Staffing by Acuity-How Does Your Facility Compare?

Handout Prepared for:
Wisconsin Health Care Association

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HEALTH CARE PRACTICE

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About the Presenter!

Patricia J. Boyer
Health Care Director

Certifications:

Registered Nurse

Nursing Home Administrator

Current Position and Responsibilities

Pat Boyer brings more than 30 years of experience to Wipfli LLP's senior living health care practice. Her clients appreciate her deep knowledge and understanding of the challenges they face and her assistance with achieving performance improvement and process development as well as meeting and exceeding state and federal compliance standards. Pat is dedicated to providing exceptional client service to help long-term care and senior living providers attain their strategic goals.

Specializations

- Resource Utilization Group (RUGs)-based Medicare/Medicaid reimbursement
- Performance improvement and process development
- State and federal compliance programs
- Long-term care and subacute operations
- Assisted living operations

Past Experience

- Founder and president of Boyer & Associates, LLC (merged with Wipfli LLP in February 2014)
- Operations consultant for BDO Healthcare Group, LLC
- Director of nursing services and administrator, quality improvement specialist, and director of regulatory compliance for a national nursing home company
- Conducted RUGs-based Medicare and Medicaid operational assessments in nursing facilities
- Conducted numerous workshops at the national, state, and local levels

Professional Memberships and Activities

- Authors the monthly Ask the Payment Expert column in *McKnight's Long-Term Care News*
- LeadingAge Wisconsin - Program Committee member

Education

St. Petersburg College

- Nursing

Cardinal Stritch University

- Master of science degree in management

More changes are occurring in the industry and it has become more and more important to understand how acuity of care affects staffing in facilities. This workshop will dive into the staffing calculations being utilized to evaluate the Five Star staffing component, discuss how surveyors may be utilizing these numbers to evaluate your compliance with staffing requirements and evaluate how you can meet these challenges. In addition, we will focus on the MDS Focused Surveys which expanded nationwide in 2015 and will now add a staffing component. You will walk away with a staffing tool that can be implemented to assist you in monitoring your facility acuity and staffing.

At the completion of this session, participants should be able to:

- Identify how staffing is evaluated in the Five Star program
- Determine how new electronic staffing requirements will affect your facility
- Describe other initiatives that can result in staffing deficiencies

Power Point Slides!

Staffing by Acuity

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What Is Sufficient Staffing?

- 42 C.F.R. § 483.30(c), F353, based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being
- The determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents

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Sufficient Staffing

- Staff numbers: Do you have the right numbers and type of staffing?
- Staff qualification: Does your staff meet the qualifications of staffing needs?
- Staff training: Is your staff proficient in providing resident care?

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Interpretive Guidelines

Determine nurse staffing sufficiency for each unit:

- Is there adequate staff to meet direct care needs, assessments, planning, evaluation, supervision?
- Do workloads for direct care staff appear reasonable?
- Do residents, family, and ombudsmen report insufficient staff to meet resident needs?
- Are staff responsive to residents' needs for assistance, and are call bells answered promptly?
- Do residents call out repeatedly for assistance?

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Interpretive Guidelines (Continued)

- Are residents who are unable to call for help checked frequently (e.g., each half hour) for safety, comfort, and positioning and to offer fluids and provision of care?
- Are identified care problems associated with a specific unit or tour of duty?
- Is there a licensed nurse who serves as a charge nurse (e.g., supervises the provision of resident care) on each tour of duty (if facility does not have a waiver of this requirement)?

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Interpretive Guidelines (Continued)

- What does the charge nurse do to correct problems in nurse staff performance?
- Does the facility have the services of an RN available eight consecutive hours a day, seven days a week (unless waived)?
- How does the facility ensure that each resident receives nursing care in accordance with his/her plan of care on weekends, nights, and holidays?
- How does the sufficiency (numbers and categories) of nursing staff contribute to identified quality of care, resident rights, quality of life, or facility practices problems?

