House
Legislative
Analysis
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NURSING HOMES: MODIFY STAFFING REQUIREMENTS

House Bill 4176 (Substitute H-2)
First Analysis (5-5-98)

Sponsor: Rep. Burton Leland
Committee: Health Policy

THE APPARENT PROBLEM:

Staffing ratios for nursing homes have remained unchanged for decades, resulting in staffing shortages in many homes. Staff shortages translate into a poorer quality of care for nursing home residents. The result often is that residents may go unfed, teeth may not be brushed, soiled clothing and bedding may go unchanged, and patients may be left in one position so long that life-threatening bed sores develop. Reportedly, horrendous living conditions can be found in about 10 to 15 percent of the state's approximately 430 nursing homes. According to the attorney general, complaints against nursing homes have increased from 1,499 in 1996 to 1,760 in 1997. Complaints for 1998 are expected to be about 11 percent more than last year. The majority of complaints by patients, their families, and nursing home staff identified short staffing as a problem in the poor delivery of care with the primary complaints centering around inadequate pressure sore treatment and inadequate food preparation and distribution. Recently, criminal charges have been brought against several homes in Michigan for such abuses of care as not properly monitoring a patient on an automatic feeding pump so that when the patient's stomach became full, the contents spilled into the patient's lungs. The patient subsequently died from pneumonia. In another case, a patient died after having to undergo amputation of a leg from bedsores on a foot. A 27-year-old died from a massive bed sore on the back of his head. Such problems are usually attributable in part to understaffing. In addition, continually working in conditions with inadequate staffing puts a tremendous burden on even the most caring of nursing home workers. Meanwhile, many homes have changed from the traditional care provided by nursing homes to providing more short-term care with a focus on rehabilitation, and so current laws are a poor fit. In response to pressure by advocacy groups and industry members, legislation has been introduced to modify and increase the minimum staffing level for nursing homes.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to modify the required patient to nursing care personnel ratio, and to allow nursing homes to use unlicensed nursing personnel in meeting those ratios. Currently, a licensed nursing home must have at least one licensed nurse on duty at all times and must employ additional registered nurses and licensed practical nurses to maintain a patient to nursing care personnel ratio of not more than eight to one for morning shifts, not more than twelve to one for afternoon shifts, and not more than fifteen to one for nighttime shifts. In addition, a nursing home must maintain a nursing home staff sufficient to provide not less than 2.25 hours of nursing care by employed nursing care personnel per patient per day.

The bill, by comparison, would establish a staff-to-patient ratio that would require at least 3.0 hours of direct patient care by a direct patient care provider. The ratio would be computed on a 24-hour basis so that at no time could the ratio fall below one direct patient care provider to 15 nursing home residents. A "direct patient care provider" would be a registered professional nurse (RN) or a licensed practical nurse (LPN) whose primary function was as a nurse, or a competency-evaluated nurse assistant (CENA), and would exclude the director of nursing, a quality assurance nurse, the staff development nurse, a physical therapist, a certified speech and language therapist, an occupational therapist, an activities director or activities staff, and an individual employed by a resident or his or her family to provide care only for that resident.

Direct Patient Care: The bill would specify that direct patient care would mean one or more of the following activities or services provided by a direct patient care provider:

*Personal care, such as bathing, skin care, routine mouth care, hair and nail care, shaving, dressing, and other matters of personal hygiene.

*Nutrition, including measuring and recording a patient's food intake, and assisting a patient in fluid intake and eating.

*Elimination, including preventing incontinence, catheter care, measuring and recording bladder output, and so on.

*Restoration and rehabilitation, including turning a patient; range of motion exercises; assistance and encouragement with ambulation, walking, and transferring from location to location or position to position; and the use of wheelchairs, walkers, canes, and crutches; and so on.

*Feeding and clothing patients and making and changing beds.

*Administration of medications.

*Other activities or services performed with or for the care provider's assigned patient to enhance that patient's quality of life.

