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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

March 6, 2024

On behalf of our nearly 5,000 member hospitals and health systems who work with long-term care (LTC) facilities to serve hundreds of thousands of patients each year, our professional membership groups and affiliates, including the American Organization for Nursing Leadership (AONL) and our 2,425 post-acute care members, the American Hospital Association (AHA) writes to share the hospital field's comments on proposed regulations for minimum staffing standards for LTC facilities and their potential impact on access to care.

The AHA and its members are committed to safe staffing to ensure high-quality, equitable and patient-centered care in all health care settings, including LTC facilities. However, CMS' proposal to implement mandatory nurse staffing levels would have serious negative, unintended consequences, not only for nursing home patients and facilities, but the entire health continuum. The AHA is pleased to support Protecting America's Seniors' Access to Care (H.R. 7513), which would prohibit the Secretary of Health and Human Services from finalizing a proposed rule on minimum staffing for long-term care facilities.

Safe staffing is complex and dynamic. It must account for the acuity of the patients' needs, the experience and clinical expertise of the nurses and health care professionals on the care team, and the technical capabilities of the facility. Organizational leaders, nurse managers and direct-care nurses who know the needs of the patients they serve best must be empowered to collaboratively make staffing decisions, rather than reacting

to “one-size-fits-all” thresholds. If implemented, the rule could severely limit access to nursing home care, particularly in rural and other underserved communities; lead to longer waits for emergency and inpatient hospital care; worsen staffing shortages across the care continuum; and hinder innovative, new approaches to delivering quality care. The AHA urges the Centers for Medicare & Medicaid Services (CMS) not to finalize the rule; instead, CMS should develop more patient- and workforce-centered approaches focused on ensuring a continual process of safe staffing in nursing facilities.

The AHA opposes implementation of minimum thresholds for registered nurse (RN) and nurse aide (NA) care. This type of standard is a static and ineffective tool that CMS’s own commissioned analysis shows does not guarantee a safe health care environment nor the quality level to achieve optimum patient outcomes. The number of patients for whom nurses and other health care providers can provide safe, competent and quality care is dependent upon multiple factors that are not captured in a raw number of hours, including the type and degree of illness; functional status and level of independence of residents; the makeup of the overall care team including caregivers who may not be nurses; the physical layout of the facility; and the experience and tenure of the professionals working in the facility.

NUMERICAL STAFFING THRESHOLDS ARE NOT CONSISTENT WITH MODERN CLINICAL PRACTICE

Mandated nurse staffing standards remove from the practice of nursing real-time clinical judgment and flexibility. Numerical staffing thresholds do not consider advanced capabilities in technology or the interprofessional team care model that supports data-driven decision-making and collaborative practice. Emerging care models incorporate nurses at various levels of licensure, respiratory therapists, occupational therapists, speech-language pathologists, physical therapists and case managers. A simple mandate of a base number of RN and NA hours per resident day emphasizes staff roles of yesterday, rather than what current and emerging practices may show is most effective and safe for the patient, and best aligned with the capabilities of the care team.

AHA is concerned that these rigid standards would stymie innovation in care delivery. Our members have begun to deploy technology-enabled solutions, such as virtual nursing models, that include remote patient monitoring that provide an extra support to bedside nurses. Some organizations are using their non-physician and non-nursing caregivers to take on tasks that do not require clinical licensure to perform. Enabling practice at the top of one’s education and license can lead to greater staff satisfaction while maximizing the use of limited clinical staff resources. Nursing homes need the flexibility to test, evaluate and — when the evidence supports it — implement these new models.

PROPOSED STANDARDS WOULD EXACERBATE DIRE WORKFORCE SHORTAGES ACROSS THE CONTINUUM

Mandating staffing levels would exacerbate severe long-term shortages of nursing staff across the care continuum. In 2017, the majority of the nursing workforce was close to retirement, with more than half age 50 or older, and almost 30% age 60 or older. A comprehensive analysis from a 2022 survey conducted by the National Council of State Boards of Nursing and National Forum of State Nursing Workforce Centers showed that nearly 900,000 — or one-fifth of the 4.5 million total registered nurses — expressed an intention to leave the workforce due to stress, burnout and retirement. The study also noted that over 33,800 licensed practical nurses (LPNs) and vocational nurses left the field since 2020, disproportionately impacting nursing homes and LTCs.[1]

In the CMS proposed rule, the agency estimates that 75% of LTC facilities would have to increase staffing to meet the proposed standards, including the new standard requiring 24/7 RN staffing. Considering the massive structural shortages described by recent studies, it is unclear where this supply of nurses will come. **Given the shortages we described above, it is inconceivable that LTC facilities will be able to meet these standards without detrimental effects to workforce availability throughout the care continuum.**

IMPLEMENTATION OF THESE STANDARDS WOULD HURT ACCESS TO CARE

If faced with required staffing levels, skilled nursing facilities and other LTC facilities may be forced to reduce their capacity or even close their doors when they are unable to meet these mandates. Organizations considering opening new LTC facilities would likely be discouraged from doing so. This would have a ripple effect across the entire continuum of care, since general acute care hospitals, inpatient rehabilitation facilities and other health care facilities already struggle to find appropriate placement for their patients.

Hospitals and health systems already are experiencing significant challenges in moving patients through the health care continuum in a general sense, and specifically into skilled nursing facility care. Longer stays in hospitals result in delays in patients receiving the next level of medically necessary care. They also lead to longer wait times in hospital emergency departments because hospitals are unable to move current patients out of inpatient beds. Constrained access to LTC facilities is a quality-of-care issue affecting all types of patients across the care continuum.

CONCLUSION

Thank you for your leadership on these important issues and for the opportunity to provide comments. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

[1] https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext