lesser nursing needs than other residents.

The effort should be on increasing the pool of nurses and nurse aides in rural and underserved areas, following some of the strategies discussed earlier in this letter, including higher wages and benefits, and creation of stronger career ladders. The Institute of Medicine has identified strategies for bolstering the availability of nurses, including: establishing loan repayment programs, strengthening local educational opportunities for people who are more likely to continue living in those communities, and upgrading existing nursing facility staff.<sup>80</sup>

**Question 17: What constitutes “an unacceptable level of risk of harm?” What outcomes and care processes should be considered in determining the level of staffing needed?**

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<https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1532-5415.2010.03209.x>  
(abstract)

<sup>79</sup> Min M. Chen, David C. Grabowski, “Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes,” *Health Economics*, Vol. 24, No. 7, pages 822-839 (July 2015),

<http://onlinelibrary.wiley.com/doi/10.1002/hec.3063/abstract;jsessionid=D1C94F93FE069B7A5AAC7C44F6C202D6.f02t01> (abstract)

<sup>80</sup> Institute of Medicine, *Nursing and Nursing Education; Public Policies and Private Actions* (1983), Chapter VI, Alleviating Nursing Shortages in Medically Underserved Areas and Among Underserved Populations, <https://www.ncbi.nlm.nih.gov/books/NBK218556/>

There is no way to responsibly quantify staffing deficiencies that would create a risk of harm. We respectfully suggest that this question is not helpful in determining appropriate staffing levels.

As you know, federal law requires that facilities, through comprehensive assessment and care planning, “provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”<sup>81</sup> The regulations expand upon this requirement:

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).<sup>82</sup>

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<sup>81</sup> 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2).

<sup>82</sup> 42 C.F.R. §483.35.

