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A Voice for Nurses. A Vision for Healthcare.

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VIA EMAIL AND U.S MAIL

RE: 3.5 Direct Care Hours Staffing Requirements; Skilled Nursing Facilities (SB 97)

The California Nurses Association/National Nurses United (CNA) was invited to participate in the stakeholder meeting on August 4, 2017 to discuss the repeal and amendment of 22 CCR 72329.1 pursuant to SB 97 (Ch. 52, Stats. of 2017). At the meeting, we explained that we would send written comments and recommendations to CDPH, once we had the opportunity to thoroughly review the discussion questions that were distributed just before the stakeholder meeting. While the mandate handed to CDPH lacks specificity with respect to the need for oversight and care planning by registered nurses, our comments are based on what we see as the Legislature's intent based on the limited information available. CNA believes that some guidance can be gleaned from an earlier bill, AB 2079 (Calderon), which was active during the 2016 legislative session. AB 2079—which died on the Senate Inactive File—was approved by both the Assembly and the Senate policy committees, thus giving CNA some guidance on Legislative intent when submitting these comments to CDPH.

1. Do you envision the direct care hours being converted into a staffing ratio?

In reviewing the statutory changes made in Section 1276.65 of the Health and Safety Code, we note that CDPH was instructed to "repeal and amend existing regulations and adopt emergency regulations to implement the amendments made by the act that added this subparagraph."[1] SB 97 amended Section 1276.65(c) which was added to the Health and Safety Code in 2001 by AB 1075 (Shelley).[2] The 2001statute instructed CDPH to develop regulations that establish staff-to-patient ratios and explained in the findings that "it is difficult for residents, residents' families,

[1] Section 1276.65 (c)(1)(D).
[2] Ch. 684 Stats. of 2001 (AB 1075).

facility employees, and state inspectors to monitor a skilled nursing facility's compliance with a staffing standard based on the nursing hours per patient day provided by a facility."[3] The stated intent of AB 1075 was to require that "minimum staffing requirements be set forth as ratios of patients per direct caregiver, so that residents, residents' families, facility employees, state inspectors, and others may assist in ensuring compliance with the law."[4] On January 22, 2009, the Office of Administrative Law filed a Title 22 regulatory action with the Secretary of State adopting five sections: 72038, 72077, 72077.1, 72329 and 72329.1.[5]

SB 97 now instructs CDPH to repeal and amend **existing** regulations and amends (c)(1)(A) only to the extent that it deletes the provision requiring separate licensed nurse staff-to-patient ratios in addition to the ratios established for other direct caregivers, which are not deleted. We believe that it remains the intent of the Legislature to translate the nursing care hours per patient day into staff-to-patient ratios using the newly increased nursing care hours of 3.5 per patient per day and the minimum CNA 2.4 nursing care hours per patient care day. Both the findings and the intent language of AB 1075 are applicable today. In construing a statute, courts "presume that the Legislature, when enacting the statute, was aware of existing related laws and intended to maintain a consistent body of rules." (*Stone St. Capital, LLC v. California State Lottery Comm'n*, 165 Cal. App. 4th 109, 118, 80 Cal. Rptr. 3d 326, 333 (2008))

Unfortunately, the legislative process for SB 97 does not give CNA or CDPH the guidance that the usual legislative process provides since the bill was a budget trailer bill and thus was not heard in policy committee. However, we can take some guidance from AB 2079 (Calderon, 2016) which was approved by policy committees in both the Senate and the Assembly. Under AB 2079, the total nursing hours per patient day (NHPPD) would have been greater (4.1 NHPPD), and the total CNA nursing care hours per patient day would have been greater (2.8 CNA NHPPD) than was authorized in SB 97. However, the CNA staff-to-patient ratios in the earlier legislation are instructive in that the proportion of care that would be allocated to CNA care over three shifts is laid out in more detail.

By adapting the lower CNA staff-to-patient nursing hours per patient day (2.4) from SB 97 to the same proportionate staffing ratios, CDPH can easily determine the appropriate minimum ratio that would be needed in order to assure more reasonable and balanced assignments throughout the 24 hours period for all CNA staff and for the protection of each patient.

