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Defining the Direct Care Worker in Nursing Facilities

A Report to the Minnesota Legislature

Nursing Facility Rates & Policy PO Box 64973 St. Paul, MN 55164-0973 651-431-2882

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Prepared by the Minnesota Department of Human Services
Nursing Facility Rates and Policy Division
PO Box 64973
St. Paul, MN 55164-0973
651-431-2282

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Cost to Prepare Report

Minnesota Statutes, chapter 3.197 requires disclosure of the cost to prepare this report. Approximately $2,000 of staff salaries were spent to analyze the issue, gather stakeholder input and write this report.

I. Introduction

Laws of Minnesota, 2008, Chapter 317, Section 4, directs the Department of Human Services (DHS) to report on staffing criteria as it relates to direct care workers in nursing facilities to the Legislature by January 15, 2009. The requirement states:

The commissioner of human services in consultation with the commissioner of health, as well as consumers, nursing facility providers, and nursing facility employees, shall: (1) review the definitions of nursing facility direct care staff in Minnesota Statutes, Minnesota Rules, and agency bulletins; (2) determine how to standardize definitions to allow the public to compare direct care staffing across facilities; and (3) examine how new and emerging staff positions and titles, including but not limited to "resident assistant," should be incorporated over time into direct care staffing. The commissioner shall report recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services by January 15, 2009.

This report is submitted to the Legislature in response to these requirements.

II. Background

Currently, direct care staff hours are collected routinely from nursing facility providers and used both at the federal and state level. For example, the Center for Medicare and Medicaid Services (CMS) collects staffing information for purposes of assigning a star rating on the National Nursing Home Compare web-based report card. This information comes from data that the nursing home reports to its state agency. It contains the nursing home staffing hours for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) for a two-week period prior to the time of the state inspection. CMS receives this data and converts it into the number of staff hours per resident day. To calculate the star rating, the number of staff hours per resident day are case mix adjusted. Case-mix adjustments take into account the different levels of resident needs in different nursing homes. Other types of nursing home staff such as clerical, administrative, or housekeeping staff are not included in these staffing calculations.

CMS also requires nursing facilities to post nurse staffing data on a daily basis at the beginning of each shift in a prominent place readily accessible to residents and visitors. The data requirements for the posting include the total number and the actual hours

worked by nursing staff directly responsible for resident care. This is limited to RNs, LPNs, and CNAs and is not case-mix adjusted.

Minnesota also collects staffing information from nursing home providers on its annual cost report among other reasons, for purposes of assigning a star rating on the web-based MN Nursing Home Report Card, www.health.state.mn.us/nhreportcard. While similar data is used for similar purposes, the staffing data included in the MN report card is significantly more expansive than the staffing data used by CMS and is based on a full year of compensated hours rather than just 2 weeks. During the development phase of the MN report card quality measures, there was a strong desire by affected stakeholder groups that the direct care worker hours used on the report card be more inclusive than the traditional RN, LPN and CNA worker roles. As a result, nursing administration staff, social workers and activity staff, mental health workers, certified feeding assistants and physical and occupational therapy assistants that are not performing separately billed services are defined as direct care workers. Defined direct care worker hours are then converted into hours per resident day figures by staff type. Hours per resident day are then weighted for relative wage per staff type (using statewide average salary ratios). Finally, the wage adjusted hours per resident day are case mix adjusted. The adjusted hours per resident day are then assigned a star rating for the MN Report Card within 3 peer groups: boarding care facilities, hospital attached facilities and all other nursing homes. While the approach used for the MN Nursing Home Report Card is considerably more complex, it is perceived by most stakeholders to be a more fair and accurate way to present direct care staffing data.

Finally, MN also uses its staffing quality measure as a pay for performance mechanism. For rate years, October 1, 2006 and 2007, nursing facilities received an operating payment rate increase as a quality add-on. In 2007, the amount of the quality add-on that a facility received depended on how well they performed on six quality measures. The direct care staff measure accounted for 10% of the score used to determine the quality add-on. For the rate year beginning October 1, 2008 there was not an appropriation for a quality add-on.

Beginning October 1, 2008, DHS began an 8-year phase-in period to establish nursing facility operating payment rates in accordance with Minnesota Statutes, section 256B.441. This legislation was established to rebase nursing facility operating payment rates to more closely align payments to facilities with the cost of providing care. Per Minnesota Statutes, section 256B.431, subdivision 50 (b), beginning with rates determined for October 1, 2016, the total care-related limit shall be a variable amount based on each facility's quality score. The quality score is based on the facility's performance on six quality measures, again one of which is the amount of direct care staffing. Additionally, because different methods are used for setting cost limits for direct care and support services, clear definitions are needed where confusion or gaming may otherwise occur.

The direct care staffing quality measure and underlying definitions are important components in the Minnesota nursing home quality management, consumer information, pay for performance and rate setting systems. For this reason, it is essential that when DHS is collecting staffing data from nursing facilities, direct care staff hours must use clear definitions that are consistently applied.

III. Analysis

Given the variety of approaches to defining a direct care worker currently in use, a search of state statutes, rules and agency bulletins was conducted to seek out any existing definitions of a direct care worker. The definition of a direct care worker was not evident in any of these sources. Instead, the instruction manual which nursing facility providers use as a guide when completing the MN annual statistical and cost report, contains specific information defining which staff are to be included as a direct care worker when reporting hours worked

Secondly, an extensive effort was made to engage stakeholders knowledgeable about the issue in discussion. Stakeholders involved in the discussion included nursing home providers, consumer advocates, trade association representatives and nursing home worker's union representatives. Early in these discussions, it became apparent that the primary issue in defining the direct care worker was related to new staffing models emerging within nursing facilities as a result of the culture change movement occurring over the last few years. The culture change philosophy is to shift to a more resident-directed, resident-centered model of care. To achieve the goals of culture change, a blended worker role has evolved, most commonly referred to as "universal workers." Universal workers perform multiple job tasks that blend direct care and support services functions. For example, a certified nursing assistant (CNA) may be responsible for traditional nursing service tasks, but may also have responsibilities for dietary, laundry and housekeeping duties.

Stakeholders identified the following criteria as important in considering options for defining the direct care worker:

- The direct care worker should be clearly defined. Consistent reporting across providers is important in making accurate and fair comparisons.
- The definition should be transparent, easily understood by both providers and consumers.
- The definition should not create excessive reporting burden on the providers or difficult audit processes for DHS.
- The definition should be aligned as much as possible with Federal reporting guidelines.

Stakeholders were provided the following detailed information about what was currently considered a direct care worker according to the instruction manual for completion of the annual cost report.

The following job classifications are considered direct care workers for purposes of assigning stars on the MN Nursing Home Report Card.

- *Nursing Administration*[1]
- *Registered Nurses*
- *Licensed Practical Nurses*
- *Certified Nursing Assistants*
- *Trained Medication Aides*
- *Mental Health Workers*
- *Social Workers*
- *Activity Staff*[2]

- *Other Direct Care Staff*[3]

[1]*Nursing administration includes licensed nursing staff responsible for management of the nursing department or primarily responsible for record keeping. Examples of nursing administration staff include: DON, ADON, MDS coordinator, Medicare nurse, in-service educator, infection control nurses and quality coordinators. Staff performing administrative duties that are not licensed as a nurse, such as a unit coordinator, scheduler or medical records staff are not to be counted as direct care nursing administration staff.*

[2]*Activities staff includes volunteer coordinators and beauty shop staff.*

[3]*Other direct care staff means any other staff providing direct care to residents including: feeding assistants and religious personnel. Room service attendants are not considered direct care staff. Dietary aides who are not trained and certified as feeding assistants should not be included. Do not include licensed therapists or assistant therapists working under a licensed therapist's supervision performing billable therapy services. Generally, employees should be classified according to their certification or licensure category regardless of the job title. Universal workers who are C.N.A.s should be reported on the C.N.A. line.*

Again, the focus was mostly addressing how the "Universal Workers" hours should be reported. The following excerpt is from the current cost report instruction manual:

Employees performing both direct care and support care services must have their hours and wages allocated between cost categories. The allocation methodology must be documented by the facility and be available upon request by the Department. Direct care hours worked by Universal workers who are C.N.A.s should be allocated to the C.N.A. line. The proportion of hours related to non direct care duties such as housekeeping or dietary, are not be included as direct care hours.

The instructions for reporting blended worker hours are quite general and do not contain any specifics as to how hours should be allocated between the direct care category and the support services category. This is likely resulting in inconsistent reporting across providers, reducing the integrity of the data needed for the direct care staffing quality measure and other uses. Several options for dealing with the blended worker role were considered in stakeholder discussions:

- Consider reverting back to traditional reporting methods that only recognize nursing staff providing bedside services. This option is similar to Federal reporting guidelines.
- Retain the definition of direct care workers that currently exists for cost reporting purposes.
- Include all blended worker hours as direct care with no requirement to allocate a portion of hours worked to support services.
- Discount blended worker hours per a ratio determined by state wide averages for non-direct care worker categories.

After consideration of these options using the above stated criteria as a guide, stakeholders participating in the discussion unanimously agreed to the following recommendation:

- Retain the definition of direct care workers as currently exists for cost reporting purposes.
- Provide additional specifics about how to allocate hours between direct care and support services including documentation requirements. The requirements are to be consistent with Medicare reporting guidelines.

