New Staffing Requirements: It's Not Just 3.5

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OVERVIEW

What does the new statute in SB 97 do?

- Changes to HSC 1276.5 and 1276.65; WI 14126.022
- Definitions, Counting criteria, Waivers

Key Areas of Discussion in SB 97

- Effective July 1, 2018, SNFs must have a minimum of 3.5 direct care service hours per patient day, and SNFs shall have a minimum of 2.4 hours per patient day for certified nursing assistants (CNAs) – statute excludes D/P of a GACH, state-owned hospital or developmental center, or STP/IMD
- Requires development of emergency regulations to implement 3.5 and 2.4 → CDPH must provide a 90-day notice prior to adoption
- Requires the ability of two staffing waivers: (1) patient acuity needs (2) workforce shortage

HSC 1276.65: Direct Care Service Hour and Direct Caregiver Defined

(1) “Direct care service hours” means the actual hours of work performed per patient day by a direct caregiver, as defined in paragraph (2). Until final regulations are promulgated to implement this section as amended by the act that added this paragraph, the department shall recognize the hours performed by direct caregivers, to the same extent as those hours are recognized by the department pursuant to Section 1276.5 on July 1, 2017.

(2) “Direct caregiver” means a registered nurse, as referred to in Section 2732 of the Business and Professions Code, a licensed vocational nurse, as referred to in Section 2864 of the Business and Professions Code, a psychiatric technician, as referred to in Section 4516 of the Business and Professions Code, and a certified nurse assistant, or a nursing assistant participating in an approved training program, as defined in Section 1337, while performing nursing services as described in Sections 72309, 72311, and 72315 of Title 22 of the California Code of Regulations, as those sections read on July 1, 2017.

HSC 1276.65: Phase-In of Penalties

(g) (1) Notwithstanding any other law, the department shall inspect for compliance with this section during state and federal periodic inspections, including, but not limited to, those inspections required under Section 1422. This inspection requirement shall not limit the department's authority in other circumstances to cite for violations of this section or to inspect for compliance with this section.

(2) A violation of the regulations developed pursuant to this section may constitute a class "B," "A," or "AA" violation pursuant to the standards set forth in Section 1424. The department shall set a timeline for phase-in of penalties pursuant to this section through all-facility letters or other similar instructions.

HSC 1276.65: Development of Waivers

(l) The department shall adopt emergency regulations or all-facility letters, or other similar instructions, to create a waiver of the direct care service hour requirements established in this section for skilled nursing facilities by July 1, 2018, to address a shortage of available and appropriate health care professionals and direct caregivers. Waivers granted pursuant to these provisions shall be reviewed annually and either renewed or revoked. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(m) The department shall evaluate the impact of the changes made to this section by the act that added this subdivision regarding patient quality of care and shall work with other state departments, as necessary, to evaluate the workforce available to meet these requirements, including an evaluation of the effectiveness of the minimum requirements of 2.4 hours per patient day for certified nursing assistants specified in subparagraph (C) of paragraph (1) of subdivision (c). The department may contract with a vendor for purposes of conducting this evaluation.

What is currently taking place before SB 97 goes into effect?

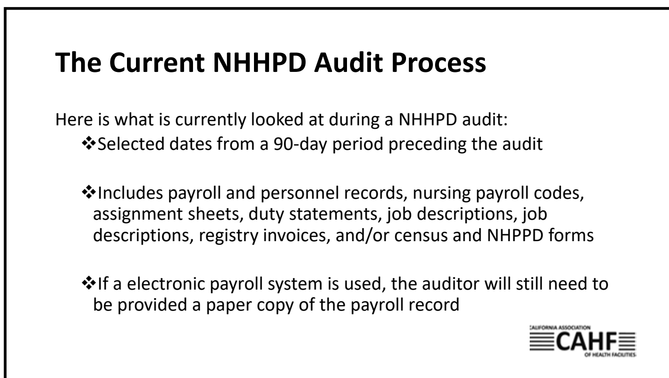
- Constant communication from CAHF to various Departments from the time the Deal/Trailer Bill came out to the present (DPH, DHCS, DOF, HHS, Governor's office)
  - Appropriate funding
  - Workforce development and sustainability
  - Now that it is law, what can be made reasonable and fair
- One-off meetings with the three category groups (Advocates, Labor, Providers) prior to Stakeholder Group Meetings
- Stakeholder Group Meetings: October, November, December, February
- Comments posted on: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Skilled-Nursing-Facility-Staffing-Requirements-Meetings.aspx

