

# **Licensing of Nursing Facilities**

## **216-RICR-40-10-1**

### **Benefit-Cost Analysis**

**December 2021**

The Rhode Island Department of Health (RIDOH) is amending the Regulation Licensing of Nursing Facilities (216-RICR-40-10-1) to implement recently passed legislation regarding caregivers and staffing and preserve COVID-19 protocols that were issued as emergency regulations. This analysis will be divided to address the two topic areas of the proposed amendments: COVID-19 Practices and Procedures and Minimum Staffing.

#### **COVID-19 Practices and Procedures**

##### ***Background***

On March 9, 2020, former Rhode Island governor Gina Raimondo declared a state of emergency for the State of Rhode Island due to the dangers to health and life posed by COVID-19, the new disease caused by the novel coronavirus SARS-CoV-2. Two days later, the World Health Organization (WHO) declared COVID-19 a global pandemic.

By the end of 2020, SARS-CoV-2 had mutated into a more infectious strain, with the ability to be twice as contagious as the original COVID. By Spring 2021, the Delta Variant was the most predominant variant in the United States<sup>1</sup>.

Governor McKee issued a new state of emergency due to the Delta Variant on August 21, 2021. The week of July 4, 2021, Rhode Island had a “moderate transmission” rate of 11.2 cases per 100,000 people, but as of August 17, 2021, Rhode Island transmission rate had increased to “high transmission” of more than 187 cases per 100,00 people. New weekly hospitalizations had more than quadrupled within that same time period.

Nursing Home residents are one of the most vulnerable populations to COVID-19. In Rhode Island, all nursing facilities have experienced COVID-19 infections of residents and staff. According to recently published Kaiser Family Foundation data, of all states, Rhode Island (78%) and New Hampshire (81%) have the highest percentage of long-term care deaths as a share of total state COVID-19 deaths. COVID-19’s impact on this vulnerable nursing home population is dramatic and disproportionate to the general population. The COVID-19 pandemic continues to have a profoundly disruptive effect on the lives of Rhode Island’s nursing home residents and their families. RIDOH’s goal is to

mitigate the effects of COVID-19 on this imperiled population by proposing regular testing and masking for unvaccinated personnel and residents.

### ***Proposed Regulation***

RIDOH is proposing that nursing home residents and personnel be tested regularly. For residents who are not vaccinated, the proposed regulation requires testing for COVID-19 at least once every 14 days during a period of moderate (or higher) transmission, defined as a prevalence rate greater than or equal to ten cases per 100,000 people in the past seven days.

On August 17, 2021 RIDOH issued an emergency regulation (Requirement for Immunization Against COVID-19 for All Workers in Licensed Health Care Facilities and Other Practicing Health Care Providers, 216-RICR-20-15-8) to mandate that all health care workers and health care providers be vaccinated for COVID-19 by October 15, 2021. All nursing home personnel are required to be vaccinated, unless a medical exemption applies. Therefore, the proposed regulation would require nursing facility personnel to be tested at least once every seven days during a period of high transmission, defined as a prevalence rate greater than or equal to 100 cases per 100,000 people in the past seven days).

All required testing, for both residents and personnel, will need to be documented by the nursing facility to ensure compliance.

### **Status Quo**

As of December 1, 2021, 2,932 Rhode Islanders have lost their lives to COVID-19 since the beginning of the pandemic. In that same timeframe, Rhode Island is averaging 393 COVID-19 cases among nursing facility staff per month and 351 COVID-19 cases among nursing facility residents per month.

While the State has approached over 80% of all Rhode Islanders receiving at least one dose of a COVID-19 vaccination, it will still take some time before herd immunity is reached. Testing for COVID-19 is a valuable tool that prevents against community spread as infected individuals can quickly isolate themselves from others in the event of infection.

Residents in nursing facilities often reside in these settings due to inability to care for themselves or may not have family members to provide the level of care they need. These comorbidities can further exacerbate a COVID-19 infection, making this population especially vulnerable. The congregation of residents and the staff who care for them allows for infections to spread easily.

Without regular testing and thus isolation of infected residents and/or staff, COVID-19 quickly spreads through these facilities and can result in severe illness, hospitalization and death.

### ***Resident Testing Costs and Benefits***

Rhode Island has made COVID-19 testing widely available since the late spring of 2020. As testing is a valuable surveillance tool and due to an influx of funds from the federal government, the State made testing free. It is expected that the State will not be covering all COVID-19 testing costs forever and that the costs would be transferred over to the insurer or individual if he or she is uninsured.