IV. Recommendations/Conclusion

This report has discussed the dynamics of defining the direct care worker role in nursing facilities. How staffing data is used both by the Department of Human Services and the Centers for Medicaid and Medicare Services was reviewed. Several important issues/criteria to be used as guidelines for defining the direct care worker were identified. Stakeholders considered a variety of options and unanimously agreed to the following recommendation:

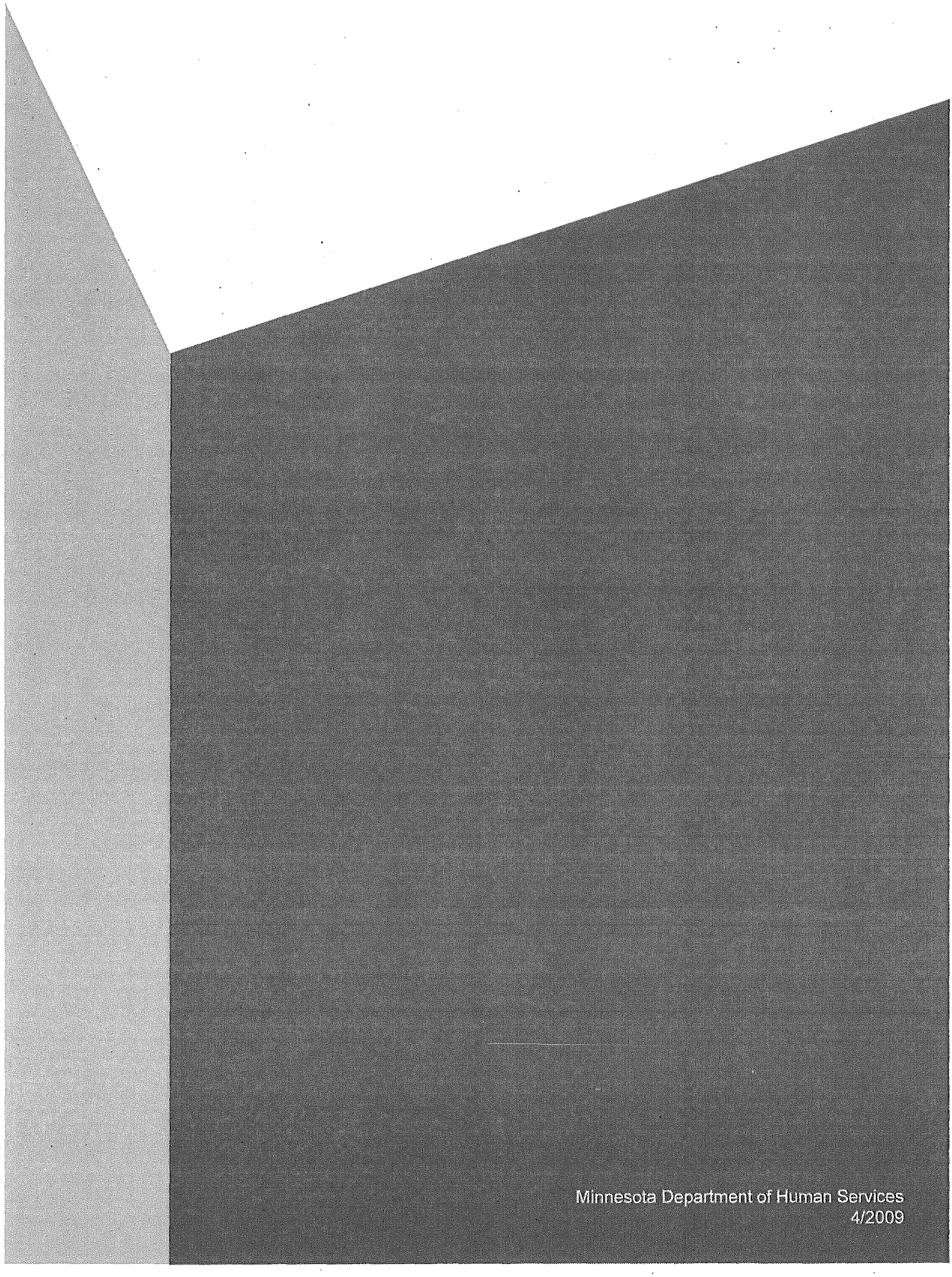
The current cost report instructions will continue to apply in defining the direct care worker. The following information will be added to the cost report to clarify how blended worker roles should be reported:

Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs between the applicable cost categories. The time studies must meet the following criteria:

a. *A minimally acceptable time study must encompass at least one full week per six month period of the reporting period.*
b. *The weeks selected should vary among the two required weeks, e.g., one the first week of the month, one the third week of the month.*
c. *The time study should not occur in two consecutive months.*
d. *The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.*
e. *The time study must be facility specific. Thus, chain organizations may not use a time study from one facility to allocate the costs of another facility or a time study of a sample group of facility to allocate the costs of all facility within the chain.*

We believe this clarification will improve the integrity of the data on direct care staffing, resulting in the achievement of important goals related to defining the direct care worker. The definition continues to include a broader spectrum of direct care workers than traditional nurse staff positions; is understandable both by providers and consumers; stakeholders agreed the definition does not create excessive reporting burdens on the provider and allows for more clear interpretation of documentation requirements for audit processes. While the definition is not consistent with Federal reporting guidelines, stakeholders have reported that the broader definition of a direct care worker more appropriately captures the degree to which services are provided and creates incentives to properly staff a nursing facility according to the needs of the resident.

Implementation of this recommendation does not require any legislative action.



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