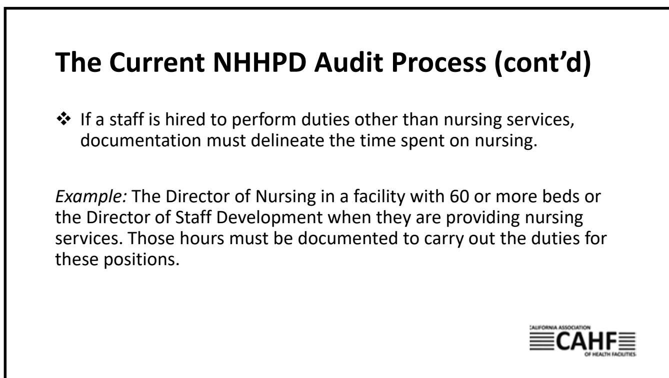
	Providers	Unions	Advocates
Calculation of 3.5 Direct Care Hours with 2.4 CNA hours	• Once nurse assistant trainees pass a skill check, they are able to provide care outside of in-class training • Currently CDPH counts trainee time only if the facility operates a training program (i.e. is on the facility pay-roll). Providers would like CDPH to consider allowing trainee time to count for facility direct care hours whether the training program is facility based or not • Stated that MDS Coordinator hours should count toward meeting the staffing requirement and that there should be no limit on the number of MDS coordinators counted • As an alternative to tracking MDS coordinator time CDPH suggested a percentage of the MDS coordinator time count as non-direct care (administrative) hours. Providers did not view CDPH's suggestion favorably. • CAHF proposed counting therapy (occupational and physical), and social service time as part of the direct care hours.	• Recommended modifying existing process for determining staffing to meet the new requirement • Advised, that if nurse assistant trainees are used in the calculation, it is important that there is adequate licensed staff to monitor their work • Stated that MDS Coordinator hours should only count toward meeting the staffing requirement while providing patient care	• Expressed concern that the standard includes a minimum of CNA hours but not a maximum and requested clarity about the use of licensed staff • Expressed concern about the use of nurse assistant trainees in the calculation of the 3.5 direct care hours

	Providers	Unions	Advocates
Available Training for CNAs	• Anticipate need for 1400-2000 new CNAs requiring training to meet the staffing requirements • Training programs vary widely with certain programs closing and other programs having waiting lists, while rural areas may have only one training program • Will be difficult to hire staff if there are no training programs in rural areas • A previous effort to increase training opportunities, the Caregiver Training Initiative, is no longer funded	• Expressed need to train more CNAs and are supportive of additional training opportunities for CNAs	• Not discussed- no comments
Conversion of 3.5 and 2.4 into a ratio	• Ratio is considered impractical as facilities have different shifts, staffing needs are dynamic and can depend on shift length, and patient acuity can change hourly • Ratios take away flexibility	• Shift ratios are a long term goal • Supportive of ratio as patients and family members can more easily determine if patients are receiving adequate care	• Supportive of ratio as it is difficult for consumers to monitor adequate staffing without having a ratio

	Providers	Unions	Advocates
Waiver of 3.5 if there is a shortage of healthcare workers and direct care workers	• Proposed the possibility of looking at OSHPD data for 2 year compliance with 3.5 requirement, and show advertising efforts and evidence of a competitive wage • Noted that there may be challenges with paying competitive wages for facilities with a high percentage of Medi-Cal patients and are concerned that requiring facilities to show evidence of offering competitive wages may affect the facility's eligibility for a waiver • Stated that when the economy is good it is harder to get CNAs. • Commented that the language used in the regulations should be consistent with that of CMS. If patient care is not compromised and a facility is making sure that the recruitment effort is there to meet the staffing minimum, a waiver for the facility should be considered.	• Expressed need for guidelines to determine a staffing shortage and requested clarity about how CDPH will determine whether a staffing shortage exists and how the shortage will be measured • Suggested using information on the labor market in the area • Indicated that it is important to monitor patient welfare	• Requested information regarding how the shortage will be determined • Requested that there be an evaluation of due diligence for staff recruitment • If facilities are unable to meet staffing requirements, then they should reduce the census of the facility

REGULATION





Patient Census and How it is Counted

The facility shall provide the auditor with the patient census at either (a) the beginning of each shift if a facility has three (3) shifts within a 24-hour period or (b) the beginning of the 24-hour patient day and again both at eight hours and 16 hours after the start of the 24-hour patient day, for all the days requested. The facility shall provide the exact time it begins it patient day.

The Calculation of 3.2 NHPPD

Based on:

- ❖Patient day: The 24-hour period of time used to determine compliance
- ❖Average census
- ❖Number of hours worked by direct caregivers

Total number of nursing hours/average census=NHPPD

Definitions

Absent Patient: Patient that is not in the facility or receiving services

Average Census: Determined by either (a) beginning of each shift if a facility has 3 shifts within a 24-hour period or (b) the beginning of the 24 patient day and again both at eight hours and 16 hours after the start of the 24-hour patient day and dividing the total by three. "Census Period" means the period of time covered by the method chosen to figure the average census

Definition of a Direct Care Giver

Registered Nurse (as defined in Business and Professions Code 2732)

Licensed Vocational Nurse (Business and Professions Code 2864)

Certified Nurse Assistant or a nursing assistant participating in a approved training program, as defined in HSC 1337, while performing nursing services as described in Title 22 Section 72309, 72311

A licensed nurse serving as a MDS coordinator

What is Not Considered Nursing Services

Paid or unpaid time spent on meal breaks, except paid meal periods where documentation supports that nursing service were performed in lieu of a meal break

Time spent in non-nursing services functions such as restocking, scheduling, food preparation, housekeeping, laundry, maintenance, administrative and financial recordkeeping, and administrative maintenance of health records.

