

April 28, 2004

Administrator Mark McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-3121-P; Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Nursing Services; Posting of Nurse Staffing Information; February 27, 2004; p. 9282, Federal Register.

Dear Administrator McClellan:

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of care, including about 1,300 hospital-based skilled nursing facilities (SNFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule concerning posting of nurse staffing information, which was published in the Federal Register on February 27, 2004.

This proposed rule would elaborate upon the current requirement under the Benefits Improvement and Protection Act of 2000 (BIPA) that skilled nursing facilities post daily, per shift, the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. Today, facilities already uniformly post this required information using the format recommended by CMS, as also required by BIPA.

The AHA fully supports helping patients and their families make informed decisions about nursing home care options. However, we are concerned that several provisions of the proposed rule do not meaningfully facilitate this goal, and present an unnecessary administrative burden to providers. Of particular concern are the recommendations that exceed the nurse staffing requirements under BIPA, and provisions that suggest benefits to patients and the public that are, in fact, impossible or unlikely.

This letter includes comments on the Background, Provisions of the Proposed Rule, and Collection Information Requirements sections of the proposed rule.



Background Section

Definition of Long Term Quality Needs Further Work. In the Background section of the proposed rule, CMS suggests that consumers and the public will find the nurse staffing information to be a useful indicator of “the quality of care provided in individual nursing homes.” However, this information only provides limited insight into one component of the complex decision-making required to select the best nursing home for the patient. Further, **there is no existing valid measure of nursing facility nurse staffing; nor is there conclusive evidence on staffing levels that correlates to quality.** It is important that a national consensus on a definition for long term care quality be established that accurately and reliably encompasses the multiple dimensions of quality. This will be a substantial improvement over the current situation in which various limited measures are used across the country, creating confusion and possibly misleading patients who need to select a nursing facility.

Until pending research into appropriate staffing levels for SNFs is completed, CMS should avoid blanket statements about nurse staffing and patient outcomes. This position is supported by two Abt Associates, Inc. studies that were funded by CMS:

- *Identification & Evaluation of Existing Quality Indicators (QI) That Are Appropriate for Use in Long Term Care Settings.* This study found that “conceptually any QI derived from LTC does not necessarily characterize the overall quality performance of a facility and generalizing from a single measure is likely to result in an incorrect interpretation.”
- *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.* This study found “no substantial evidence exists that there [is] a relationship between levels of staff and resident outcomes.”

Calculation and Reporting Full Time Equivalents is Unnecessary. The proposed requirement to report nurse staffing by calculating and posting staffing through a “full time equivalent” (FTE) measure would represent the third manner in which nursing facilities report staffing. Nursing facilities are already required to provide nursing staff totals collected during their standard surveys by state survey agencies and when reporting to CMS for the Nursing Home Compare Website. It is unnecessary for CMS to require facilities to administer yet a third method for reporting staff.

Posted Information Will Not Improve Nursing Shortage. The Background section includes a troubling comment on nurse staffing levels: “With reliable information, nurse-staffing levels may simply increase due to the market demand created by an informed public.” This over-simplistic comment fails to recognize the multiple contributing causes of our present nursing shortage. The causes of and solutions to the long term care workforce shortages are complex and not likely to be resolved by a single step. The extensive study of this issue highlights multiple causes, including the aging of nurses, the limited capacity of nursing schools, and a shortage of nursing faculty, which would not be improved by the posting of nurse staffing information in nursing homes.

Nurse Staffing Information has Limited Usefulness for Patients. We question whether the public and consumers can meaningfully relate nurse staffing information to the quality of a nursing facility and ultimately to the selection of a facility. CMS studies have not led to conclusive evidence about staffing levels or a staffing measure that correlates to quality, which has been acknowledged by Health and Human Services Secretary Thompson and the Assistant Secretary of Planning and Evaluation. The proposed rule also suggests that it is “essential that information that enables the public to make informed judgments about a facility’s reported staffing levels be provided within the context of the facility’s case mix.” However, actually applying the FTE information to the notion of case-mix is unlikely for most patients and families.

CMS Should Appropriately Support Care for Medically Complex Patients. The AHA strongly concurs with the research finding “higher staffing levels are warranted for facilities with residents of more profound acuity and functional limitations.” This finding highlights the AHA’s concerns about the financial vulnerability of hospital-based SNFs, which are known to serve a greater proportion of medically complex patients that are underfunded by the current SNF prospective payment system.

