Critical Staffing Management in Long-Term Care

RCS Trainings 1 & 2 Q & A 10/20/2021

<table>
<tr><th>Questions</th><th>Answers</th></tr>
<tr><td>Is CMS aware of this guidance document?</td><td>Yes. CMS has been consulted.</td></tr>
<tr><td>Can you elaborate what "restorative programs" means in this context?</td><td>In NHs there are restorative aides who assist residents in maintaining flexibility and mobility once they graduate from physical therapy. Restorative programs outline the exercises to be done, individualized to each resident.</td></tr>
<tr><td>Related to the Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID): In the Critical Staff Management in LONG-TERM CARE (LTC) Guidance, it refers to restorative programs—should I take that to mean Active Treatment programs in the context of ICF where we train individuals to maintain and gain new skills? What does “independent” mean in this sentence--“Stop with exception of independent programs”. Can you give an example?</td><td>Restorative programs to prevent Activities of Daily Living (ADL) decline are specific to the Nursing Home regulations. This does not mean Active Treatment in the ICF/IID setting.

Example: Resident engages in restorative program by riding the seated bike in the gym for 15 minutes 3 days / week
Not independent: resident is dependent on staff to escort resident to and from the gym, PT or restorative staff assist resident to access the stationary seated bike and cue the resident to use it
Independent: resident ambulates to the gym at the appointed time and uses the stationary bicycle independently. No supervision or prompting is required
Resource to better understand restorative programs: Guide to Restorative Programs
https://www.aapacn.org/products/restorative-programs-guide/</td></tr>
<tr><td>For Intermediate Care Facility (ICF) is there still an expectation of doing Active Treatment when in contingency or crisis?</td><td>The Guide document does not list every possible modification to care under crisis standards. Each LTC setting should identify what care can be modified to meet basic resident/client needs at contingency and crisis levels.

Focus on
Providing essential supportive services including eating/drinking, personal hygiene, and safety
Administering only essential medications and treatments
Comfort care, including fluids and pain management</td></tr>
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Questions	Answers
	The Developmental Disabilities Administration (DDA) needs to answer the question: Is Active Treatment an essential supportive service for DDA clients living in ICF/IID?
What does that mean to administer only essential medications when in crisis?	If there are a lot of medications to administer, maintain the focus on the essential medications such as seizure medications. There may be only one nurse to pass the medications, focus on the essential medications. The primary care provider can identify which medications are essential.
Does 'risk to provider' mean possible citation due to inability to complete all regulatory compliance that isn't directly related to functional care?	It is not a risk for a citation. The risk is in not meeting the resident/client care needs with the resources and staff you have. Reach out to the Rapid Response Team (RRT) to ask for help in meeting resident/client care needs.
For the staffing management RCS guide, how would that apply to 24hr clients	The guide outlines options to fulfill care delivery when faced with critical staffing shortages. Most Long-Term Care (LTC) settings provide 24 hour care. Modifications depend on the type or kind of staffing shortage. For example, if there is a shortage of staff to deliver medications, focus on giving essential medications.
Are the legislatures aware of how short programs are of staffing? The biggest issue is cost of rents and the pay is not enough to live.	Yes. This has been a discussion throughout the pandemic.
How can we utilize volunteers in this crisis?	The volunteers must meet credential criteria. There are no exceptions to this. They must meet minimal credential requirements.
What are your thoughts on moving clients in Community Residential Services settings, such as Supported Living (SL)? Would this fall under last resort like it does for facilities?	Transferring residents is a last resort. It is best to keep residents/clients in their home. The best option must be selected. Basic care and services need to be provided such as ADLs, meals, and medications. If you are unable to care for the residents or deliver basic care needs, then we might look at discharge or transfer. This is not easy, as this is their home.

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Should facilities that are short staffed (or any facilities) start asking residents if they have/want an essential support person (ESP)? Could we utilize family members to help with their specific resident if able and willing?	Yes, volunteers, families and designated ESP can come in any time for the resident/client. This is especially helpful for those that are unvaccinated or in quarantine status. They can assist with certain things such as one on one activities, ADLs, and meals. This is good time to have essential people come in provide support and assist with care and services with residents/clients. Nurse delegators work on the weekend and after hours. They are also available via tele medicine depending on what resources are available. Use is done case by case. For a DDA client, nurse delegators will step in and help, also HCS will step in and help.
We are seeing a trend in changes with Physicians in our area leaving their practice or moving. It has been difficult to get the residents' prescriptions renewed. How can the current prescriptions be extended in the interim until we can set them up with a new physician? This is specific to pain medications.	This is a pharmacy regulation not related to RCS. The medical clinics are using tele medicine to trouble shoot. If you are a nursing home, get your medical director involved. There is understanding of the staffing crunch, now there are lack of pharmacy or physician staff. For other LTC settings that don't have medical directors, directly approach your pharmacy/pharmacist or physician, as well as the residents and family on how to reach a solution.
I can see a facility being in Contingency level for some things, and crisis level in other areas. Are we supposed to choose just one option?	Great observation. The emergency literature talks about this. You want to modify your operations and deploy staff to maintain the functional level of care. This is the basic care needs of providing care and services to the residents/clients. This is a continuum where you may be short staff one week with Licensed Nurses (LNs), the next week there is a shortage of housekeeping staff followed by the next week with caregivers/NACs. Review the options if you need to move people out of building. Please make an RRT request if you are using crisis care standards.
Is there a magic number to determine contingent and crisis?	I wish, no there is not. All resident needs are a different contingency. The crisis mode is when you can't provide the basic care and services. Think if you can provide ADLs, medication administration or assist with meals.
What does it mean to meet basic needs?	The bottom line is to provide residents/clients a safe environment, stability, preventing them from decline, and behavioral support if that is their basic need. The emergency management literature recommends that LTC settings Focus on:

Questions	Answers
	• Providing essential supportive services including eating/drinking, personal hygiene, and safety • Administering only essential medications and treatments • Comfort care, including fluids and pain management
Do we need to contact you before we implement a plan?	You know your challenges you are facing. We want to see you implementing actions and then submitting the RRT request to activate a multi-agency response.
When do we notify the CRU?	Notify the CRU if you need to evacuate residents/clients out of your home. Notify CRU if you are going into crisis mode. This is in your regulation. RCS is asking you to notify us if you are thinking about a modification at the crisis level. Try to avoid evacuation at all costs as it is a disruption to the residents. It is best to maintain residents/clients in their home. Look at support and interventions to keep them in the home and not evacuate. Use the RRT to seek support to provide basic needs and safety for the residents and clients.

Rapid Response Team Questions

Questions	Answers
We have reached out to Rapid Response and requested assistance. When would we expect to hear back?	The RRT will keep your request. When they can help with staff, they will let you know. Remember to document priorities. The RRT will try their best to accommodate you and your needs and everyone else. They will try their best to help a request for a day or maybe a shift.
How quickly can we expect to get staffing support from the RRT, and how does the response vary by region?	This is managed case by case with available resources on hand at that time to prevent LTC settings being placed in the crisis column. We will look for availability of RRT in that area and address as soon as possible.
We have been told the rapid response teams will only help for a few days, not weeks/months. Is this true?	That is correct. There are currently 50 staff including managers. We wish we could help more, that is it. There will be consideration to cross over from one area to another if needed to support the LTC setting and avoid being placed in a crisis care situation.

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Are there fees associated when utilizing the rapid response team?	No. This is a free service
Are LTC facilities prioritized over hospitals?	The RR team only responds to LTC settings. The Federal government General Services Administration (GSA) contracted monies are only used for LTC. The RRT is trying to raise their capacity to respond to critical staffing shortages in LTC settings.
Who should we call for help for RCS behavioral team?	To request support from the RCS Behavioral Health Support Team (BHST), please email RCSBHST@dshs.wa.gov or call (360)725-3445. Please note that the RCS Behavioral Health Support Team offers support with suggestions and ideas to the LTC setting for working with a BH client. The BHST does not support the client directly or work in the building as the Mental Health Professional (MHP).
How expedient is the rapid response team? If I sent in a form, how long would it typically take to approve and how long would it take for help to come?	Very responsive. If they have staffing available in your area, they will be in touch. If not, they will hold onto your documents to see if a shift opens to try and help out an area. Again, they will move staff around the state to help. Remember, they might be on the phone helping others so you might not hear from them in a while. They really are trying to help all LTC settings who make a RR team request.
What is the current back log of requests?	There is not a huge back log. At one time there was a prioritization for availability of the support team. Now with critical staffing shortages we are attempting to minimize the crisis with the contingency plan.
Is the rapid response team available to help in rural areas...Chelan and Douglas counties?	When there is a need, the RRT will assess to help in those areas. Make sure to contact them. They will look at their resources from one part of the state to another part of the state to assist as much as they can.

Miscellaneous Questions

Questions	Answers
Will there be more direction relating specifically to Certified Community Residential Supports & Services (CCRSS) settings?	For CCRSS settings there is information in the guide. Be sure to read the entire guide. The guide is posted here https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services

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Is there a possibility of waivers in hirings NARs to increase work?	Yes, this is work in progress. RCS will talk with the Department of Health (DOH). This is a good question for them.
How about the possibility of hiring Home Care Aides in SNFs?	This is a discussion with DOH
We submitted our rapid response request in early September with no reply or staffing supplied. We are a facility type, Enhanced Services Facility (ESF), who is not allowed to admit from acute care settings, and we are at capacity. We have staff ratio requirements. We are needing staffing to meet these ratio requirements. At this time, we continue to be able to provide all the services outlined in care plans, service agreements, etc. A waiver for staffing ratios (especially on night shift) would alleviate the need for utilizing resources here. Has there been any discussion specifically about ESF facilities and staffing ratios?	There are specific contract and WAC requirements for care and services, as well as staffing in the ESF program (and many of our other programs). The point of critical staffing management is to help facilities determine what to do when meeting those requirements is just not possible. The reality is that staffing is at a crisis level across our state. We want to help LTC settings determine the best way to manage the staff they do have when it becomes critical, and to encourage them to call us and HCS as early as possible so we can help as much as we can.
There was mention that quarterly Minimum Data Set (MDS) assessments that are due may be able to be decreased. Is this accurate?	Yes, there is an option on the guide, for MDS assessments to be delayed under crisis standards. If LTC settings reach a crisis standard, they need to submit the RRT request. We need to work together so LTC settings can meet minimal, basic requirements in providing the care and services to the residents/clients.
On page 3 of the guide, MDS assessments are mentioned. What are the financial repercussions if they	Under contingency staffing levels, there is no change in MDS assessment requirements. A facility might change to a completing only initial and Significant Change assessment under crisis care standards. These

Questions	Answers
are reduced, i.e., payments frozen till next MDS is done? I can see facilities being hesitant to claim crisis level if their income will be impacted.	are options available to providers. You need to think how you can mitigate or modify your operations. What are you going to do if there are no staff to do the work? The question about MDS completion is more about the financial impact on default rate when MDS assessments are not done or are late. It is a common practice in nursing homes to adjust the assessment date. The MDS will be still done, it is just going to be late. CMS issued numerous emergency waivers throughout the pandemic. The waiver for 42 CFR 483.20 to provide relief to SNFs on MDS assessment and transmission timeframe requirements ended on 05/10/2021. Facilities must determine what to do when faced with critical staffing conditions. National Emergency management literature requires that under crisis management – "functionally equivalent care" is required with a focus on: • Providing essential supportive services including eating/drinking, personal hygiene, and safety • Administering only essential medications and treatments • Comfort care, including fluids and pain management

For Questions About:

Safe Start plan: please contact the RCS Policy Unit - RCSPolicy@dshs.wa.gov
Vaccine Mandate please contact DOH: covid.vaccine@doh.wa.gov

DSHS Provider Resources:

Documents posted on: https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services
Rapid Response Team: rapidresponse@dshs.wa.gov