A CVS Minute Clinic lists the cost of a COVID-19 PCR test (the most accurate test available) for \$139<sup>2</sup>. Kaiser Family Foundation has estimated there are about 7,600 residents in Rhode Island nursing facilities. Of the 7,600 residents, 95% of them are vaccinated, leaving 380 residents unvaccinated<sup>3</sup>. All unvaccinated residents must be tested at twice per month, then the following costs are expected:

380 Residents x \$139 for COVID-19 PCR test x 2 per month = \$105, 640 per month for all unvaccinated residents each month.

For an individual, unvaccinated resident, the cost would be \$278 per month.

The \$278 monthly testing cost is also not to persist forever. The proposed regulation only requires COVID-19 testing during a period of moderate transmission or higher. It is difficult to predict the transmission rates going forward due to a variety of variables such as increases in vaccination rates and emergence of new strains. However, it is likely that routine testing of unvaccinated residents will be required for the next few years.

It is also incredibly unlikely that the resident will bare the sole cost of the COVID-19 test. There are very few cases of uninsured nursing facility residents, and therefore testing costs would be covered under the resident's insurance.

Vaccinated individuals are fully protected from hospitalization and severe illness, with most vaccinated individuals being asymptomatic. However, some individuals may not be able to be vaccinated due to medical or choose not to be vaccinated for religious reasons, therefore testing is the next best option to mitigate the spread of COVID-19. Routine testing is able to identify infected individuals before symptoms appear, allowing the individual to isolate and reduce the spread of COVID-19. The unvaccinated individual can also begin treatment sooner and thus reducing the likelihood of hospitalization or severe infection.

### ***Personnel Testing Costs***

Rhode Island has been at or above high transmission rates for 359 days (approximately 51 weeks) since the beginning of the pandemic (approximately 80 weeks). As mentioned above, COVID-19 tests have been made available at no charge to Rhode Islanders since the early days of the pandemic, however, this may not be the case in the future.

In reports to RIDOH by nursing homes, there are 11,424 nursing home personnel<sup>4</sup>. While the regulation requires nursing facilities to bill the personnel's insurance prior to using other methods of payment and the State is currently fronting the cost of testing for

all individuals, regardless of insurance status. the following costs are estimated to be incurred:

11,424 Nursing Facility Personnel x \$139 for COVID-19 PCR test = \$1,587,936 per week

As mentioned above, it is very unlikely that the personnel would be required to pay this out-of-pocket cost due to insurance or the State paying the testing cost. Additionally, routine testing will only be required during periods of high transmission. As stated in the resident section, transmission rates are difficult to predict due to the variety of variables. Yet it could be assumed that with recent approval for vaccinations for individuals older than five that vaccination rates will improve. With greater vaccination rates, COVID-19 transmission is slower due to fewer available hosts.

Even with high vaccination rates, breakthrough infections can still occur. Routine testing can ensure early identification of COVID-19 cases and thus the personnel can be isolated from residents and others and mitigate the spread of COVID-19.

### ***Testing Benefits***

Testing is a critical for combating the COVID-19 pandemic especially when used in combination with other mitigating strategies. The available vaccines are protective against COVID-19, although the data are still inconclusive of the length of protection offered. While the CDC has yet to recommend boosters, numerous public health agencies have been strongly recommending individuals to receive boosters six months after completion of their primary series. Since no vaccine is 100% effective against infection, testing provides the opportunity to prevent spread of infection in the event of break through cases.

In a study on the impact of surveillance testing on college campus, researchers noticed that while weekly surveillance testing resulted in a marginal reduction in viral transmission when vaccine effectiveness was at 90%. However, when vaccine effectiveness was between 50% to 75% the surveillance testing provided over a ten-fold reduction in the number of infections during the semester<sup>5</sup>.

Applying the above study to a nursing facility with 100 residents and personnel would mean that routine testing could prevent ten additional infections if such testing identified even one positive individual<sup>6</sup>. And as mentioned previously, long term care residents are at significantly higher risk for hospitalization and death from COVID-19 than the average population. In nursing homes alone, one in ten residents has died of COVID-19 nationally. The ten infections that could be prevented from routine testing could mean that one resident's life is saved. When analyzing costs and benefits of policies, a statistical life is valued at \$9.1 million<sup>7</sup>. Therefore, one resident life saved would be a benefit of \$ 9.1 million to the state. There are 8,767 nursing home beds in the state, however, it is extremely unlikely that all 8,767 beds are occupied<sup>8</sup>. The pandemic has brought on a strain in staffing, causing numerous nursing homes to remove beds.