Nursing hours per patient day do not assure that any single patient will actually receive the minimum amount of care from licensed- (1.1 NHPPD) and unlicensed (2.4 NHPPD) staff. Instead, it assures only that a certain level of staffing will be available within the facility during a 24 hour period. Minimum staff-to-patient ratios assure more *reasonable* staff assignments and provide for more equitable basic physical care oversight for each patient. Needless to say, ratios

[3] Id. at § 1(a)(3).
[4] Id. at § 1(b)(2).
[5] CDPH AFL 09-47.

also provide more visible evidence for patients of families of minimum staffing standards for CNAs who provide the bulk of physical care for long-term care patients not in need of specific Skilled Nursing Care but still in need of scrupulous physical care and nutritional assistance in order to mitigate complications associated with a patient's inability to provide for his/her own basic care needs, including such basics as ambulating, toileting, bathing, and eating.

The Senate Appropriations Committee analysis of AB 2079 suggested that the bill should be amended to specify direct care services and to authorize a process for providing a short-term waiver of the bill's requirements if certain conditions are met.[6] This waiver requirement was included in SB 97 for CDPH to develop either during rulemaking or through All Facility Letters or through other similar instructions.

CNA has attached a possible amendment of the existing regulatory language that is to be repealed, amended and re-submitted to full rulemaking (a requirement even when the temporary emergency rulemaking process is utilized to rapidly implement needed change).

During rulemaking, both the Emergency Rulemaking Process and the process to make the regulations permanent, CNA will submit more thorough comments that will contain information from various studies regarding mandated staffing standards in Skilled Nursing and in Long-Term Care Nursing. However, CDPH's need to move this initial process forward at this time prevents us from a more thorough review of current literature on the subject. On this point, briefly, AB 2079 (Calderon) referenced the 2001 Federal Center for Medicare & Medicaid Services Report, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Home* as the basis for its staffing proposal.[7] We have also identified a report authored by C. Harrington et. al, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes,*[8] and we need to be clear that the current allocation of 3.5 is well below the recommended reported minimum by CMS of 4.1 NHPPD. The CMS minimum is reported as 1.3 NHPPD of the total for Licensed staffing NHPPD and 2.8 being CNA NHPPD.

2. Considering the requirement to maintain 3.5 direct care hours with a minimum of 2.4 hours performed by CNAs, what are the minimum standards needed to ensure safe patient care?

Please see attached modifications of existing regulations. The California Nurses Association reiterates its position that we do not believe the current NHPPD provides minimum protections as determined by CMS. However, we have attempted to work within the guidance provided by SB 97 to assist CDPH is its efforts to protect patients. The original work done on 22 CCR

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[6] Senate Committee on Appropriations Analysis - Addendum Suspense File. AB 2079 (Calderon), August 11, 2016.
[7] March 29, 2016 Assembly Committee on Health analysis of AB 2079 (Calderon) As Introduced February 17, 2016
[8] Harrington et al. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Services Insights* 2016:9 13-19 doi: 10.4137/HIS.S38994.

72038, 72077, 72077.1, 72329 and 72329.1 on January 22, 2009[9] provides many of the necessary protections for interpreting the paucity of information contained in SB 97 and providing for the implementation of these NHPPD in the most efficient and effective manner. We would hope that CDPH would build on its previous effort in the development of the Emergency Regulations for implementation of this new standard.

3. **What process do you recommend for determining that certified nurse assistants are working 2.4 direct care service hours within 3.5 direct care service hours per patient day?**

We see the minimum ratios and the documentation that would accompany this staffing as an aid to enforcement by CDPH. The guidelines noticed in the AFL Revision Notice dated January 31, 2011 appear adequate for measuring the actual nursing care hours during a complaint visit to determine whether or not the actual minimum direct care service hours are being met in addition to the minimum ratios for licensed and unlicensed staff .

4. **What process do you recommend for determining the direct care service hours for licensed nurses per patient day within a total of 3.5 direct care service hours per patient day?**

Same as above, except that the RN MDS Coordinator's time assessing the status of patients, developing or updating the nursing plan of care, documenting the findings for each patient and supervising the implementation of the patient's plan of care may be calculated in the licensed nurse direct care service hours. Administrative time and time used for the purpose of documenting information specific to facility reimbursement should not be included in direct patient care hours.

