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State Regulatory Provisions for Residential Care Settings: An Overview of Staffing Requirements

Paula Carder, Janet O'Keeffe, Christine O'Keeffe, Erin White, and Joshua M. Wiener

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RTI International
3040 East Cornwallis Road
PO Box 12194
Research Triangle Park, NC
27709-2194 USA

Tel: +1.919.541.6000
E-mail: rtipress@rti.org
Website: www.rti.org

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About the Authors

Paula Carder, PhD, is an associate professor at the Institute on Aging in the School of Community Health at Portland State University.

Janet O'Keeffe, DrPH, RN, is a consultant in Macon, North Carolina.

Christine O'Keeffe, BA, is a consultant in Frome, England.

Erin White, MS, is a research public health analyst in RTI's Aging, Disability, and Long-Term Care group in Washington, DC.

Joshua M. Wiener, PhD, is a Distinguished Fellow in Aging, Disability, and Long-Term Care at RTI International in Washington, DC.

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Abstract

Residential care settings (RCSs), such as assisted living facilities, provide community-based services for older adults and younger people with disabilities who require long-term services and supports. Within RCSs, staffing adequacy is a key factor for ensuring residents' quality of care. However, because residential care settings are licensed and regulated by the states, staffing requirements vary considerably among states. This paper provides an overview of state regulations related to staffing in residential care, highlighting the variance among state regulations. The primary data source for this analysis was the Compendium of Residential Care and Assisted Living Regulations and Policy, 2015 Edition, funded by the Office of the Assistant Secretary for Planning and Evaluation/US Department of Health and Human Services. Consumers and regulators need to be aware of the state variance in RCS staffing requirements and assess whether a state's staffing requirements are adequate to meet residents' needs.

Introduction

Residential care settings (RCSs), such as assisted living facilities, are an important option for older adults and younger people with disabilities who require long-term services and supports (LTSS). As of 2012, the United States had an estimated 22,200 RCSs with 713,300 residents (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013), and the demand for residential care is expected to increase as the population ages and the need for LTSS increases (Caffrey, Harris-Kojetin, Rome, & Sengupta, 2014).

RCSs provide assistance with activities of daily living (ADLs; activities such as dressing, bathing, and toileting); instrumental activities of daily living (IADLs; activities such as housework and meal preparation); and health maintenance tasks (e.g., medication management) (Harris-Kojetin et al., 2013). Residential care is largely provided by direct care staff including aides, registered nurses (RNs), licensed vocational or practical nurses (LVNs or LPNs), and social workers (Harris-Kojetin et al., 2013).

A substantial proportion of RCS residents are impaired in their physical or cognitive functioning and need ADL assistance. In 2012, 61 percent of RCS residents required help with bathing, 45 percent with dressing, 37 percent with toileting, and 18 percent with eating. Additionally, approximately 39 percent of residents had a diagnosis of Alzheimer's disease or other dementias (Harris-Kojetin et al., 2013).

RCSs are licensed and regulated at the state level; and regulatory requirements vary considerably among states. Because a large percentage of RCS residents have functional impairments necessitating ADL assistance, staffing adequacy in RCSs is a key factor to ensuring residents' quality of care (Khatutsky, Wiener, Greene, Johnson, & O'Keeffe, 2013). Recognizing the importance of staffing adequacy in RCSs and the variance among state RCS regulations, the purpose of this paper is to provide an overview of state regulations related to staffing in residential care.

Methods

Terminology

Many facility types fit under the broader term "residential care settings," including assisted living facilities, board and care homes, residential care facilities, rest homes, adult care homes, domiciliary care homes, personal care homes, and adult foster care homes. This paper uses the term "residential care setting" as a generic term that encompasses all of these state licensure categories. When describing a specific state's rules, we use that state's licensure term.

Inclusion Criteria

This paper focuses on RCSs that are licensed by the states and that serve older adults and working-age adults with physical disabilities. It does not include RCSs that predominantly serve people with serious mental illness or intellectual and other developmental disabilities.

Data Sources

The primary data source for this study is the *Compendium of Residential Care and Assisted Living Regulations and Policy, 2015 Edition*, developed by Paula Carder, Janet O'Keeffe, and Christine O'Keeffe (Carder et al., 2015). Funded by the Office of the Assistant Secretary for Planning and Evaluation, the *Compendium* summarizes and compares the RCS regulations for each of the 50 states and the District of Columbia. The *Compendium* outlines each state's residential care licensure categories, highlights key areas of commonality among the states' regulatory provisions, and notes similarities and differences among states' regulations for each of these key provision areas.

