



August 22, 2017

**To:** California Department of Public Health

**From:** SEIU Local 2015

**Re:** SB 97 Implementation Questions – 3.5/2.4 HPRD requirement

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

While we strongly support resident to staff ratios, and hope that in the future the 3.5 hours minimum requirement is converted into a shift-specific staffing ratio, our main goal is to implement the minimum staffing requirements of 3.5 HPRD with a 2.4 HPRD requirement for CNAs at this time.

**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?**

The 3.5 direct care hours minimum staffing requirement was developed to address the needs of both the residents and workers at nursing facilities. Previously, there was no specific staffing requirement for CNAs, so if the 2.4 HPRD is followed by facilities, the safety of both residents and workers will be accounted for given that the vast majority of direct care is provided by CNAs, not licensed staff. The 3.5/2.4 hours requirements is a minimum standard, and the majority of facilities are already staffing at the 3.5 hours level or higher despite the current state minimum requirement being 3.2 HPRD. This is because many facility staff are taking into consideration the care needs of residents that have higher acuity and more complex medical needs. However, this is not the case in every facility and that is why it is time that the minimum staffing standard must be increased from 3.2 to 3.5 HPRD with a minimum of 2.4 CNA hours given that nursing facility residents have changed over the past 16 years, with many requiring a higher level of care.

**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?**

Our understanding is that CDPH currently has a system in place for nursing facilities to report their staffing hours under the 3.2 HPRD requirement, so the most logical way to report the 2.4 CNA hours and overall 3.5 direct care hours is to use the system that already exists to create as little disruption and room for errors as possible. There is no need to create an entirely new system to report hours; CNA hours should just be added into the current reporting system.

However, another option to consider is to use the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) data, which requires nursing facilities to report quarterly the facility's daily staffing hours based on individual payroll records or other supplemental information. Facilities must also provide job classification information for each individual employee, so it will be easy to differentiate CNA hours versus licensed staff. However, the PBJ does not require the facilities to report resident census information on a daily basis, so CDPH would need to require facilities to report their daily resident census information in order to determine if the facility is meeting the 3.5/2.4 hppd requirement on a daily basis. Since all Medicaid and Medicare certified facilities are now required to submit PBJ data to CMS, this may be an alternative worth considering in order to reduce provider burden so they do not have to fill out various forms with duplicative information.

**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?**

The same process that is used to count the 2.4 CNA 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?**

See answers to questions 3 and 4.

**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?**

We anticipate that some nursing facilities will need to hire additional CNAs to meet the requirements of this law, and that in some areas training programs are needed to build up the workforce. We think it's important to determine what geographic areas have documented workforce shortages, and to figure out what CNA training programs exist that could be utilized to train more workers in this field. Additionally, it is important to determine what other types of healthcare workers are available that can be trained to become CNAs as part of a career advancement.

**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?**

A waiver process will undoubtedly be complicated and must account for various factors. We recognize that some rural areas may have workforce shortages, and that smaller independently

owned facilities may experience some difficulty in increasing their staffing levels, but in order for the new 3.5 HPRD requirement to be effective and address the needs of the patients and workers, waivers should be granted only for facilities that have thoroughly documented hardships that would prevent them from reaching the new staffing levels for a limited time period. We envision waivers to be approved only in extenuating circumstances where it is clear that the facility has exhausted all options of hiring staff to meet the 3.5 HPRD requirement.

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

Facilities must thoroughly document that they have taken various steps to attempt to hire the appropriate staff to meet the 3.5 HPRD requirement. First, facilities must provide their starting wage rates for direct care staff as well as the turnover rates for employees at their facility. They must show that they have properly advertised the positions and made attempts to recruit new employees. Information on local CNA training programs as well as data on the workforce will be collected to determine if the facility could reasonably hire enough staff. If there are local hospitals or other types of healthcare facilities in the area that employ CNAs, those hiring wages and turnover rates should be observed in order to evaluate the options that a CNA has in obtaining employment. Lastly, for facilities that are part of a large chain that has ample resources, waivers should be restricted.

**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?**

The intent of the new regulations is to ensure that 2.4 of the 3.5 HPRD is being met by CNAs, so facilities should not be permitted to meet the 2.4 HPRD with non-CNA staff. If the facility has a documented hardship, they will be held to the standards described in question 8, and to reiterate, we do not anticipate a large number of waivers being granted as it takes away from the intention of the bill. If a facility is staffing with more licensed nursing staff, they should continue to maintain that level since their resident population likely has a higher acuity level and requires a higher level of care, however the 2.4 CNA minimum will help support the licensed staff as having more CNA staff available will help provide additional attention for residents.