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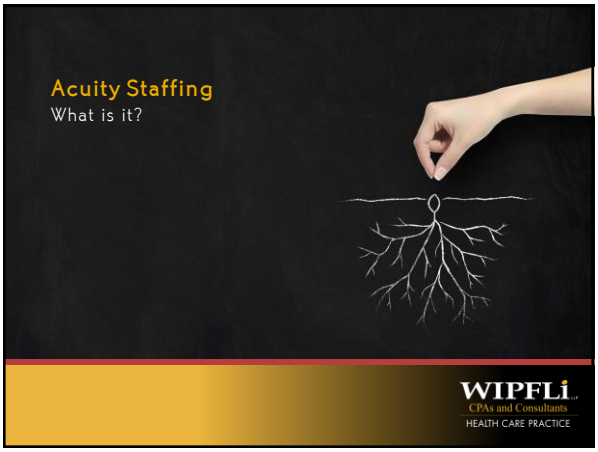

What Is Staffing by Acuity?

- One that is based on a measure of intensity that takes into consideration the aggregate population of patients and the associated roles and responsibilities of the nursing staff
- Staffing levels that take into consideration the medical, behavioral, cognitive, and functional needs of residents

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Staffing by Acuity

In our environment….

- Utilizing the RUG levels to determine resident acuity and staffing to those needs
- Which RUG levels, Medicare or Medicaid?

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AHCA 2012 Staffing Report

A study by Nicholas Castle and John Engberg (2007):

- Higher levels of RN staffing are positively associated with quality.
- High rates of CNA stability correspond with high overall quality in 7 out of 11 quality measures that reflect care for the long-stay resident.

Staff turnover has been extensively examined for its association with quality.

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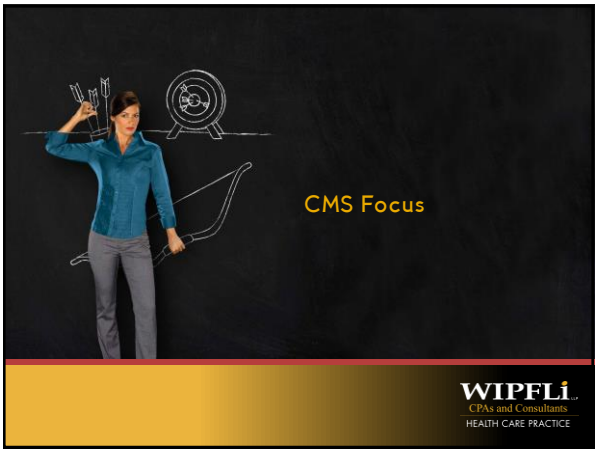
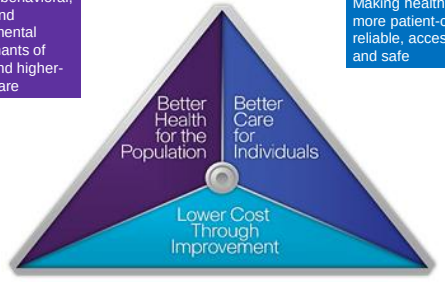


The Triple Aim

Interventions to address behavioral, social, and environmental determinants of health and higher-quality care

Making health care more patient-centered, reliable, accessible, and safe



Reduce cost of quality health care

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CMS 2012 Nursing Home Action Plan

Enhance Consumer Engagement (Objective #1)

- Hold the health care system accountable for the quality of services and support that should be provided
- Increase the array of understandable information that can be readily accessed by the public
  - Nursing Home Compare: Enhancement of the Five-Star Quality Rating System
  - Publicizing facilities on the Special Focus list
  - Involving families/residents in decisions on resident-centered care

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Staffing by Acuity

Who utilizes resident acuity levels?

- Five Star
  - Consumers
  - Bankers
  - Insurance agents
  - Etc….
- New proposed federal regulations
- Attorneys/litigation

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Staffing Data

- Self-reported information collected from facility at the time of the Standard Survey (CMS-671)
  - RN, LPNs, and CNAs
- DON/ADON hours are used
- Includes FT, PT, and contract staff
- Does not include private-duty, hospice, or feeding assistants

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Staffing Data (Continued)

- Census data based on count of total residents from CMS-672 (Resident Census and Conditions of Residents)
- HRD = Total hours for each nursing discipline/resident census/14 days

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Staffing Data (Continued)

- Case-Mix Adjusted
  - **RUGs 53 Medicare Grouper** staffing time
  - Based on CMS Staff Time Measurement Studies from 1995-1997
- Staffing Five-Star Rating

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Staffing Data (Continued)

"Reported" hours – Those reported by the facility on the CMS-671

"National Average" hours – Unadjusted national mean of the reported hours across all facilities for April 2012

	National Average Hours PPD
Total Nursing Staff	4.0309
RNs	0.7472

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Case Mix Adjustment

- Adjusted Hours = Reported Hours divided by Expected Hours equals National Average Hours
- Average case mix for the quarter of RUG III data in which the staffing data was collected
- "Target" date is seven days prior to the most recent standard survey date
- Downloadable file that contains the "expected," "reported," and case-mix adjusted hours used is available at:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

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CMS Expected and Adjusted Staff Time Values Data Set

What you reported on the CMS 671

				Reported Hours Per Resident Per Day				
CCN	Provider Name	CITY	STATE	Aides	LPNs	RNs	Total Licensed	Total Nursing

Expected Hours Per Resident Per Day					Adjusted Hours Per Resident Per Day				
exp_aide	exp_LPN	exp_RN	exp_nurse	exp_all	adj_aide	adj_lpn	adj_rn	adj_nurse	adj_total

Hours based on the case mix

The results of the formula. Used to determine your Star Rating.

Reported Hours/Expected Hours x National Average Hours = Adjusted Hours

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Staffing Points and Rating – Updated February 2015

RN rating and hours		Total staffing rating and hours (RN, LPN, and CNA)				
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥ 4.418
1	< 0.283	*	*	**	**	***
2	0.283 – 0.378	*	**	***	***	***
3	0.379 – 0.512	**	***	***	****	****
4	0.513 – 0.709	**	***	****	****	****
5	≥ 0.710	***	***	****	****	*****

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Facility Example

- Data Submitted
  - DON/RNs: 27.79= 0.397 hours ppd (actual 0.39675)
  - LPNs: 84.70 hours = 1.210 hours ppd
  - CNAs: 153.93 hours = 2.199 hours ppd
  - Total hours: 266.42 hours = 3.81 hours ppd (actual 3.80732)
  - Case mix = 3.74 (2/26/2015) – Facility staffing at 3.81 (survey date)

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Facility Example-Staffing

Hours (Reported)/Hours (Expected)

Hours (National Average) = Hours (Adjusted)

3.8073/3.7473 times 4.0309 = 4.0954

0.3967/0.8759 times 0.7472 = 0.33842

Two stars for RN staffing and
Three stars for all staffing = Three stars

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MDS/Staffing-Focused Surveys

History:

- In mid-2014, CMS piloted a short-term MDS-focused survey
- The pilot surveys were conducted in nursing homes in five states

About the Pilot:

- Five nursing facilities in each of the five states were surveyed
- The total number of homes surveyed was 25
- Deficiencies were written in 24 out of 25 homes

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CMS S&C Memorandum 15-06-NH

DATE: October 31, 2014

SUBJECT: Nationwide Expansion of Minimum Data Set (MDS) Focused Survey

DOWNLOAD:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-06.pdf

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Report Staffing

Reported Staffing:

- The scope of some or all of the focused surveys will also be expanded
- The increased scope will include an assessment of the staffing levels of nursing facilities
- Two aims:
  - Verify the data self-reported by the nursing home
  - Identify changes in staffing levels throughout the year

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MDS/Staffing-Focused Surveys: Survey and Enforcement Information