Requirements for Different Types of Staff

Administrators

All states require RCSs to employ a manager, director, or administrator who is responsible for daily operations, including staffing, oversight, and regulatory compliance. Generally, the administrator is expected to be employed full time, but some states permit smaller settings to employ a part-

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time administrator. For example, Delaware permits facilities licensed to serve 5 to 24 residents to employ an administrator for 20 hours per week; and facilities with 1 to 4 residents are required to have a director on site for 8 hours weekly, in addition to a health service manager (8 hours weekly) and a full-time house manager.

Licensed Health Care Professionals

Licensed health care professionals include physicians (MDs), physician assistants, RNs, and LVNs or LPNs. The primary function of licensed nurses in RCSs is the provision and oversight of nursing services that are covered by the state's Nurse Practice Act. For example, Montana's rules specify that Category B assisted living facilities must employ or contract with an RN to provide or supervise nursing services, which include (1) general health monitoring for each resident; (2) performing a nursing assessment on residents when and as required; (3) assisting with the development of the resident health care plan and, as appropriate, the development of the resident service plan; and (4) carrying out routine nursing tasks, including those that may be delegated to LPNs and unlicensed assistive personnel in accordance with the Montana Nurse Practice Act.[1] Additionally, a small number of states require licensed nurses to administer medications or certain types of medications, such as injections.

As reflected in Table 1, 38 states require a licensed nurse (RN, LVN, or LPN) to be on staff or available, either through employment or as a consultant, whereas 12 states do not have specific licensed nurse staffing requirements within state RCS staffing provisions.

Direct Care Workers

In addition to administrators and licensed health care professionals, all states require RCSs to employ direct care workers to provide personal care and related daily services to residents. States use a variety of terms to describe these staff, including personal care assistant, attendant, and caregiver. In virtually all states, direct care workers are unlicensed, although states may require training or certification.

[1] In Montana, assisted living facility licensure categories—A, B, or C—are based on resident level of care needs. Category A residents can self-medicate, need assistance with no more than three ADLs, and are generally in good health. Category B residents may be in need of nursing services and be consistently and totally dependent in four or more ADLs. Category C residents have cognitive impairments and are not capable of expressing needs or making basic care decisions.

Table 1. Licensed health care professional staffing requirements, by state

Licensed health care professional[a] required to be on staff or otherwise available			Licensed health care professional[a] staffing requirement not specified
Alabama	Maryland	Oklahoma	Alaska
Arkansas	Minnesota	Oregon	Arizona
Connecticut	Mississippi	Pennsylvania	California
Delaware	Missouri	South Carolina	Colorado
District of Columbia	Montana	South Dakota	Georgia
Florida	Nebraska	Tennessee	Kentucky
Hawaii	New Hampshire	Utah	Louisiana
Idaho	New Jersey	Vermont	Massachusetts
Illinois	New Mexico	Virginia	Michigan
Indiana	New York	Washington	Nevada
Iowa	North Carolina	West Virginia	Rhode Island
Kansas	North Dakota	Wyoming	Texas
Maine	Ohio		Wisconsin
Total: 38			**Total: 13**

[a] Licensed nurse (registered nurse, licensed practical nurse, licensed vocational nurse) or other licensed health care professional (physician, physician's assistant).

Source: RTI analysis of the *Compendium of Residential Care and Assisted Living Regulation and Policy, 2015 Edition* (Carder, O'Keeffe, & O'Keeffe, 2015).

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Other Staff

In addition to the types of staff described previously, states may require RCSs to employ qualified dieticians or nutritionists, medication assistants or technicians, consultant pharmacists, case managers, social services staff, and activities staff. Ohio, for example, requires facilities to employ or contract with a psychologist or physician if any residents have specified conditions associated with late-stage cognitive impairment or have serious mental illness. Missouri is unique in requiring each facility to be supervised by a physician who must be informed of any treatments and medications prescribed by other authorized personnel.

Staffing Level Requirements

State regulations reflect two basic approaches for determining RCS staffing levels: (1) flexible, or as-needed, staffing; and (2) minimum ratios based on either number of staff to number of residents, or a specified number of staff hours per resident per day or week (Table 2).

Flexible Staffing

Regulatory provisions in flexible staffing states routinely require that RCSs provide a "sufficient" number of staff who are adequately trained, certified, or licensed to meet residents' needs and to comply with applicable state laws and regulations. Flexible staffing is the more common staffing approach, used by 40 states.

