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Independent Regulatory Review Commission

From: Donovan Carper
To: DH, LTCRegs
Cc: Lori Mateyak
Subject: [External] comments re: the proposed increase in staffing: good for you!
Date: Thursday, August 19, 2021 7:10:19 AM

I saw the Leading Age "talking points" as I am a member, guidance they are providing to members regarding what to say to you at the DOH regarding your proposed minimum staffing guidelines.

As first a charge nurse in long term care, then a supervisor, then DON, and now Administrator, I can attest that the former regulatory guidelines of a 2.7 hppd are horribly outdated. Quality care is impossible to provide at that staffing ratio, and anyone that has ever worked the floor knows it.

Worse, during my NHA training as well as at conferences where I sat at tables with NHA's (usually non-nurse NHA's in this case), comments were repeatedly made such as "when my staff complain that they do not have enough help, I tell them the state minimum is 2.7, and we are staffed at (whatever their facility is staffed at)."

The state minimum has been used to justify understaffing by administrators and companies for way too long. Unfortunately, you will mostly hear from these very people as front line workers (aides, LPNs, floor RNs) do not spend time in emails or reading the latest reg proposals, nor are they members of groups such as Leading Age or PADONA, etc. Our aides have been abused for long enough. High injury rates, high turnover rates, high burnout rates. The leaders all go these seminars and know its a problem, but when asked to address it, their response is always "well, the industry staffing average is 'x', and state minimum is 'y', so, we're well within the norm."

The Leading Age talking points are insulting to someone such as myself who has worked side by side with my aides, LPNs, and RN's.

Flawed arguments from Leading Age:

High HPPD does not equate quality...that's insulting and dumb. Quality is complex, involves training, data analysis, PDSA's, leadership, etc. However, you have to have a baseline set of tools to work with. While an elevated HPPD does not equate quality by itself, a lack of caregivers almost certainly guarantees a compromise in quality due to short cuts, misses, near misses, errors, increased stress, burnout, etc.

Staffing crisis: this part is true right now. We are in a staffing crisis, its very difficult to recruit staff. However, unrealistic expectations of staff fuel burnout and turnover, and further the crisis/ make nursing home work unattractive. DOH will need to factor in the labor shortage somehow w/ their plan. Grace periods, good faith efforts, as well as training program incentives, etc are needed (aide instructor RN's get very low pay rates, making it unattractive for RN's).

4.1 may "stifle innovation...": this one is laughable. We've had 20 plus years to innovate with low staffing levels as the norm. What a joke of an argument. Innovate in reality means workers take short cuts because they can't find second assists, or they get injured from rushing around, or mistakes happen. Management then blames workers for "rushing" or for sloppiness, or blame the department heads while refusing to provide necessary resources to achieve

regulatory requirements and a safe work environment. What a joke re: this talking point. When a tragedy happens, they escort the DON and admin off the property, replace them, and the risks continue.

Uncertain timing and ramp up: right, you will need to provide this information and provide time, strategies, and contingencies for how nursing homes are to meet the regulation should it come to pass (and I pray it does!)

"nurses and nurse aides aren't the only ones who provide care to the residents": again, a really really dumb argument. Yes, therapy staff help (for residents during short periods of time they are on caseload), yes activities provide stimulation, etc. The reality though is that walking, bathing, toileting, turning/ repositioning, assessing, med pass, treatments, most feeding, cleaning, procedures, charting, providing emergency care (sepsis, post op complications, etc)--90 percent plus is done by nursing staff. Plus, nursing staff is there 24 / 7, unlike many of the other services. When I talk to my staff about what is creating challenges in meeting the demands of the job, hands down it is the nursing specific demands of the job. Activities do not help when a resident truly has to use the bathroom. 2 assist/ hoyer lift residents with urgency / frequency--social services and therapy do not help when you have a hall full of residents like this, etc. (and we all know residents are entering into LTC at later stages of illness).

Financing: this is really why the industry leaders are fighting this proposal. And they do have a case here. The financing piece has to be addressed if we are all to staff at 4.1. Our facility actually does staff at 4.1 (I would NOT want to see it lower, my staff bust their butts to meet the resident needs while sticking to the rules for 2 person lifts, etc). We are losing money as a facility currently in our skilled program and have lower numbers of medicaid residents versus other facilities. We are buffering these losses through other revenue streams currently. So this part definitely needs addressed. Medicaid has failed to adapt to inflation, and this has to be addressed to serve the goals of DOH in terms of providing quality care.

Please do the right thing, its clear those at the CEO level, admin level will crowd out the voices of the front line caregivers and residents! Don't let this happen!!! You are doing the right thing!!! However, please address the medicaid issue as well as labor crisis with your plan, as putting a standard on paper versus logistics of execution are two different things. Good faith efforts demonstrated, medicaid adjustments for those that meet these goals...those are good ways to incentivize compliance!!!

Feel free to call me to discuss, thanks so much for this!

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