Staff-to-patient ratios. Between October 1, 1998 and April 1, 1999, the per-patient-per-day ratio of direct patient care would be gradually increased from the current 2.25 hours to 2.75 hours. The required ratio would increase again to 2.85 hours between April 2, 1999 and October 1, 1999, and then increase again to 3.0 hours after October 1, 1999. Duties other than direct patient care performed by a direct patient care provider could not be counted for the ratio, but time spent in documenting a provider's care for a patient could be used in the computation. A direct patient care provider could not perform duties such as food preparation, housekeeping, laundry, or maintenance (except in an emergency, at which time the hours spent in these activities could be used to compute the ratio). RNs and LPNs who primarily perform administrative duties would be subject to a similar restriction. A home also could not use a non-CENA in computing the ratio, but could use such an aide to provide services in the home as long as he or she had received proper training in that service. An aide who had completed the necessary training to become a CENA, but had not yet taken the test, could be used to satisfy the staff-to-patient ratio and the hours-per-patient-per-day ratio, but not for longer than 120 days.

Funding. If the nursing home's costs of operation were increased in order to comply with the new staffing ratios, the home could advise the department (the bill is not clear if this is the Department of Community Health or the Department of Consumer and Industry Services, as the duties are intermingled, with DCH administering funding and emergency rate relief, and DCIS monitoring licensing, staffing levels, and patient care) in writing of the increased costs and request a reimbursement. The department would have to immediately adjust the home's Medicaid reimbursement sufficient to cover the increased costs, regardless of previously applied cost limits. Should the department not adjust the Medicaid reimbursement rates, all of the following would occur:

*The home would be exempt from the new staffing ratios until the reimbursement rate was adjusted.

*The home would staff according to the staffing requirements in place before the bill's effective date.

*The home would have to return to the bill's staffing ratios within 30 days of being notified that the reimbursement rate would be adjusted.

If the department failed to increase the reimbursement within the 30-day time period, the department would have to file a written report with the House and Senate Appropriations Committees and appropriate subcommittees that included its reasons for not adjusting the home's reimbursement rate. The department would also have to determine if the home's operating costs were actually increased or not during its audit of the home's annual cost report. If it were determined that the home's costs were not increased, the department could retroactively disallow the increased costs claimed by the home. Such a retroactive disallowance would be considered an "adverse action" as defined under administrative rules (R 400.3401), and would be subject to appeal.

A nursing home could also file a petition for temporary, emergency rate relief from either the new 15 to 1 staffing ratio, or the new 3.0 hours of direct patient care ratio, or both. The department could grant the home's petition if the home demonstrated that the new ratios had a substantial effect on the nursing home's operating costs. A decision on the petition would have to be issued within 90 days. If the petition were denied, the department would have to notify the home in writing of the reasons. A failure to rule on the petition within 90 days would constitute a granting of the petition.

A nursing home could appeal a denial for temporary, emergency relief. The department would also have to hold an informal hearing on the appeal. The

department would have to issue a written decision of the appeal within 30 days of the hearing. A denial of an appeal would have the effect of creating an emergency under provisions in the federal Social Security Act.

A nursing home could appeal an adverse decision in response to an appeal to the circuit court for the county in which the home was located, or the circuit court for Ingham County. If the nursing home prevailed in court, the court could award the home compensatory damages for the cost of providing care to its residents during the petition and appeal process, and could also award court costs.

Legislative intent. The bill would state that the exemption was not intended to allow the department to reimburse a home at a rate lower than what was needed to maintain the new 3.0 hours of direct care per patient per day. Further, the bill would state that the intent was for the department to sufficiently increase the Medicaid reimbursement rate so that homes could meet the new staffing requirement.

Miscellaneous provisions. A nursing home would have to do one of the following:

*Post the name of the charge nurse in a conspicuous place near the nurse's station. The charge nurse would have to be available to patients and their families to answer questions and provide information about patients and their assigned direct patient care providers. The nurse would also have to locate the direct patient care provider assigned to that patient upon request of a family member or legal guardian.

*Post the name of the direct patient care provider who was assigned to a particular patient directly outside the patient's door near the patient's name.