Of the 40 states using the flexible staffing approach, 34 also specify some type of minimum staffing requirements. For example, many states specify that at least one employee with CPR and first-aid certification must be on duty at all times and at least one awake staff must be on duty at all times. In addition, states may require staff to be on duty if residents have specific needs—for example, if residents require nursing services, sufficient nursing staff must be available.

Some states require overnight staff to be awake based on the number of residents in the facility. For example, Nevada requires awake staff at night only in residential facilities with 20 or more residents. In Texas, night shift staff in Type A assisted living facilities with 16 or fewer residents must be

Table 2. Staffing-level requirements, by state

Flexible (as needed) staffing approach[a]			Minimum staff-to-resident ratio staffing approach	
Alabama	Maine (ALP)	Ohio	Arkansas	North Carolina
Alaska	Maryland	Oklahoma (ALC)	Colorado (ACF)	Oklahoma (RCH)
Arizona	Massachusetts	Oregon	Connecticut (RCH)	Pennsylvania
California	Michigan	Rhode Island	Florida	South Carolina
Colorado (ALR)	Minnesota	South Dakota	Georgia	West Virginia (ALR)
Connecticut (ALSA)	Montana	Tennessee	Idaho	
Delaware	Wyoming	Texas	Illinois (SLF)	
District of Columbia	Nebraska	Utah	Indiana	
Hawaii	Nevada	Vermont	Iowa (RCF)	
Illinois (ALF, SHE, SCF)	New Hampshire	Virginia	Maine (RCF/PNMI)	
Iowa (ALP)	New Jersey	Washington	Mississippi	
Kansas	New York (ALR)	West Virginia (RCC)	Missouri	
Kentucky	North Dakota	Wisconsin	New Mexico	
Louisiana			New York (AH, EHP)	
Total: 40			**Total: 19**	

ACF = alternative care facility; AH = adult home; ALC = assisted living center; ALF = assisted living facility; ALP = assisted living program; ALR= assisted living residence; ALSA = assisted living service agency; EHP = enriched housing program; PNMI = private nonmedical institution; RCC = residential care community; RCF = residential care facility; RCH = residential care home; SCF = sheltered care facility; SHE = shared housing establishment; SLF = supportive living facility.

[a] No minimum staffing level ratios required. Number of staff must be adequate to meet resident needs.

Note: Some states have different requirements for different residential care licensure categories.

Source: RTI analysis of the *Compendium of Residential Care and Assisted Living Regulations and Policy, 2015 Edition* (Carder, O'Keeffe, & O'Keeffe, 2015).

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immediately available, but they are not required to be awake; in Type B facilities, night shift staff must be immediately available and awake, regardless of the number of licensed beds.[2]

Minimum Staff-to-Resident Ratios

Nineteen states specify minimum staffing ratios, usually for direct care staff, but some specify staffing ratios for nursing staff as well. About half of these states specify different direct care staff-to-resident ratios depending on the work shift. For example, Missouri requires (a) 1:15 direct care staff-to-resident ratios during the day shift, 1:20 during the evening shift, and 1:25 during the night shift; and (b) the employment of a licensed nurse, whose required hours are based on the number of residents: 8 hours per week for 3 to 30 residents, 16 hours per week for 31 to 60 residents, 24 hours per week for 61 to 90 residents, and 40 hours per week for more than 90 residents.

Arkansas, Florida, New York, and North Carolina have very detailed requirements for staffing ratios. New York varies case manager hours based on the number of residents. West Virginia is unique in requiring ratios of direct care staff based on the number of residents who have two or more of the following care needs: dependence on staff for eating, toileting, ambulating, bathing, dressing, repositioning, special skin care, or one or more specified inappropriate behaviors that reasonably require additional staff to control.

Training Requirements

Staff training requirements are an important topic because a skilled, qualified workforce can improve residents' quality of life and care (Harahan & Stone, 2009). States' residential care regulations typically do not require training for licensed health care professionals, who are assumed to have the requisite training, but states generally require initial and ongoing training for administrators and direct care staff. However, the degree of specificity in direct care staff training requirements varies considerably. Some states' regulations require only that staff be "trained," whereas other states' regulations specify training requirements such as mandatory training topics, requisite training hours, time frames for completing orientation or initial training, approved training courses, or some combination thereof. Notably, although 47 states require initial training for direct care staff in at least one residential care licensure category, only 12 states specify an initial training requirement of more than 10 hours (Table 3).