Additionally, and also due to the pandemic, many families opted to move their loved ones out of nursing facilities and care for them themselves. If we were to conservatively assume that 50% of the beds are occupied, that would be 4,384 occupied beds. Applying the above model in the event of waning vaccine effectiveness, routine testing could reduce infections of this population by 438 cases and 44 deaths, for a total benefit of \$400.4 million. Benefits could be higher if there is a higher rate of bed occupancy.

### ***Nursing Facility Documentation***

The proposed regulation requires the nursing home to document all testing of residents and personnel. While these systems are likely already in place due to identical requirements in the Emergency Nursing Facility regulation, issued on May 25, 2020, RIDOH could assume the following costs to set up the systems:

Estimated time for Nursing Home Administrator to set up tracking system: 4 hours

Nursing Home Administrator wage: \$60.52<sup>9</sup>

Estimated number of hours for weekly tracking: 1 hour

4 hours x \$60.52 = \$242.08 for initial set up of tracking system

1 hour x \$60.52 = \$60.52 per week for tracking or \$242.08 per month or \$2,904.66 per year per facility.

\$2,904.56 x 81 Licensed Nursing Facilities = \$ 235,269.36 per year for all licensed nursing facilities in Rhode Island

Requiring the nursing facility to track testing of residents and personnel ensures compliance with the regulation. Additionally, a record can assist RIDOH in contract tracing purposes in the event of an outbreak.

### ***Alternatives***

The Department considered requiring testing for unvaccinated residents at a higher transmission rate, such as substantial transmission (defined as greater than or equal to 50 cases per 100,000 in the past seven days) or high transmission (defined as greater than or equal to 100 cases per 100,000 in the past seven days). However, given the vulnerability of the nursing facility residents, only requiring surveillance testing at substantial or high transmission rates puts unvaccinated residents at greater risk of infection, hospitalization, and death. Therefore, this alternative is not preferred.

Similarly, the Department also considered requiring surveillance testing of personnel at moderate or substantial transmission. As mentioned above, all health care workers and health care providers are required to be vaccinated for COVID-19. While the vaccines are not 100% effective against a COVID-19 infection, a study published in September by the Center for Disease Control (CDC) indicated the likelihood of a breakthrough infection is 1 in 5,000, and in areas of low transmission (defined as less than or equal to 9.99 cases per 100,000 in the past seven days) the likelihood is 1 in 10,000<sup>10</sup>. Due to

the low risk of a breakthrough infection among vaccinated individuals, requiring surveillance testing for vaccinated personnel during periods of low, moderate, or substantial has no additional benefit. Therefore, this alternative is not preferred.

## **Essential Caregiver**

### ***Background***

In July 2021, the Rhode Island General Assembly passed legislation requiring nursing home and long-term care facilities to be designated an essential caregiver who can visit them during a period of declared emergency. This legislation was borne in response to the COVID-19 pandemic, where visitation was restricted, and for a period of time prohibited. This legislation also required RIDOH to create regulations.

The proposed regulation requires the nursing facility to establish and implement policies and procedures related to the development of policies and training of essential caregivers when an emergency is declared by the governor.

### ***Cost and Benefits***

The documentation requirements are likely to be completed by staff social workers and take about five hours to complete. The average wage for this position is \$27.23<sup>1</sup> for a one-time cost of \$136.15 to develop the policies. And an additional cost of \$68.00 could be included annual to revise the policies and procedures (about 2.5 hours per year for revisions).

The regulations also require nursing facilities to train essential caregivers on topics such as infection prevention/control; signs and symptoms of any communicable disease associated with the declared emergency; and safety and efficacy of any available vaccinations associated with the declared disaster emergency. The working assumption here is that the facility retains an average of 12 essential caregivers per year and the required training is two hours per year. If the social worker conducts the training for the essential caregivers individually (24 hours x \$27.23), the total annual cost for this requirement would be \$653.52. This total amount may increase depending upon the nature of the declared emergency and the number of essential caregivers. These trainings will ensure proper care of the resident by the caregiver during the emergency.

## **Minimum Staffing**

### ***Background***

On May 27, 2021, the Rhode Island General Assembly enacted Public Law 21-024, the “Nursing Home Staffing and Quality Care Act.” The statute requires an average of 3.58 hours of direct nursing care per resident per day commencing January 1, 2022 and 3.81 hours starting on January 1, 2023.

