Nursing Counts

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Addressing the Dramatic Decline in RN Staffing in Nursing Homes

Nurses, consumer advocates, and some policymakers have lobbied hard for increased nurse staffing levels in U.S. nursing homes. Despite these efforts, average RN staffing levels in certified long-term care facilities declined 25% between 1999 and 2003, from 0.8 to 0.6 hours per resident day. Average staffing levels for licensed practical and licensed vocational nurses held steady at 0.7 hours per resident day, while those for nursing assistants increased from 2.1 to 2.3 hours per resident day, in response to the lost RN hours. During the same time period, average RN staffing levels also declined dramatically in Medicare-only facilities, from 3.3 to 2.5 hours per resident day.

The declines in RN staffing levels are a direct result of the Balanced Budget Act of 1997, which mandated that Medicare pay the costs of skilled nursing home care following hospitalization under the prospective payment system (PPS). Implemented in 1998, this system was intended to reduce Medicare's overall payments to nursing homes, but it had few safeguards to ensure that the quality of care did not also decline. Under the PPS, Medicare rates are based in part on the resident case mix (acuity) in each facility, in order to take into account the levels of staffing and therapy services that residents require. Skilled nursing homes, however, are not required to demonstrate that the levels of staff and therapy time provided are related to payment allocations under the PPS rates. Since the PPS was implemented, the annual average number of regulatory deficiencies (notices that a facility has violated federal standards) has also increased.

A study for the Centers for Medicare and Medicaid Services found that the quality of care in nursing homes improves with each increase in nurse staffing levels, until a threshold is reached (that level beyond which "no further significant benefits with respect to quality" occur with added staff, and below which "facilities [are] more likely to have quality problems"). It revealed that total nurse staffing levels below 4.1 hours per resident day (and RN staffing levels below 0.75 hours per resident day) can jeopardize the health and safety of the residents. About 97% of nursing homes do not meet one or more of the threshold standards.

Policies that can increase staffing and improve the quality of care are needed. One option is revising the PPS reimbursement formula so that it specifies a minimum percentage of Medicare payments that must be used for nurse staffing and therapy services. Stricter limits on administrative costs and profit margins for skilled nursing facilities are others. Minimum state and federal nurse staffing levels of 4.1 total nursing and 0.75 RN hours per resident day should be established in accordance with recommended levels. Nurses need to advocate legislation such as the proposed Long Term Care Quality Improvement Act of 2005 (HR 1166), which aims to ensure adequate payment for skilled nursing care and to improve nurse staffing levels in long-term care facilities.—*Charlene Harrington, PhD, RN, FAAN*

Harrington C, et al. *Nursing facilities, staffing, residents, and facility deficiencies, 1997 through 2003.* San Francisco: University of California, 2004: 73. http://www.nccnhr.org/public/245_1267_9316.cfm; Medicare Payment Advisory Commission (MedPAC). Skilled nursing facility services. In: *Report to the Congress: Medicare payment policy.* Washington (DC): MedPAC, 2002: 86-90. http://www.medpac.gov/publications/congressional_reports/Mar02_Entire%20report.pdf; Konetzka RT, et al. *Health Serv Res* 2004;39(3):463-88; Feuerberg M. Overview of the phase II report: background, study approach, findings, and conclusions. In: *Report to Congress: appropriateness of minimum nurse staffing ratios in nursing homes. Phase II final report.* Washington (DC): Centers for Medicare and Medicaid Services; 2001. vol. 1. p. 1-22. http://www.cms.hhs.gov/medicaid/reports/rp1201-1.pdf.

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Proposed Medicaid Cuts

A threat to nursing home residents.

On April 28 Congress passed the 2006 budget resolution, which includes cuts to federal spending for Medicaid amounting to $10 billion over the next five years. It also provides for the appointment of a commission, led by U.S. Department of Health and Human Services secretary Michael O. Leavitt, to study the Medicaid program. A concern is whether the commission will recommend cuts that will hurt those beneficiaries most in need of services.