- Record review, augmented by resident observations and staff and/or resident interviews, will be used by the surveyors to validate MDS 3.0 coding and staffing levels
- In addition, while on site, the surveyors will ask a series of questions regarding staffing and MDS-related practices of the facility staff, leadership, and others as appropriate

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New Conditions of Participation

New Requirements of Participation

Final Rule

Phase 1 – Implementation

November 28, 2016

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Implementation Dates

- Phase 1 – November 28, 2016
- Phase 2 – November 28, 2017
- Phase 3 – November 28, 2019

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Nursing Staffing

Key points

- The regulations add a competency-based staffing approach that requires the facility to evaluate its resident population and its resources and base its staffing plans and assignments on these assessments. This evaluation must include:
  - The number and acuity levels of the residents.
  - The range of diagnoses and resident needs.
  - The content of individual care plans.
  - The training, experience, and skill sets of individual staff members.

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Nursing Staffing

- The facility will have to take into account its assessment of all residents as well as the skill sets of individual staff when making staffing decisions
- Facility determinations of what is sufficient staff as well as the necessary competencies and skill sets must take into account the number, acuity, and diagnoses of the facility's resident population

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Difference From Previous Requirements

- The new regulation adds the requirement that facilities ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments and care plans

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Difference From Previous Requirements

- Consistent with CMS's clarification that nurse aides are included in the term "other nursing personnel," the requirements relating to hiring and utilizing nurse aides previously located in § 483.75 of the regulations are now included in § 483.35. Specifically:
  - Nonpermanent caregivers must meet the same competency, knowledge, and skill requirements as permanent personnel. These caregivers may have less familiarity with a facility's residents and processes, which needs to be considered when using, orienting, and assigning nonpermanent staff.
  - Meeting the minimum requirements for hiring a nurse aide does not automatically mean meeting the staff competency requirement that would be specific to the needs of each individual resident.

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Key Aspects

- This will require facilities to identify, document, and maintain any training, certification, and similar records in an existing personnel file or training record for direct care personnel
- This specifically includes nursing services and food and nutrition services workers but may apply to any direct care provider

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What This Means for Facilities

- The facility must ensure that licensed nurses and nurse aides have the knowledge and skills needed to care for residents' needs, as identified through resident assessments and as described in each resident's individual plan of care
  - Caring for a resident's needs includes assessing, evaluating, planning, and implementing resident care plans and responding to each resident's needs
  - These requirements apply equally to employees or contract staff utilized by the facility
- CMS intends to focus on ensuring that not only are there a sufficient number of staff in a facility, but also that staff have the necessary abilities, knowledge, and competencies to be effective and efficient in carrying out the work necessary to meet the needs of each resident receiving care in the facility

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CMS Expectations

CMS anticipates that any initial competency requirements will be identified by the facility assessment, with documentation of individual accomplishments managed by an administrative position as an addition to existing documentation.

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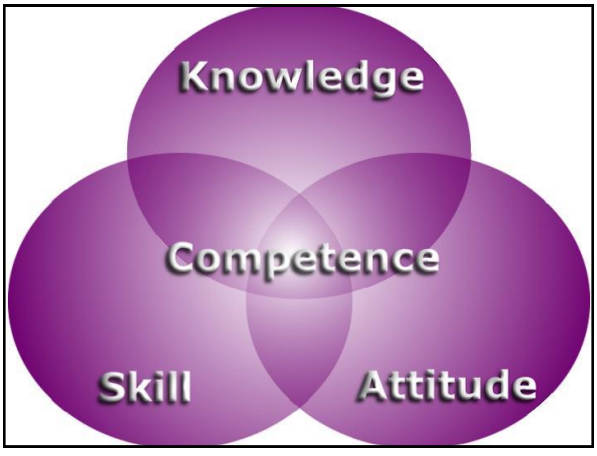

"THE BEST DEFENCE IS A GOOD OFFENCE."