Section 2 of the Act requires incremental increases in Medicaid nursing home reimbursement rates through October 2023, provide nursing facilities with approximately

\$12 million per year in additional Medicaid funding. Eighty percent (80%) of the rate increase must go directly to compensation/benefit increases for nursing facility direct care staff.

### ***Status Quo***

Rhode Island has had no minimum staffing requirements in effect for direct caregivers in nursing homes (January 1, 2022 - new statute takes effect). However, section 1.16.6 of the nursing facility regulations (216-RICR-40-10-1)<sup>1</sup> contains the nursing facility staffing requirements that read as follows:

Each facility shall have a registered nurse on the premises twenty-four (24) hours a day. In addition, the necessary nursing service personnel (licensed and non-licensed) shall be in sufficient numbers on a twenty-four (24) hour basis, to assess the needs of resident, to develop and implement resident care plans, to provide direct resident care services, and to perform other related activities to maintain the health, safety and welfare of residents. Further, RIDOH may determine that additional staffing is necessary to provide adequate nursing care and treatment or to ensure the safety of residents.<sup>2</sup>

1. There shall be a master plan of the staffing pattern for providing twenty-four (24) hour nursing service; for the distribution of nursing personnel for each floor and/or residential area; for the replacement of nursing personnel; and for forecasting future needs. The staffing pattern shall include provisions for nurses, aides, orderlies and other personnel as required.
2. The number and type of nursing personnel shall be based on resident care needs and classifications as determined for each residential area. Each nursing facility shall be responsible to have sufficient qualified staff to meet the needs of the residents.
3. At least one individual who is certified in Basic Life Support must be available twenty-four hours a day (24 hours/day) within the nursing facility.<sup>3</sup>

The Licensing of Nursing Home regulations also require posting of the number of nursing staff and the facility census.

A federal 2001 Centers for Medicare and Medicaid Services' (CMS) study<sup>4</sup> established the importance of having minimum nursing Hours Per Resident Day (HPRD). CMS guidance included recommendations as follows: 0.75 Registered Nurse (RN) HPRD; 0.55 Licensed Vocational Nurse/Licensed Practical Nurse (LVN/LPN\_ HPRD; and 2.8 Certified Nursing Assistant (CNA) HPRD, for a total of 4.1 nursing HPRD, to meet federal guidance.

Federal statutes and regulations, applicable to all federally certified nursing homes, do *not* require a specific staffing ratio or minimum number of hours per resident day, but do require:

- An RN to serve in the role of director of nurses (DON);
- Licensed nurses on each shift, with an RN on duty for no less than eight hours per day;
- “Sufficient” nursing staffing with the “appropriate competencies” to provide services and assure that the residents are safe and attain their well-being;
- The nursing facility to complete an assessment, and update it at least every year, to evaluate the resident population in order to determine what resources are necessary to care for its residents;
- Facilities to post the number of nursing staff as well as the facility census. <sup>5</sup>

Approximately 40 states have established higher staffing standards than the federal; however, even with higher standards, most state standards remain below the levels recommended by experts.

### **Proposed Regulation**

The new minimum staffing statute was enacted during a time of persistent staffing shortages in nursing homes due to a myriad of reasons, including: the COVID-19 pandemic, required COVID-19 vaccination for all licensed health care workers and health care providers (taking effect on October 1, 2021), longstanding low wages, and difficult working conditions for certified nursing assistants (CNAs). Rhode Island long-term care leadership report that recruitment of direct care staff in nursing homes is a challenge throughout the industry.

There are several significant changes being proposed in the Licensing of Nursing Facility regulations. The following list highlights the key substantive changes that will be the focus of this analysis:

#### **Key Change 1:**

§ 1.16.6(C)(5) &(6): Establishes minimum hours of direct nursing care that must be provided to each resident on a daily basis in accordance with R.I. Gen. Laws 23-17.5-32(c)(i) and (c)(ii)

*Commencing on 1 January 2022, nursing facilities shall provide a quarterly minimum average of three and fifty-eight hundredths (3.58) hours of direct nursing care per resident, per day, of which at least two and forty-four hundredths (2.44) hours shall be provided by certified nursing assistants.*

*Commencing on 1 January 2023, nursing facilities shall provide a quarterly minimum average of three and eighty-one hundredths (3.81) hours of direct nursing care per resident, per day, of which at least two and six-tenths (2.6) hours shall be provided by certified nursing assistants.*

**Key Change 2:**

§ 1.16.6(6)(a): Adds language to specify that administrative duties or non-direct caregiving tasks may not be counted toward compliance with the minimum staffing hours requirement:

*Director of Nursing hours and nursing staff hours spent on administrative duties or non-direct caregiving tasks are excluded and may not be counted toward compliance with the minimum staffing hours requirement in this section.*

**Key Change 3:**

§ 1.16.6(C)(8): Refers to R.I. Gen. Laws § 23-17.5-33 regarding the protocol for compliance.

*Compliance and enforcement for § 1.16.6 of this Part shall be done in accordance with R.I. Gen. Laws 23-17.5-33.*

The statute is prescriptive in how nursing facilities will be evaluated for compliance with statute. To further detail the compliance procedure, RIDOH has developed a guidance document, titled *Nursing Home Minimum Staffing Levels Enforcement Guidance Document*, that will be publicly circulated and travel with the proposed regulations. The core methods RIDOH is implementing from the statute include:

- For nursing facilities certified by the U.S. Centers for Medicare & Medicaid Services (CMS), access their most current [PBJ Daily Nurse Staffing report](#)
- For nursing facilities not certified by CMS and which only have State licensure, access data provided directly to RIDOH via a portal for this purpose
- Access most current *Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates - Providence-Warwick, RI-MA* from the US Bureau of Labor Statistics
- Extract *median hourly wage* data for all direct care staff
- Access most current *Employer Costs for Employee Compensation* from the US Bureau of Labor Statistics
- Calculate total staff hours (TSH) for each day at each facility
- Calculate average CNA hours per resident for each day at each facility
- Calculate average staff hours per resident for each day at each facility

- For each day that a facility is out of compliance with average CNA staffing levels, calculate the additional CNA hours that were needed for that day
- For each day that a facility is out of compliance with average all staff levels, calculate the additional all staff hours that were needed for that day
- Total Cost for each facility on each day that it is in non-compliance with the minimum staffing requirements and apply penalty factor
- A facility that is in non-compliance for three consecutive quarters will be referred to EOHHS for action pursuant to R.I. Gen. Laws § 23-17.5-33(b)(7).

### **Benefits**

Quality of care improvements are often a goal of establishing minimum direct care staffing standards in nursing homes. Numerous research studies conducted over the last 20--25 years throughout the United States, Canada, United Kingdom, Germany, Norway, and Sweden reveal that total nurse staffing levels (i.e., RN, LVN/LPN, and CNAs) are associated with higher quality of care. Evidence shows that a minimum staffing threshold must be reached before staffing levels demonstrate higher quality.<sup>6</sup>

While a minimum staffing level is a necessary prerequisite to providing quality care, staff must also be well-trained and supervised. Low turnover rates, consistency of staffing, and low use of temporary agency staff have all been determined to be strongly associated with higher quality care. The turnover rates among RNs in Rhode Island nursing facilities was 35 percent in 2018. In spite of the challenges, Rhode Island nursing facilities have historically demonstrated a lower number of deficiencies<sup>7</sup> and higher resident satisfaction scores, compared to other states.

In her 2015 study, Mary Ellen Dellefield *et al*/ reviewed the relationship between registered nurses and nursing home quality. The studies that these authors examined reported, “higher registered nurse staffing and higher ratios of registered nurses in the nursing skill mix are related to better nursing home quality.”<sup>8</sup>

Bowblis also noted that higher staffing is associated with increased quality of care, but the skill mix of the staff is an important variable. The author comments: “Interestingly, nursing homes that are less reliant on Medicaid reduce the total percentage of staff that is licensed but keep the proportion of staff that is an RN constant. One possible explanation for this result is nursing homes that are less reliant on Medicaid are required to increase staffing but cannot increase non- Medicaid reimbursement to offset the cost of the staff. It may be more cost- effective for the low Medicaid reliant nursing homes to meet staffing requirements by hiring CNAs compared with licensed nurses.”<sup>9</sup>

In addition to quality improvements, eighty percent (80%) of the Medicaid rate increase must go directly to compensation increases for nursing facility direct care staff. It is not clear how much the rate increase will raise individual wages. Higher compensation may

result in improved morale, higher retention rates, and a greater ability to recruit additional direct care workers.

### **Costs**

The minimum staffing statute did not establish a restricted receipt account for fines/penalties for RIDOH's use for implementation purposes. All monies collected from fines/penalties go to the General Revenue fund.

Scopes of work for the data analytics professional and project manager are attached at Appendix "A."

Yearly implementation costs incurred by RIDOH are approximated as follows:

**Budget:**

- Pay Grade 37 – Project Manager

Salary and benefits for .75 state full-time equivalent:

\$94,872.