Medicaid is the major health insurer for nursing home residents. Under Medicaid, states must cover certain "mandatory" populations and may extend coverage to other "optional" groups; covered services and benefits are also categorized as either mandatory or optional. Mandatory recipients are those with incomes at or below the 2004 Supplemental Security Income of $564 per month who meet certain "need" criteria, such as those who are elderly (age 65 and older) and have chronic disabilities. Mandatory services include, for example, nursing facility care for eligible patients older than 21 years of age. However, as the most recent *Kaiser Commission on Medicaid and the Uninsured* states, "Some of the sickest and poorest Medicaid beneficiaries are considered 'optional' and many 'optional' benefits provided under Medicaid often are essential."

Only 8% of Medicaid spending for long-term care is for mandatory institutional care. Expert Leighton Ku, PhD, MPH, senior fellow in health policy at the Center on Budget and Policy Priorities in Washington, DC, estimates that 86% of all Medicaid recipients who are nursing home residents are optional recipients; they will be vulnerable to the proposed budget cuts. Many of them have already depleted their assets; there is nothing optional about their dependence on Medicaid.

Preservation of optional benefits and services depends upon bipartisan cooperation. The Senate Finance Committee and the House Energy and Commerce Committee will review information, including reports from the National Governors Association and Secretary Leavitt's commission, and make budget decisions by September 16.

For information, visit www.familiesusa.org. Then share your thoughts with Congress.—*Sarah Greene Burger*

Families USA. *Medicaid budget cuts will cause harm to America's low-income seniors and children.* Washington (DC): Families USA; 2005. http://www.familiesusa.org/site/PageServer?pagename=Media_Statement_Medicaid_Budget_Cuts_04_28_05; Kaiser Commission on Medicaid and the Uninsured. *Medicaid's optional populations: coverage and benefits.* Henry J. Kaiser Family Foundation. 2005. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51052.

Research Brief

Adverse Drug Events

Older adults in long-term care settings commonly take multiple drugs and are routinely transferred between hospitals and nursing homes. A recent study identifies medication changes that occur during such transfers as a cause of adverse drug events.

Boockvar and colleagues studied 87 nursing home residents who underwent 122 home-to-hospital and 111 hospital-to-home transfers. Seventy-eight participants completed the study. Study participants (mean age, 78.4 years) were admitted to the hospital for at least 24 hours and were followed to hospital discharge and nursing home readmission and for two months thereafter. During home-to-hospital and hospital-to-home transfers, a mean of 3.1 and 1.4 drug changes occurred, respectively.

Physician-identified adverse drug events occurred in 14 (20%) of 71 "bidirectional transfers" (transfers from nursing home to hospital and back to the nursing home). Seven of these events (50%) were caused by discontinuation of drug use, and five (36%) resulted from dosage changes. Most medication changes occurred in the hospital, and most adverse drug events occurred after readmission to the nursing home.

Gurwitz and colleagues examined the incidence of adverse drug events in one nursing home for a period of eight months and in another for a period of nine months. Among the 1,247 residents (mean age, 86 years), physician reviewers identified 815 adverse drug events, of which 28% were judged to be serious, life-threatening, or fatal. Of the 42% of events found to be preventable, most were due to errors in medication ordering and monitoring.—*Malvina Kluger*

Boockvar K, et al. *Arch Intern Med* 2004;164(5):545-50; Gurwitz JH, et al. *Am J Med* 2005;118(3):251-8.

FAST FACTS

▼ **For "long-stay" nursing home residents, the Institute of Medicine recommends staffing levels of**

- **one RN for every 32 residents (0.75 hours per resident day).**
- **one licensed practical or vocational nurse for every 18 residents (1.3 hours per resident day).**
- **one nursing assistant for every 8.5 residents (2.8 hours per resident day) for a total of 4.1 nursing hours per resident day.**

▼ **Among people ages 65 years and older, malnutrition occurs in an estimated 40% to 85% of those in nursing homes and 20% to 60% of those cared for at home. Among those ages 65 and older who are hospitalized, 40% to 60% are likely to be either at risk for or suffering from malnutrition.**

Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses.* Page A, editor. Washington (DC): National Academies Press; 2004: p. 11. http://www.nap.edu/books/0309090679/html; Nutrition Screening Initiative. *Nutrition statement of principle.* 2002. American Dietetic Association, American Academy of Family Physicians. 2002. http://www.eatright.org/Public/Files/nutrition(1).pdf. ▼