Insights on staffing ratios in U.S. Assisted Living/Residential Care

To the members of the Senate Committee On Human Services, Mental Health and Recovery:

We are writing in support of using data based on residents' health, social support, and care needs to designate staffing in assisted living and residential care (AL/RC) communities. However, minimum staffing ratios alone will not solve care delivery concerns. Required changes to staffing in AL/RC communities must be designed in addition to providing communities resources that promote person-centered care environments.

Staffing levels are one component of providing care in AL/RC communities. Staff availability, retention, training, and continuing education are key components of quality care delivery to older adults and persons with disabilities. AL/RC communities have for many years had to compete for the limited numbers of people willing and able to work in long-term services, including home care, residential care, nursing homes, adult foster homes, and group homes that serve persons living with intellectual/developmental disabilities and persistent and serious mental illness. Even licensed health care professionals avoid geriatrics. Ageism, recently recognized by the United Nations as a global challenge that results in poor health among older adults, might be partly to blame for a disinterest in older adults and people with disabilities who need long-term supports.

In 2020, over 550 AL/RC/MC communities provided care to an estimated 24,000 residents in Oregon. The Institute on Aging (IOA) at Portland State University conducts an annual, representative study of AL/RC and memory care (MC) communities currently licensed and operating in Oregon (funded by the Oregon Department of Human Services, Office of Aging and Persons with Disabilities). Administrators who responded to our survey reported that 23% of residents regularly receive assistance from two staff members and 46% of residents regularly receive assistance during nighttime hours (11PM to 6AM).

We collected information on currently employed care-related staff, defined as staff who primarily provide care to residents: registered nurses (RNs), licensed professional/vocational nurses (LPNs/LVNs), certified nursing assistants (CNAs), certified medication aides (CMAs), unlicensed personal care staff, and activities staff. Based on data collected in Fall 2019 from 389 responding AL/RC/MC communities, we found:

- **81% of all care-related staff were employed full time (at least 35 hours per week).**
- **Unlicensed personal care staff comprise the largest percentage of care staff (82%), followed by activities staff (6%), RNs (5%), and CNAs (3%).**
- **Of responding communities:**
    - **66% employed at least one RN full time (at least 35 hours per week), 34% part time (max 17.5 hours per week)**
    - **28% employed at least one LPN/LVN full time, 7% part time**
    - **22% employed at least one CNA full time, 8% part time**

    - **84% employed at least one unlicensed personal care staff full time, 76% part time**
    - **6% employed at least one activities director or staff full time, 7% part time**

We encourage policymakers to consider the several equity concerns raised by only introducing this legislation.

- **In 2020, an estimated 43% of AL/RC and 44% of MC residents primarily used Medicaid to pay for services.** Medicaid is a substantial payer source for long-term services and supports users. In Oregon, the Medicaid monthly reimbursement rate for an assisted living resident ranges from $1,371 (receiving the lowest level of care) to $3,221 (receiving the highest level of care). Private pay assisted living residents in Oregon pay an estimated $4,056 per month receiving the lowest level of care, **on average.** Mandating minimum staffing levels without commensurate increase in reimbursement rates may unintentionally disincentivize AL/RC as a care option for Medicaid-eligible residents.
- **Potential differential impact in urban and rural counties.** Of the 587 AL/RC/MC communities licensed in 2020, 40% of AL/RC and 36% of MC communities in Oregon operate in rural or frontier counties. The Oregon Office of Rural Health defines rural as "any geographic area in Oregon ten or more miles from the centroid of a population center of 40,000 people or more" and frontier as "any county with six or fewer people per square mile." Even if communities in these areas utilize acuity-based tools, staff available and qualified to work may be significantly limited in rural/frontier counties compared to urban and suburban areas, presenting logistic barriers to meeting minimum staffing requirements.
- **Protecting and growing the existing direct care workforce.** Good quality of care and residents' quality of life are contingent on a work environment that supports and empowers staff to care for residents. In 2003, Oregon participated in a national demonstration, "Better Jobs, Better Care," to improve the work environment for direct care workers so that they could provide better and more person-centered care. Fifteen years later, the IOA talked with residents in long-term care settings to learn about their experiences. **Across time, limited staffing and high turnover were consistent issues for both staff and residents.** Staff reported that they cannot do the work the way they feel it needs to be done because of heavy workload. When asked "how could this place be run better?" residents often suggested increasing staff and reducing turnover.