- Pay Grade 35 - Data Analytics Professional

Salary and benefits for 1.0 state full-time equivalent

\$117,749.

- Legal staff time as follows: (Pay Grade 34 x 375 hours)

23,393.

Quarterly Volume of Appeals	Attorney Hours @10	Attorney Hours @8	Attorney Hours @5
35	350	280	175
45	450	360	225
55	550	440	275
65	650	520	325
75	750	600	375

**Total Projected Program Staff Cost/Year**

**\$236,014.**

### **Costs to the Long-term Care Industry**

As part of project planning, several parameters were calculated using calendar year 2021 quarter one data for 78 Rhode Island nursing facilities reporting into CMS' payroll-based journal database. It was determined that approximately 350 additional CNA FTEs, at a cost of approximately \$15,650,000 (350 CNA FTEs x

\$46,030.40), would be required for the industry to meet the CNA Minimum Staffing Levels that will be required as of 1 January 2022. It was also determined that approximately 125 additional “all staff” FTEs would be required to meet the Minimum Staffing Levels. Even if these positions are filled with CNAs, the estimated additional cost would be approximately \$5,670,000 (125 CNA FTEs x \$46,030.40).

The total additional cost to the industry for year one would be approximately \$21,320,000.

The same data were used to calculate the potential fines and penalties associated with the “missing” staff hours. Per statute, penalty amounts are 200% of the cost of wages and benefits for missing staff hours for the first offence, 250% for the second offense and 300% for the third and subsequent offense(s). The penalties for this quarter for all 78 facilities totaled **\$8, 268,224**. Eleven facilities would have incurred penalties in excess of \$200,000 as follows:

Facility Identifier	Certified Nursing Assistant (CNA) Penalty	All Penalties Quarter One CY 2021	Total Penalty Quarter One CY 2021
	Quarter One CY 2021		
Facility "A"	\$379,451.78	\$121,825.06	<b>\$501,276.84</b>
Facility "B"	\$454,575.08	\$17,758.01	<b>\$472,333.09</b>
Facility "C"	\$371,352.92	\$0.00	<b>\$371,352.92</b>
Facility "D"	\$361,991.57	\$0.00	<b>\$361,991.57</b>
Facility "E"	\$305,390.85	\$1,282.70	<b>\$306,673.56</b>
Facility "F"	\$297,053.07	\$0.00	\$297,053.07
Facility "G"	\$238,435.95	\$0.00	\$238,435.95
Facility "H"	\$221,303.85	\$0.00	\$221,303.85
Facility "I"	\$215,223.52	\$4,017.32	\$219,240.84
Facility "J"	\$210,767.91	\$154.77	\$210,922.68
Facility "K"	\$177,358.72	\$23,005.90	\$200,364.62
<b>TOTALS</b>	<b>\$3,232,905.22</b>	<b>\$168,043.76</b>	<b>\$3,400,948.98</b>

Annual fines and penalties for non-compliant facilities could be staggering and are estimated to be about \$33 million for all nursing facilities in the state.

### **Regulatory Alternatives**

The statute is prescriptive and directive, offering RIDOH little flexibility in its implementation. The only discretion RIDOH has is contained in R.I. Gen. Laws § 23-17.5-33(c)(2). As such, there are no regulatory alternatives proposed here.

### **Determination**

Based on the above analysis, RIDOH has determined that the current proposed nursing home minimum staffing regulations provide the only solution given the parameters of the statute. Implementation may be expensive for the long-term care industry, depending upon compliance. The benefits related to quality care and workforce recruitment and retention will take longer to evaluate.

## References

### COVID-19 Practices and Procedures

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## Essential Caregivers

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## Minimum Staffing

- 1 See also section 1.5 of the Licensing of Nursing Facilities Regulations (216-RICR-40-10-1) below:

### 1.5 General Requirements for Licensure

A. No person or governmental unit acting severally or jointly with any other person or governmental unit shall conduct, maintain or operate a or hold itself out as a nursing facility without a license in accordance with the requirements of R.I. Gen. Laws Chapter 23-17.

B. The provisions of this Part, in addition to the provisions of R.I. Gen. Laws Chapter 23-17, shall apply to all nursing facilities and to all residents housed therein, except that persons caring exclusively for relatives shall be exempted from the provisions of R.I. Gen. Laws Chapter 23-17 and herein.

C. Facilities meeting the definition of nursing facilities by virtue of the residence therein of persons who are mentally, physically and/or emotionally dependent on others for fulfilling the requirements of daily life but which do not include primary medical and nursing components shall not be subject to this Part but shall be subject to the requirements of R.I. Gen. Laws Chapter 23-17.4 and to the "Rules and Regulations for Licensing Assisted Living Residences [R23-17.4-ALR]".

D. Any nursing facility that utilizes latex gloves shall do so in accordance with the provisions of the rules and regulations pertaining to the Use of Latex Gloves by Health Care Workers, in Licensed Health Care Facilities, and by Other Persons, Firms, or Corporations Licensed or Registered by the Department (Part 20-15-3 of this Title) promulgated by the Department of Health.

\* E. The nursing facility shall maintain sufficient financial resources to provide adequate staffing and supplies to care for the residents.

- 2 Section 1.16.7 (F) of the Licensing of Nursing Facilities, RIDOH Regulations 216-RICR-40-10-
  - a. Available here.
- 3 Licensing of Nursing Facilities, RIDOH Regulation 216-RICR-40-10-1. Available here. Accessed on November 26, 2019.
- 4 Abt Associates, Inc. Baltimore, MD. CMS, December 24, 2001. Retrieved from: [https://www.justice.gov/sites/default/files/elderjusstice/legacy/2015/07/12/Appropriateness\\_of\\_Minimum\\_Nurse\\_Staffing\\_Ratios\\_in\\_Nursing\\_Homes.pdf](https://www.justice.gov/sites/default/files/elderjusstice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf) Accessed on November 27, 2019.
- 5 Nursing Home Reform Act, as contained in the 1987 Omnibus Budget Reconciliation Act. See: GovTrack.us. (2019). H.R. 3545 – 100th Congress: Omnibus Budget Reconciliation Act of 1987. Retrieved from

- <https://www.govtrack.us/congress/bills/100/hr3545>. Accessed on November 27, 2019.
- 6 Harrington, Charlene et al. "The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes." *Health services insights* vol. 9 13-9. 12 Apr. 2016, doi:10.4137/HSI.S38994. Accessed on November 27, 2019.
  - 7 Centers for Medicare and Medicaid Services. (2019) Nursing Home Compare State US Averages. [Data file]. Retrieved from: <https://data.medicare.gov/Nursing-Home-Compare/State-US-Averages/xcdc-v8bm>. Accessed on November 27, 2019.
  - 8 Dellefield, Mary Ellen, Nickolas G. Castle, Katherine S. McGilton, and Karen Spilsbury. "The Relationship between Registered Nurses and Nursing Home Quality: An Integrative Review (2008 – 2014)." *Nursing Economics*, March-April 2015, Vol. 33, No.2.
  - 9 Bowblis, JR. Staffing Ratios and Quality: An Analysis of Minimum Direct Care Staffing Requirements for Nursing Homes. *Health Services Research*, 1475 – 6773, 2011 Oct., Vol 46, Issue 5.

## **APPENDIX “A”**

### **Nursing Home Minimum Staffing Data Analytics Manager**

#### Scope of Work

Goal: To implement the Rhode Island Nursing Home Staffing and Quality Care Act

(Public Law 21-024)

Overview: RIDOH is seeking a professional with data analytics expertise to implement statutory requirements and determine quarterly compliance using CMS’ payroll-based journal (PBJ). The statute requires an average of at least 3.58 of direct nursing care per resident per day beginning January 1, 2022 and 3.81 hours starting on January 1, 2023. Additionally, five nursing facilities do not submit data to CMS’ PBJ; a system for determining compliance for these five facilities will need to be established and implemented. {CMS does not allow non-CMS certified entities to report into the PBJ}.

#### Reference Documents:

- a. Public Law 21-024 (enabling statute);
- b. Preliminary draft nursing facility regulations;
- c. Companion document to regulations that includes the methodology for assessing quarterly fines and penalties: Nursing Home Minimum Staffing Levels Enforcement Policy and Procedures (Policy)
- d. Sample spreadsheet that includes penalties calculated by RIDOH for last quarter CY 2020 and first quarter CY 2021.

#### Duties and Responsibilities may include:

1. Evaluate compliance with the minimum staffing levels for nursing facilities established by R.I. Gen. Laws Title 23, Chapter 17.5;
2. Complete the full lifecycle activities of data analytics to include requirements and design, data cleaning, developing analysis and reporting capabilities, linking databases and datasets, and continuously monitoring performance and quality control plans to identify improvements in models;

3. With a significant level of latitude and independence, ensure the integrity of project data, including data extraction, storage, manipulation, processing and analysis;
4. Provide a high level of expertise to query and interpret data, analyze results, provide ongoing reports;
5. Work closely with management to prioritize project and information needs;
6. Develop and implement data collection systems and other strategies that optimize data quality;
7. Provide data visualization and presentation of analytical findings to RIDOH, EOHHS, and other stakeholders;
8. Acquire data from primary/secondary data sources and maintain databases/data systems;
9. Identify, analyze, and interpret trends or patterns in complex datasets related to this project;
10. Link databases and datasets to generate integrated datasets;
11. Filter and “clean” data, and review computer reports, printouts, and performance indicators to locate and correct data problems;
12. Participate in ongoing decisions concerning data collections, methodology, and data analysis;
13. Review, and revise as needed, RIDOH methodology for soundness and validity based upon knowledge of CMS’ Payroll-based Journal (PBJ) database; Review, and revise as needed, the spreadsheet to confirm that calculations are correct based upon the methodology;
14. Access most current *Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates - Providence-Warwick, RI-MA* from the US Bureau of Labor Statistics;
15. Identify any unintended consequences of the statute, such as any impact upon a facility’s CMS “5-star” rating;
16. Provide technical expertise that may be necessary to respond to comments on the proposed regulations and advise stakeholders on the databases being developed;
17. Develop protocols for the five nursing facilities not certified by CMS and which only have state licensure and advise on how to ensure that the data collected through the RIDOH database for the five homes that do not submit PBJ data is as similar to PBJ data as possible;

18. Develop facility-specific noncompliance (with minimum staffing requirements) reports for inclusion with the Notice of Deficiencies;
19. Develop statistical summaries of nursing home minimum staffing level data for posting on the Department's website and a written explanation of the data to assist members of the public in interpreting this information;
20. Other duties as reasonably requested by RIDOH.

**Preferred Qualifications:**

- Expertise in PBJ data analytics, nursing home ratings, and reimbursement
- Thorough knowledge of data models, database design development, and data mining techniques;
- Thorough knowledge of reporting packages and databases;
- Thorough knowledge of techniques utilized for analyzing large datasets;
- Ability to collect, organize, analyze, and disseminate significant amounts of information with attention to detail and accuracy;
- Ability to conduct queries, draw conclusions, prepare written reports and present findings in a clear and concise manner;
- Ability to establish and maintain effective working relationships with state and municipal officials, superiors, subordinates, stakeholders, and the general public; and related capacities and abilities.

## **Nursing Home Minimum Staffing Project Manager**

Goal: To implement the Rhode Island Nursing Home Staffing and Quality Care Act

(Public Law 21-024)

**Overview:** RIDOH is seeking a professional with project management expertise to implement statutory requirements related to a new statute that requires an average of at least 3.58 of direct nursing care per resident per day beginning January 1, 2022 and 3.81 hours starting on January 1, 2023.

### **Reference Documents:**

1. Public Law 21-024 (enabling statute);
2. Preliminary draft nursing facility regulations;
3. Companion document to regulations that includes the methodology for assessing quarterly fines and penalties: Nursing Home Minimum Staffing Levels Enforcement Policy and Procedures (Policy)
4. Sample spreadsheet that includes penalties calculated by RIDOH for last quarter CY 2020 and first quarter CY 2021.

### **Duties and Responsibilities may include:**

1. Serve as the primary point of contact for the minimum staffing project and any related data requests;
2. Ensure that all potential project-related issues are addressed and ensure project team members know their roles in resolving those issues;
3. Monitor compliance with the minimum staffing levels for nursing facilities established by R.I. Gen. Laws Title 23, Chapter 17.5;
4. Prepare monthly and annual updates on the minimum staffing project;
5. Stay current on latest trends in long-term care minimum staffing and develop new analyses based on these trends that may impact this project;
6. Assist with “back office” functions, such as generation of standard correspondence (e.g., compliance/legal letters) and the establishment of record-keeping systems;
7. Work closely with management to prioritize project and information needs;
8. Provide expertise that may be necessary to respond to comments on the proposed regulations and advise stakeholders on the databases being developed;

**Preferred Qualifications:**

- Ability to collect, organize, analyze, and disseminate significant amounts of information with attention to detail and accuracy;
- Ability to conduct queries, draw conclusions, prepare written reports and present findings in a clear and concise manner;
- Ability to utilize a computer and common applications used in public health including Word, Excel, and Scheduling Software;
- Ability to communicate effectively verbally and in writing;
- Ability to mentor and/or supervise less experienced analysts as required;
- Ability to develop and maintain effective working relationships; and related capacities and abilities.