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Submitted electronically to: LTCCOP@cms.hhs.gov

RE: Medicare Conditions of Participation, Requirements for Long-term Care Facilities, 42 CFR §483 Subpart B

Dear Ms. Tavenner and Dr. Conway:

The Coalition of Geriatric Nursing Organizations (CGNO), in conjunction with the American Nurses Association (ANA), appreciate the opportunity to provide comments on the Requirements for Participation for Long Term Care Facilities, 42 CFR §483 Subpart B. We are particularly interested in addressing §483.30 Nursing Services, specifically 24 hour RN staffing and a full time RN Director of Nursing without waivers, and would urge the Center for Medicare and Medicaid Services (CMS) to commence with a review of this section of the Medicare Conditions of Participation through the formal regulatory process.

The CGNO includes eight geriatric nursing organizations whose membership has more than 28,000 nurses primarily working in long term care and is coordinated at the Hartford Institute for Geriatric Nursing (HIGN), New York University, College of Nursing by Sarah Burger. The CGNO mission is to leverage our collective strengths to create a health care environment for older adults that is accessible and reflects person centered care, quality outcomes and evidence based practice across all settings.

Nursing home quality is a priority concern of seven of the eight organizations, including the American Academy of Nursing, Expert Panel on Aging (AAN,EPoA), The American Association of Long Term Care Nursing (AALTCN), The American Association of Nurse Assessment Coordination (AANAC), The Gerontological Advance Practice Nurses Association (GAPNA),The Hartford Institute (HIGN), National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) and the National Gerontological Nurses Association (NGNA).
colleagues at the American Assisted Living Nurses Association (AALNA) devote their energies to other than nursing homes. The diverse memberships include geriatric nurses who are PhD teachers, researchers and clinicians, Masters prepared Advance Practice Nurses, RNs, LPNs, and some nursing assistants.

The American Nurses Association is the leading professional organization representing the interests of the nation’s 3.1 million registered nurses (RNs) and represents registered nurses in all roles and practice settings through our state and constituent member nurses associations and affiliated nursing specialty organizations.

**RNs: Who are they and what do they do in nursing homes?**

RNs are the largest group of healthcare professionals serving in multiple direct care, care coordination, and administrative leadership roles across healthcare settings. The aims of nursing interventions are to protect, promote, and optimize health; to prevent illness and injury; to alleviate suffering; and to advocate for individuals, families, communities, and populations. According to the Bureau of Labor Statistics, over 180,000 RNs employed in nursing and residential care facilities.

All RNs are educated at an accredited school or college of nursing and are licensed by state boards of nursing as an independent practitioner with a body of knowledge that allows them to conduct comprehensive resident assessments based on knowledge of disease states and use of critical thinking skills to manage unstable medical needs, overseeing development and implementation of the care plan and evaluation of care on a continuous basis. Based on both education and state statute, RNs are the only nursing personnel who can perform these functions.

The role of RNs in nursing homes is multi-faceted and vital to the safety of the nursing home residents. The Director of Nursing is the nursing executive accountable for quality outcomes, clinical systems evaluation, safety culture, nursing staff competencies, identification of nursing staff clinical education needs, compliance with required regulations, including clinical assessments and care planning, quality improvement and all aspects of nursing health care delivery.

The staff RN has essential functions of providing timely clinical assessment, appropriate intervention and evaluation of the nursing home residents as well as working closely with members of the interdisciplinary health care team to develop a plan of care that promotes the nursing home resident attaining and/or maintaining the highest practicable physical, mental, and psychosocial well-being. The RN is accountable for supervising all nursing health care delivery by unlicensed health care workers (for example, certified nursing assistants) as well as licensed practical nurses. The RN is responsible for quality of care outcomes in the nursing home including infection prevention and control, pressure sore prevention, falls and other accident prevention, transitions of care coordination and monitoring medication regimes for safety and appropriateness to meet the resident’s identified clinical needs. The RN serves as a clinical liaison with the physician/primary care provider to rapidly identify changes in clinical conditions, communicate those changes and respond with appropriate actions in a timely manner to prevent resident poor clinical outcomes.