  Research and demonstration projects, as well as industry examples, inform us that multiple workplace practices, in addition to adequate staffing, are needed to grow and stabilize the direct care workforce. These include increasing wages and benefits, thereby making long-term care jobs more competitive. State and local governments must do more through reimbursements so that long-term care providers can make necessary wage adjustments. Like staffing, however, wage increases alone will not address care and quality of life issues in long-term care. High performing long-term care settings

which engage in person-centered care, use groups of practices that create cohesive workplace teams. These include investing in staff, which builds trust in the organization and empowers staff to make decisions with residents about care; investing in high levels of coordination and communication among all staff, which supports engagement of all staff; flexible scheduling in response to staff and resident needs; and being a learning organization, which supports learning from mistakes and integrating new practices. This takes leadership and commitment from administration and corporate leaders. AL/RC owners must do more to invest in effective leadership and support a culture of staff support and person-centered resident care.

Given the unique needs of the AL/RC and MC populations across different regions of Oregon, it is imperative that this legislation provides flexibility and support for AL/RC communities to determine staffing levels in a way that minimizes administrative burden. AL/RC owner/operators are concerned that staffing levels and ratios will result in nursing home-like conditions. This is a familiar argument that can be applied to nearly any proposed regulation. It is useful to look at whether other states require staffing levels in AL/RC. The table below shows that 19 states required ratios or levels in their AL/RC regulations, based on a 2015 review. While this is useful, each state defines, licenses, and regulates AL/RC settings differently.

State	Ratio requirement for direct care staff in AL/RC (day shift only)
Arkansas	1:16
Colorado	1:10 in Medicaid facilities
Connecticut	1: 25
Florida	Facilities with 6–15 residents, 212 hours of staff; 16–25 residents, 253 hours of staff; and (4) 26–35 residents, 294 hours of staff. For every 20 residents over 95, 42 staff hours must be added each week, which equates to about one FTE per 20 residents
Georgia	1:15
Illinois	1 CNA at all times and 1 additional staff if CNA ratio is 1:75
Iowa	1:25
Maine	1:12
Mississippi	1:25
Missouri	1:15
New Mexico	1:15
New York	3.75 hours per resident per ?
North Carolina	Facilities serving between 20 and 30 residents must have 16 hours of personal care aide time on the first and second shifts, and 8 hours on the third shift. The amount of personal care aide hours increases with the size of the facility and reaches 96 hours for facilities with 131 to140 residents
Oklahoma	.75 hours per day per resident
Pennsylvania	Direct care staff persons on duty must be awake at all times and must provide at least 1 hour per day of assisted living services to each mobile

	resident and at least 2 hours per day to each resident with mobility needs. At least 75 percent of the assisted living service hours must be available during waking hours.
South Carolina	1:8
South Dakota	.8 hours per resident per day
West Virginia	Specific ratios of direct care staff are required on each work shift based on the numbers of residents who have the following care needs: (1) dependence on staff for eating, toileting, ambulating, bathing, dressing, repositioning, special skin care; (2) one or more inappropriate behaviors that reasonably requires additional staff to control, such as sexually acting out, removing clothing in public settings, refusing basic care, or destroying property; or (3) injurious behavior to self or others.
Vermont	1:25

This information is abstracted from the U.S. Department of Health and Human Services Compendium of Residential Care and Assisted Living Regulations and Policies: 2015 Edition

It is important to remember this legislation specifies minimum staffing ratios *only if* a community cannot demonstrate the use of an acuity-based tool to determine staffing. However, if not matched with appropriate support, resources, and technical assistance, the administrative and logistic burdens of meeting these requirements may maintain or worsen existing staff turnover, retention, and vacancy issues. AL/RC owners and operators rightly complain that the government (state and federal) has not adequately invested in long-term care. State agency staff, advocates, and other stakeholders complain that AL/RC owners and operators are driven only by profit and that they pay inadequate wages.

Addressing workforce and staffing challenges will be hard work, requiring multiple interventions developed in partnership with AL/RC operators, staff, residents, and residents' families. Oregon has a history of innovative long-term service and supports policies and programs. One example includes expanding community-based care to thousands of people who might otherwise have gone to institutions. It is time again to employ the "Oregon way" to solve the workforce, staffing, and community care challenges that affect all who provide and need long-term services and supports, including family caregivers who attempt to hire home care workers to supplement the care they provide to relatives.

Sincerely,

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