5. **What process do you recommend to document the number of direct care service hours provided by nurse assistants, i.e. nurses in training for certification?**

Section 1337.1(a)(2) of the Health and Safety Code requires:

> In addition to the 60 classroom hours of training required under paragraph (1), the precertification training program shall consist of at least 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who ***has no other assigned duties while providing the training***. (emphasis added)

[9] CDPH AFL 09-47.

Additional and unencumbered registered nurse supervision of care being provided by nurses aides in training would be the minimum requirement for the use of uncertified personnel to meet the 2.4 CNA NHPPD.

SB 97 adds nurse assistants in training to the definition of "Direct caregiver" but does not specifically include nurse assistants in the calculation of the 2.4 hours per patient day for certified nurse assistants.[10] SB 97 would seem to allow for the use of appropriately supervised nurse assistants participating in an approved training program to meet the 2.4 direct care service hours for certified nurse assistant **under a waiver** approved by the CDPH when the patient population requires more long term care than Skilled Nursing care and the facility has demonstrated a short-term shortage of certified nurse assistants.

6. **Are there sufficient training resources to enable facilities to meet 2.4 direct care service hours for certified nurse assistants? If not, what additional resources would be required to meet the required training need?**

The California Nurses Association does not represent registered nurses in the facilities covered under this legislation (freestanding SNFs that are not DP SNF attached to GACHs). We do not have this information. We have no reason to believe, however, that a higher standard of care, better working conditions, and higher wages would not address any perceived "shortages" of available staff.

7. **In creating a waiver process to meet individual patient needs while maintaining the 3.5 direct care service hours, what would you anticipate being waived?**

This waiver process would seem to be roughly equivalent to existing program flexibility requirements, except that it is a temporary waiver of the staffing regulations. We could envision CDPH allowing for increased licensed staff when the health facility has a patient population that requires more licensed care and less unskilled long term care to clients. However, in issuing any waiver, we believe that CDPH should make it clear that the licensed care needs of the facility cannot be met by increased unlicensed staffing and that the facility should expect to maintain the level of licensed staffing it needs while working on restoring the CNA staff-to-patient ratio when the waiver expires. As the question implies, it is understood that under no circumstances would CDPH approve a request to lower the 3.5 direct care service hours per patient day.

8. **In creating a waiver process due to staffing shortages, what criteria or factors should the Department consider in granting an annual waiver?**

A facility that does not have the ability to provide minimum staffing of licensed care should plan to close beds until such time as they have sufficient resources to provide the care necessary to

[10] H&S Code Section 1276.65(c)(1)(C).

meet the minimum standards. It is important to keep in mind that the existing 3.5 NHPPD do not meet the CMS recommended minimums and that requests for waivers to the 3.5 NHPPD should, if granted, involve the use of more highly trained licensed staff to comply with the 3.5 NHPPD and not the reverse.

Additionally, as discussed at the August 4th meeting, we concur with the suggestion made by legal counsel that the department review, on a less than annual basis, whether the reasons for any waiver granted still exist.

9. **If a facility submitted waiver documenting they are over staffing with registered nurses and understaffing with CNAs (i.e. not meeting the 2.4 per patient day) what considerations should the Department weigh in considering this request and how would you advise the Department on this request?**

If the facility patient population is largely Skilled Nursing with a preponderance of patients who are there for rehabilitation and have some ability for self-care, the use of RNs in lieu of CNAs would be appropriate for the patient population. We see this type of flexibility as benefiting patients whose needs for licensed assessment and Plan modification is needed to promote progress in the process of rehabilitation. In addition, we could see CDPH allowing for a waiver of the CNA requirement in lieu of higher RN staffing, if the facility had a large number of patients who were in need of licensed care because of high skill care such as ventilators for chronic respiratory care, licensed care in management of tracheostomy patients unable to self-care or any other type of care that would involve the need for complex care that should be provided by licensed nurses.

Thank you for considering these comments.

Sincerely,

Saskia Kim, Regulatory Policy Specialist
California Nurses Association/National Nurses United