Provisions of the Proposed Rule Section

Three-year Records Storage Requirement is Excessive. The proposed rule’s requirement to store nurse staffing records for three years is excessive and of questionable value. This requirement is an unnecessary and avoidable administrative burden that is not required by BIPA, yet a facility would be cited with non-compliance if it fails to store the records accordingly. Such noncompliance could be misinterpreted as an indication of poor care. Since facilities already maintain payroll records that provide staffing information, **facilities should be required to maintain nurse staffing information for no longer than one year**, or the approximate period between the facility’s standard surveys.

All Levels of Nurses Affecting Patient Care Should Be Counted. The proposed rule would exclude nursing staff whose work directly affects patients and the quality of their care, but who are not certified nurses providing direct care. For example, directors of nursing, medical data set (MDS) or resident assessment instrument (RAI) coordinators, and staff development directors make significant contributions to patient care but would not be reported under the proposed rule. This would create a misleading picture of coverage by nursing staff. In addition to the personnel noted, the following patient care personnel should also be included since they provide essential services to patients: medication aides (a position that is certified in many states); nurse aides in state-approved training programs; hospice nursing staff; and feeding assistants. **Consistent with BIPA, the posted staffing information should include all nursing staff who assist in the care of patients, more accurately portraying a facility’s capacity to care for patients.**

In addition, omitting essential nursing staff such as the MDS or RAI coordinator suggests that the nursing process itself, and the very instrument that CMS developed to serve as the basis for all care

planning and delivery of nursing services and interdisciplinary care, are irrelevant to patient care and outcomes. CMS statements in the RAI manual version 2.0 confirm this position:

“The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident’s life. This occurs not only because it follows an interdisciplinary problem-solving mode, but also because staff, across all shifts, are involved in its “hands on” approach.”

Further, this provision should accommodate the full range of professional titles for nurse-related personnel, which vary across the states.

Patient Census Data Should Not be Reported. BIPA does not require posting patient census data, which would unnecessarily utilize nursing staff time that is needed for patient care. CMS wrongly states that inclusion of census information on the nurse staffing reporting form renders the staffing information “more meaningful and useful” to the public. This information would not indicate the acuity of the patient population nor whether the available staff is sufficient to meet patients’ needs. More realistically, for most patients and families, census data would be irrelevant, and falsely imply that there is a validated benchmark for nurse staffing against which each nursing facility can be compared. It also would suggest that the public can and should make decisions about adequate staffing. Such decisions are clinical judgments for qualified professionals based on the individual needs of patients or groups of patients and are part of a dynamic process. In addition, suggesting use of patient census data in this manner overlooks the lack of consensus on a quality definition, which would be a disservice to the public and consumers because it encourages them to make inferences based on insufficient information.

Format of Posting Information is Inconsistent with Many Staffing Patterns. Hospital-based SNFs utilize a wide variety of shifts for nurse and other staffing in order to accommodate the flow of patients. While the AHA supports continued compliance with BIPA’s requirement for a “uniform manner to display the information,” the proposed format seems to go beyond that mandate by forcing facilities to report nurse staffing in units of eight-hour shifts. A single facility may use a variety of nursing shifts that may be six, 10 or more hours in length. Many facilities could have difficulty converting their nurse staffing information into the rigid format being recommended, and may produce results that don’t accurately depict the presence of nursing resources. Also, as noted, the conversion of nurse staffing information into FTE is time consuming and does not add value for patients. As such, **we recommend that nurse staffing information continue to be reported in hours, without the limitation of the eight-hour shift format.** CMS should allow facilities to use an alternate format as long as the content meets CMS requirements.

Collection Information Requirements Section

Proposed Rule Underestimates Time Requirement. CMS’ estimate of five minutes per day is significantly below the actual time that would be needed to calculate, post, and store this information

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three times per 24-hour period. This provision would impose a much greater time commitment on SNFs, especially larger facilities and those that do not utilize eight-hour shifts.

We appreciate the opportunity to comment on this proposed rule and we support CMS' continued efforts to improve the quality of care provided by nursing facilities and the sharing of accurate and valuable information with the public. To discuss our comments, please contact Rochelle Archuleta, senior associate director, policy, at 202-626-2320.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Pollack". The signature is fluid and cursive, with the first name "Rick" being more prominent than the last name "Pollack".

Rick Pollack

Executive Vice President