Specifically, we are commenting on §483.30 Nursing Services. While this is the focus of this communication, should CMS conclude that a review through the Federal Register of 42 CFR §483 Subpart B is warranted, it is likely that our organizations will provide comments on other sections of Subpart B as well.
Requirements for Registered Nurse presence on the premises:

CFR 483.30: (b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

be changed to:

(b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must have a registered nurse on the premises 24 hours a day, 7 days a week.

RATIONALE:

Registered Nurse staffing and Resident Care

Evidence supporting RN staffing as a key element for safe and effective resident care in U.S. nursing homes has grown substantially over the last two decades, typically using quality measures or deficient practice from the CMS survey data. All four literature reviews of nurse staffing in nursing homes have been published in the last six years find evidence of a positive association between levels of RN staffing and quality. (Bostic, Rantz, Flesner, Riggs, 2006), (Collier and Harrington, 2008), (Castle, 2008), (Spilsbury, Hewitt, Stirk, Bowman, 2011) Each of the articles describes the difficulty of finding the evidence out of the vast array of staff definitions, quality measures, risk adjustment, study size, and cross-sectional design; however, recent research with a new approach to ferreting out the evidence, has been able to show significant relationship between RN staffing and quality. (Castle and Anderson, 2011)

There is mounting research evidence that higher levels of RN time is associated with positive outcomes and less RN time associated with negative outcomes:

- **Unnecessary hospitalizations**: Of particular relevance to today’s health care improvement initiatives is the positive effect of RNs in decreasing unnecessary hospitalizations of nursing home residents. (Decker 2008), (O’Malley, Caudry & Brabowski 2011), (Dorr, Horn and Smout 2005), (Horn, Buerhaus, Bergstrom and Smout 2005) Most importantly, Dorr et al showed that the savings in hospitalizations paid for the increased RN time.

- **Antipsychotics and other outcome measures**: Higher RN levels significantly and positively affect quality resident outcomes including lower antipsychotic use, and fewer pressure ulcers, restraint use and cognitive decline. ( Meret Hanke, Neff, and Mor 2004); reduced incidences in four related conditions, catheterizations, Urinary Tract Infections(UTI) antibiotic use and pressure sore development. (Cherry, 1991); decreased pressure ulcers and UTIs. (Konetzka, Stearns, Park 2007); and Horn et al showed that increasing RN time was associated with less decrease in function, fewer urinary tract infections, catheterizations, weight loss and pressure ulcers.

- **Negative outcomes with lower RN time**: The importance of RNs is also reflected in the negative results of increased RN turnover on restraint use, urinary catheters, psychoactive drugs and an increased risk of pressure ulcers and catheters. (Castle, Engeberg 2005) Lower RN levels are associated with an increase antipsychotic drug use and the number of pressure ulcers. (Castle and
Engberg 2010). Castle, using a longitudinal study design, quarterly staffing data, and a large sample size, showed the RN staffing significantly affected four quality measures: restraint use, catheter use, pain management and pressure sores. (Castle and Anderson, 2011)

The presence of RNs not only affects resident outcomes, but also impacts nursing home citations for deficient practice by state survey agencies. Lower RN and total staffing levels are associated with more deficiencies. (Johnson-Paulson & Infeld 1996), (Konestski, Yi, Norton, Kilpatrick 2004), (Castle, Engberg, 2010) (Harrington, Zimmerman, Karon, Robinson, Beutel, 2000) In one large study, RN levels were consistently associated with fewer care safety deficiencies. This did not hold true for increased nursing assistant or licensed practical nurse levels. (Castle, Wagner, Castleton, Wagner 2011). Increases in RN turnover can result in increased deficiencies (Castle and Engberg 2005)

Resident Acuity Changes Dramatically

Medicare’s Prospective Payment System accelerated hospital discharges to hospital based Skilled Nursing Facilities and in the 1990’s to other nursing facilities. The case –mix acuity of residents rose 1% per year from 1996-2002. (Mor, Caswell, Littlehale, Niemi, Fogel, 2009) For RNs, this policy change combined with the tendency for the higher functioning, less complex residents to remain in assisted living has led to a dramatic shift in the medical intensity and complexity of nursing home residents. For example, discharging a resident who is elderly, frail and has multiple co-morbidities one to two days after surgery for a fractured hip requires expert nursing skills to anticipate, identify and respond to changes in condition, ensuring that appropriate rehabilitation is taking place to maximize the chance of a safe and timely discharge home. This high level of skill and knowledge for oversight and care are needed 24 hours a day, seven days a week. RN coverage for only eight hours a day leaves the residents vulnerable, undermining effective prevention and delaying intervention.

Waivers for a Director of Nursing:

CFR 483.30 (b) (2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

Delete the waiver so the regulation reads:

CFR 483.30 (b)(2)The facility must designate a registered nurse to serve as the director of nursing on a full time basis

RATIONALE:

The current regulations require that a registered nurse be designated to serve as the Director of Nursing (DON) for forty hours a week. Research shows the importance of this position in that high retention levels are associated with better outcomes. These same authors showed that an experienced DON is associated with lower immobility prevalence. (Anderson, Issel, McDaniel, 2003.) The DON is responsible for administrative, clinical, educational, staff and public relations. Core competencies include such skills as conduct root cause analysis, set benchmarks, direct change, and mentor and teach. Assistant Nurse Manager, Assistant Director of Nursing or Clinical Manger as well as charge nurse are other RN positions described as foundational to a functioning nursing department (www.AALTCN.org/corecompetencies).
The Long Term Care Professional Leadership Council (LTCPLC) has developed a document that speaks to the core functions, responsibilities, knowledge and skills for Administrators, Directors of Nursing, Consultant Pharmacists and Medical Directors in nursing homes (http://www.nadona.org/pdfs/LTCPLC_Core.pdf). The importance of the full time RN DON is obvious to this interdisciplinary group of leaders in long term care.

These recommendations are not new, but are now better supported by the evidence. In 1999, the Hartford Institute for Geriatric Nursing at NYU, College of Nursing, convened an interdisciplinary panel of experts representing professionals, providers, consumers, regulators, economists, and researchers. The RN recommendations included a full time RN Director of Nursing and at least one RN present twenty-four hours a day, seven days a week. Depending on the facility size and resident acuity, the panel recommended increasing RN staffing. (Harrington, Kovner, Kayser-Jones, Burger, Mohler, Burke, 2000)

At about the same time, CMS asked the question, ”What are the appropriate minimum nurse staffing ratios in nursing homes?” Using cost report data, CMS embarked on a study of about one-third of the nursing homes in eight of the ten CMS regions. They looked at long stay measures (functional improvement, improved ADL assistance, incidence of pressure ulcers, weight loss and skin trauma) and short stay measures (hospitalizations for UTI, Sepsis, respiratory infections, congestive heart failure, electrolyte imbalance) to ascertain the relationship between staffing and outcomes. The results of their modelling resulted in recommended .75 (45 minutes/resident per day) hours of RN care for long stay and .55 for short stay residents. Those were well beyond what current RN staffing was .31 hprd. (US CMS Kramer and Fish 2001)

CONCLUSION:

In 2004, the Institute of Medicine report, Keeping Patients Safe, Transforming the Nursing Workforce, considered the 2001 CMS study and recommended updating the nursing home regulations to require at least one RN on duty at all times and consideration of the CMS staffing recommendations for all levels of nursing. (IOM, 2004) The presence of an RN twenty-four hours a day, had also been recommended by two prior IOM reports. (IOM 1996, IOM 2001)

We appreciate this opportunity to provide input as CMS engages in this review process and look forward to future conversation on this important regulation. For additional follow up and questions, please contact Sarah Burger, 202-319-2611/sgburger@rcn.com and Cheryl Peterson, Director of Nursing Practice & Policy, ANA at 301-628-5089 / cheryl.peterson@ana.org.
References:


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