The bill would take effect July 1, 1998.

MCL 333.21720a

FISCAL IMPLICATIONS:

According to an analysis by the Department of Community Health, the bill would result in significant budget implications. The analysis reports that the nursing home industry estimates increased costs of approximately $25 million, which would be shifted to the state. (4-27-98)

ARGUMENTS:

For:

Nursing home staffing ratios have not kept up with the times. Ratios that worked for nursing homes forty years ago no longer fit today's nursing home population. Residents today are typically older and more infirm. Many residents are HIV positive, or have serious injuries that have left them mentally incapacitated. Basically, today's residents require a higher acuity of care and more direct care per patient than in the past. In addition, some nursing homes are beginning to specialize in providing skilled nursing to people recuperating from serious illness or injury. This population typically only needs nursing home care for six weeks or more, but the level of care is more intensive, with an emphasis on rehabilitative services.

Though many nursing homes currently staff above the minimum required by the Public Health Code, not all have kept up. The bill would not only raise the minimum direct care-per-patient-per-day ratio, but would also restructure the staff-to-patient ratio. Rather than the current requirement of having a minimum number of staff to patients for morning, afternoon, and night shifts, the bill instead would establish a 24-hour basis where at least one direct care provider would be available for every 15 patients. Members of the nursing home industry have praised this provision as providing more flexibility so that homes can ensure that sufficient staff is on duty to meet the needs of the residents. For example, more people may need to be scheduled for meal times, bath times, or times of the day when residents need to be transported to other departments for medical or rehabilitative services. During quiet times, such as at night, homes would still have to have at least one direct care provider per 15 patients as is currently required for night shifts. Yet, for some homes, the new requirements will result in the addition of new staff. To meet current requirements of 2.25 hours of direct care per patient, a home must have 28 workers for each 100 beds. To maintain the new 3.0 hours of direct care, a 100-bed home would need 37.5 workers. As direct care increases, so should the quality of care.

Response:

The committee-passed bill allows nursing homes to remain at the current staffing ratios if the Department of Community Health does not increase Medicaid reimbursement for homes experiencing increased costs in response to meeting the new 3.0 hours of direct

patient care per patient. The department has reported that there have been no funds appropriated for the next fiscal year in order to increase the reimbursement rate; without funding, the bill will have no effect. The provisions allowing homes to remain at current levels unless the department increases reimbursement rates should be removed. After all, the current average staffing level is 3.1 hours, with over 60 percent of homes maintaining 3.0 hours of direct patient care at the current Medicaid reimbursement rates. According to the Department of Community Health, the nursing home industry posted a profit margin of approximately $65 million last year. Industry magazines report stories of increasing nursing home profits. It is time for the industry to reinvest its profits in wages for more employees, especially since some of that money comes from taxpayer funded Medicaid and Medicare programs.

Rebuttal:

Industry members disagree with the $65 million profit figure, and point to the fact that the current administration has ended the wage pass through reimbursement, where homes received 50 cents on the dollar for employee wages and benefits. This represents a loss of funding to the industry of about $60 million. In addition, Medicare is about to change to a new payment system for skilled nursing facilities on July 1, 1998, where payment for skilled care will be made according to the needs of the Medicare beneficiary. The impact this new reimbursement scheme will have on nursing homes is unclear at this time. Since it is estimated by the industry that the bill's requirements will result in an increased cost of $25 million to implement, and since all but about a dozen of the state's 300-plus homes are not-for-profit, nursing homes need to know that increased funding will there for those homes unable to handle the cost of meeting the new requirements.

For:

The bill will allow documentation of care given by direct care workers to be counted in the 3.0 hours of direct care. This will encourage workers to take the time to record such things as the fluid intake of a patient, which can then be checked against the fluids voided by the same patient, or how much food a patient ate at dinner, which provides necessary information in monitoring the medical condition of a patient.