English Proverb

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Acuity-Based Staffing

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Staffing Need Awareness

- Be aware of what your case mix is monthly
  - RUG levels
- Know how your staffing levels measure up to the various tools
  - Five Star
  - Proposed regulatory language
    - Case mix population

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Action…

- Utilize a staffing acuity tool for all residents
  - By facility
  - By unit
- Make adjustments for heavy care
  - Exception process
- Update according to changes in resident needs
  - LTC: Monthly
  - Rehab: Weekly

Sample Acuity-Based Staffing Tool

Staffing Model Based on STRIVE Time Study

User to populate all gray cells.

Facility Name
Facility City and State
Start Date
End Date

Should the "Direct" or "Proportional" method be used to allocated non-resident specific time (see notes tab for descriptions)

Select One

Summary

Payor	Resident Days	Resident Days	Staffing Position	Needed By Position Hours Per Total Hours	Patient Day
Medicare		-			
Medicare Advantage		-	RN	-	
Private Pay		244	LPN	-	
Medicaid / Equivalent		682	CNA	-	
Total		926	Totals	-	-

Data Input

RUG	RUG 66 or 68	Resident Days for Period Reported: Medicare A	Medicare Advantage	Private Pay	Medicaid / Equivalent	Total	STRIVE Time Study Minutes by Position For Days Reported: RN and Resp Therapist	LPN	CNA & Other (a)
RUX	66					-			
RUL	66					-			
RUX	66					-			
RVL	66					-			
RMX	66					-			
RML	66					-			
RMX	66					-			
RML	66					-			

QAPI

Five Components

1. Design and scope
2. Governance and leadership
3. Feedback, data systems, and monitoring
4. Performance improvement projects (PIP)
5. Systematic analysis and systemic action

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QAPI Program

- Identify needs according to patient acuity
- Case mix
  - Respiratory therapy
  - Restorative care
  - Skilled services
    - IVs, ostomies, wound vacs, etc.
- Equipment needs
- Staff training
- Skills validation

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QAPI Program (Continued)

- Make action plans to resolve issues identified
- Ask questions:
  - How are we going to recruit more RNs?
  - What type of resident population are we equipped to handle?
  - Is there a specialty we want to train our staff to handle?
  - Do we have equipment needs?
    - What are we going to do about that?

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What Can You Do to Meet These Requirements?

- Annual skills fairs
- Acuity-based staffing monitoring
  - Skilled Unit – Update weekly
  - LTC – update monthly
- Discuss needs with referral sources/ACOs/health systems
  - Solicit assistance with education to enhance your staff's skills

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Questions?

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Speaker Information

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Attachments

Five Star Staffing Star Table

Acuity Staffing Model

Staffing Points and Rating – Updated February 2015

RN rating & hours		Total staffing rating & hours (RN, LPN, & CNA)				
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥ 4.418
1	< 0.283	*	*	**	**	***
2	0.283 – 0.378	*	**	***	***	***
3	0.379 – 0.512	**	***	***	****	****
4	0.513 – 0.709	**	***	****	****	****
5	≥ 0.710	***	***	****	****	*****