Private duty nursing services

What is Going to Change with the 3.5/2.4

The new rule will require to now be at an overall of 3.5 NHHPD of which 2.4 hours must be devoted to CNA's.

Does this change the definitions of what counts in the hours?

Depends on How the Regulation is Written

SB 97 requires emergency regulations to be written for the new requirement.

The Advocates are pushing for many changes as part of the new regulations…

What are the Advocates Proposing?

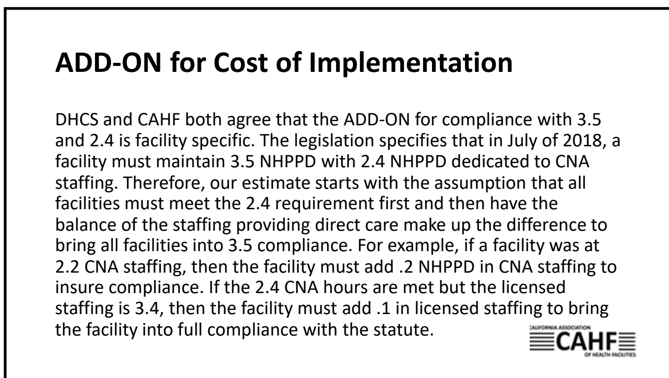
Advocates want to change what counts as direct care staff

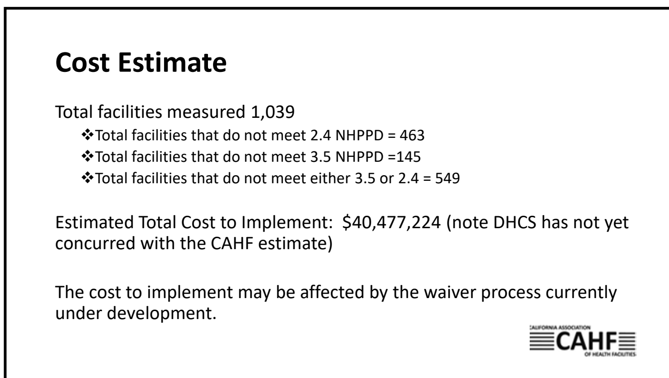
- ❖ One MDS coordinator, or only the time doing assessment counts
- ❖ Only count the CNA time if they are actually a CAN, not NA time
- ❖ Would like to see ratios developed
- ❖ Do not want nursing care compromised or reduced just to meet the 3.5/2.4
- ❖ Only true hands on time counts

What do I Need to do as a Facility?

- ❖Keep up-to-date on the changes and any changes in how direct care staff is counted
- ❖Know if might be eligible for a waiver
- ❖Be able to show the auditor the 3.5, as well as the 2.4 breakdown
- ❖Make sure all sign-in sheets are up-to-date and have the necessary information
- ❖Who is keeping track of the staffing
- ❖Do not wait until July 1, 2018 to have adequate staff

FUNDING





Cost Estimate

	No. of facilities	Total Days	Mixed of CNA/LN cost estimates	Nurse Assistant FTE needed	RN/LVN FTE Needed
SNF and Skilled Nursing Only	873	18,501,802	29,943,793	1,113	48
SNF/RES and Skilled Nursing Only	78	838,570	356,584	17	-
SNF and Mixed Care	88	2,075,689	10,176,847	564	1
Total	1,039	21,416,061	**40,477,224**	1,694	49

What is the Impact on QASP?

A requirement of QASP is that nursing facilities must comply with minimum standards as described in statute. To that end, the statute specifies that those standards are as described in SB 97 (3.5 and 2.4 as of July 1, 2018).

- ❖Important caveat is that while a facility must be in compliance with SB 97 in 2018, the impact to QASP will not occur until at least 2019-2020 performance period which will be used to determine the payments that will be paid in April of 2021. As long as a facility meets the 3.2 NRPPD requirement (the pre SB 97 requirement) providers will not be penalized until at least 2021.

What is the Impact on QASP? (cont'd)

"Notwithstanding any provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, compliance with the provisions of subdivision (c) of Section 1276.65 of the Health and Safety Code amended by the act that added this subdivision ***shall not be used to determine facility qualification for the supplemental payments provided for in this section until the performance period beginning in the 2019–20 fiscal year. "***

Questions???