Response:

This type of quick documentation definitely can provide information necessary for the charge nurse to monitor and direct a patient's care, but some are interpreting this provision, and one that provides for other activities or services to also be counted in the computation of the 3.0 hours (as long as the service enhances the patient's quality of life), as including the time that the RN or LPN spends in doing patient charts. If this charting time is allowed to be used in the computation, any gains by increasing the hours to 3.0 could be lost or greatly reduced, as charting can represent a significant portion of the nurse's shift and is spent off the floor.

Rebuttal:

If anything, not enough time for charting is provided for nurses. Yet, detailed records of the care provided and information about the patient is instrumental for the nurse to be able to properly direct the care for a patient by the CENAs and other staff. The quality and accuracy of the charts and nursing plan has a direct bearing on the quality of care provided, and anything that would encourage more detailed records of a patient's care and condition should be encouraged.

Against:

The abuses railed against in news reports and committee testimony will not necessarily go away with increases in staff. Besides, the majority of homes already exceed the 3.0 hours of direct patient care, and so would be unaffected by the bill. It is important to note that the 3.0 hour level is a minimum, and depending upon the particular needs of a nursing home's residents, 3.0 hours of direct care per person may not be enough to provide adequate care to a population needing a higher acuity of care. In fact, of the fifteen nursing homes considered to be the worst in the state, eight currently staff above the 3.0 level. Increased staff does not necessarily equal increased quality of care. With a turnover rate of 65 percent (100 percent turnover within a two-year period), the problem lies more with the inability of homes to retain trained staff. The wages for CENAs, who provide most of the unskilled labor, is typically not much higher than minimum wage. The work is too demanding for low wages and poor benefits. Nursing homes need to reinvest more of their profit margins in wages for employees.

Further, cases of abuse and neglect can often be attributed to poor administration by the nursing personnel in charge. The nurse in charge needs to be aware of whether her or his staff is out on the floor taking care of patients, or retreating to the break room. Even if all necessary functions are fulfilled such as bathing, feeding, and so on, many patients, especially those with no family members, would love to have someone to talk to. The quality of care in many homes could be improved with better administrative oversight.

Response:

The bill is not seen as a cure-all, but is an important first step in addressing the problem of understaffing in nursing homes. Nursing home residents deserve the improvements this bill would supply.

Against:

The bill raises a number of questions. For example, the emergency rate relief section of the bill creates an unknown liability for the department. A court could award compensatory damages and court costs to a nursing home regardless of whether it participates in the Medicaid program. Further, a home could appeal a denial of a petition for temporary, emergency rate relief, but if the department denies the petition for an appeal, the denial would automatically create an emergency under federal Social Security Laws, and the home could bring a suit in circuit court against the department. In effect, the department could be forced to reimburse a home at a higher rate regardless of whether there is merit in the petition.

Response:

The nursing homes must have some legal recourse to ensure adequate funding to meet the new staffing requirements; otherwise, they will continue to be hostage to the department withholding increased funding.

Against:

Several provisions of the bill remain problematic and inconsistent. For example, some read the bill as excluding nurses altogether from being able to have their direct patient care time included in the computation of the 3.0 hours with the exception of administrative nurses helping during emergencies. Others feel that the listing of specific tasks in defining direct patient care may become outdated quickly and borders on micro management. Some feel that the bill needs to be clearer in stating that nursing care provided by the CENAs is to be under the direction and supervision of the professional nurse. Posting the name of a patient's care giver outside the patient's door continues to promote an institutional "feel" and could be easily met by having the staff wear name badges and require the charge nurse to be available to identify care givers to those asking to speak to a patient's care giver. Though there have been repeated and longstanding attempts to amend this section of nursing home law, and though reform should not be delayed, there is a need to clear up inconsistent language and problematic provisions in this bill. The state's nursing home residents deserve no less.

POSITIONS:

The Health Care Association of Michigan supports the bill. (4-28-98)

The Service Employees International Union supports the bill. (5-4-98)

The Michigan County Medical Care Facilities Council supports the bill. (5-1-98)

The Michigan Nurses Association opposes the bill. (4-28-98)

The Department of Community Health opposes the bill. (4-28-98)

Citizens for Better Care opposes the bill. (5-1-98)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.