Facility Name

Medicare Acuity Based Staffing

Based on STRIVE Staff Time Study

RUG Category	Average RN Minutes per Day	Average LPN Minutes per Day	Average Aide Minutes per Day	RUG Days	Total RN Minutes	Total LPN Minutes	Total Aide Minutes	Total Minutes
RUX	68.4	111.4	131.1	-	-	-	-	-
RUL	109.1	63.9	199.9	-		-	-	-
RVX	29.2	95.9	145.9	-	-	-	-	-
RVL	67.7	97.4	140.0	-	-	-	-	-
RHX	128.8	51.9	155.2	-	-	-	-	-
RHL	67.3	48.4	135.3		-	-	-	-
RMX	97.5	74.6	148.4	-	-	-	-	-
RML	133.8	84.0	153.2	-	-	-	-	-
RLX	0.0	0.0	0.0	-	-	-	-	-
RUC	27.8	66.4	149.0	8	222	531	1,192	1,945
RUB	45.0	71.1	141.0	4	180	284	564	1,029
RUA	35.2	54.6	101.0	6	211	327	606	1,144
RVC	34.2	66.5	156.5	10	342	665	1,565	2,592
RVB	28.9	56.6	119.9	2	58	113	240	411
RVA	31.3	59.4	113.7		-	-	-	-
RHC	36.6	54.9	156.1	5	183	274	781	1,238
RHB	36.4	47.9	119.5		-	-	-	-
RHA	27.1	51.8	99.8	3	81	155	299	536
RMC	32.6	56.1	148.9		-	-	-	-
RMB	32.1	55.5	134.7		-	-	-	-
RMA	26.0	46.8	98.8		-	-	-	-
RLB	33.9	44.6	185.8		-	-	-	-
RLA	15.5	43.6	118.9		-	-	-	-
ES3	130.5	58.5	152.1		-	-	-	-
ES2	65.2	75.2	146.7		-	-	-	-
ES1	72.8	49.5	127.6		-	-	-	-
HE2	21.3	67.9	190.5		-	-	-	-
HE1	19.2	67.7	149.5	2	38	135	299	473
HD2	41.9	70.6	153.8		-	-	-	-
HD1	16.9	54.5	141.8		-	-	-	-
HC2	35.1	53.6	154.7	3	105	161	464	730
HC1	22.4	54.2	135.3		-	-	-	-
HB2	60.6	67.9	133.9		-	-	-	-
HB1	21.7	50.5	106.8		-	-	-	-
LE2	22.2	58.8	176.2		-	-	-	-
LE1	22.1	52.3	143.4		-	-	-	-
LD2	19.6	58.1	153.3		-	-	-	-
LD1	11.8	43.9	130.8		-	-	-	-
LC2	27.4	47.8	116.1		-	-	-	-
LC1	15.7	46.6	124.8		-	-	-	-
LB2	29.5	50.7	128.4		-	-	-	-
LB1	19.0	48.7	106.2		-	-	-	-
CE2	21.1	44.1	162.7		-	-	-	-
CE1	21.3	33.8	159.1		-	-	-	-
CD2	20.0	45.2	175.5		-	-	-	-
CD1	15.3	41.9	151.4	6	92	251	908	1,252
CC2	19.8	37.0	132.9		-	-	-	-
CC1	16.0	35.1	126.9		-	-	-	-
CB2	23.5	36.5	115.0		-	-	-	-
CB1	16.2	35.0	118.5		-	-	-	-
CA2	20.7	44.6	80.9		-	-	-	-
CA1	22.4	40.2	72.8		-	-	-	-
BB2	11.3	33.3	118.0	-	-	-	-	-
BB1	14.9	32.8	114.3	8	119	263	914	1,296
BA2	18.3	41.2	101.6		-	-	-	-
BA1	13.6	31.6	86.1	5	68	158	430	656
PE2	15.1	39.8	163.2	-	-	-	-	-
PE1	19.9	36.1	161.2	6	119	216	967	1,303
PD2	12.1	38.0	163.4	4	48	152	654	854
PD1	16.2	33.6	147.3	2	32	67	295	394
PC2	8.1	33.5	124.9	1	8	34	125	167
PC1	14.1	36.9	123.7	8	113	296	990	1,398
PB2	15.5	39.0	118.8	1	15	39	119	173
PB1	12.5	31.8	95.6	5	62	159	478	699
PA2	5.5	35.9	73.2	3	17	108	219	344
PA1	14.3	32.4	70.8	10	143	324	708	1,175
	Total Minutes			102	2,259	4,733	12,818	19,810
	Exception Minutes				30	30		
	Total Revised Minutes				2,289	4,763	12,818	19,870
	Total Hours				38	79	214	331
	Hours per Medicare day				0.37	0.78	2.09	3.25

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