Administrator Training

States specify varying initial orientation and training requirements for administrators, ranging from 6 to 70 hours. Florida's rules are among the most extensive, requiring administrators to complete a 26-hour core training course and pass an examination, covering a list of specified topics, which include licensure process, administrator duties, record keeping, residency requirements, food service, personal care and services, special needs populations (dementia, mental health, hospice), resident rights, and inspection and monitoring. Other states with detailed training requirements include Pennsylvania, Texas, and Washington.

Forty-four states require continuing education or ongoing in-service training for administrators or direct care staff. The number of annual continuing education hours required for administrators ranges from 6 to 30 (average 15.5 hours).

Direct Care Worker Training

States' requirements for direct care worker training similarly vary. As Table 3 shows, 47 states require an orientation or initial training for direct care workers employed by facilities licensed under any of the state's residential care licensure categories, with the number of required hours ranging from 1 (Missouri) to 80 (North Carolina).

North Carolina requires adult care home direct care staff to complete an 80-hour personal care training and competency evaluation program established by the state that includes 34 hours of classroom instruction and 34 hours of supervised practical experience. The competency evaluation covers

[2] In Texas, assisted living facility licensure type—A or B—is based on residents' capability to evacuate the facility. Any facility that advertises, markets, or otherwise promotes itself as providing specialized care for persons with Alzheimer's disease or other disorders must be certified as such and have a Type B license.

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Table 3. Direct care worker training requirements, by state

No training requirement	Training required, but hours are unspecified		1–5 hours	6–10 hours	11+ hours
Mississippi[a]	Alabama	Minnesota	Maryland	California	Idaho
North Dakota[b]	Alaska	Montana	Missouri (RCF)	Connecticut (ALSA)	Louisiana
Pennsylvania (PCH)[b]	Arizona	Nebraska	Nevada	Florida	Massachusetts
Tennessee[b]	Arkansas	New Hampshire		Oklahoma (RCH)	Missouri (ALF)
Vermont (RCH)[b]	Colorado	New Jersey			New Mexico
	Connecticut (RCH)	New York (AH, EHP)			New York (ALR)
	Delaware	Ohio			North Carolina
	District of Columbia	Oklahoma (ALC)			Pennsylvania (ALR)
	Georgia	Oregon			Rhode Island
	Hawaii	South Carolina			Texas
	Illinois	South Dakota			Virginia
	Indiana	Utah			Washington
	Iowa	Vermont (ALR)			
	Kansas	West Virginia			
	Kentucky	Wisconsin			
	Maine	Wyoming			
	Michigan				
Total: 5	**Total: 33**		**Total: 3**	**Total: 4**	**Total: 12**

AH = adult home; ALC = assisted living center; ALF = assisted living facility; ALR = assisted living residence; ALSA = assisted living service agency; EHP = enriched housing program; PCH = personal care home; RCF = residential care facility; RCH = residential care home.

[a] Training requirement is limited to quarterly training/continuing education requirement.

[b] Training requirement is limited to annual training/continuing education requirement.

Notes: Table reflects orientation/initial training requirements for direct care staff. Some states have different requirements for different residential care licensure categories.

Source: RTI analysis of the *Compendium of Residential Care and Assisted Living Regulations and Policy, 2015 Edition* (Carder, O'Keeffe, & O'Keeffe, 2015).

observation and documentation; basic nursing skills, including special health-related tasks; personal care skills; cognitive and behavioral skills, including interventions for individuals with mental disabilities; basic restorative services; and residents' rights.

Forty states—including the five states that do not specify an orientation or initial training requirement for all residential care licensure categories—require continuing education or in-service training for direct care workers, ranging from 4 to 16 hours per year.

Licensed Health Care Professional Training

Most states exempt licensed health care professionals from residential care–specific training requirements. However, a few states require licensed health care professionals to receive training in the care of geriatric populations. For example, Texas requires facilities to provide annual in-service training for licensed nurses, certified nurse aides, or certified medication aides on one or more of several suggested topics, including the following:

- Communication techniques and skills useful when providing geriatric care (including skills for communicating with the hearing impaired, visually impaired, and cognitively impaired; therapeutic touch; and recognizing communication indicating psychological abuse)
- Geriatric pharmacology (including treatment for pain management, food and drug interactions, and sleep disorders)
- Common emergencies of geriatric residents and how to prevent them (including falls, choking on food or medicines, and injuries from restraint use; recognizing sudden changes in physical condition, such as stroke, heart attack, acute abdominal pain, and acute glaucoma; and obtaining emergency treatment)
- Ethical and legal issues (including advance directives, abuse and neglect, guardianship, and confidentiality)

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Background Checks

Because RCSs serve vulnerable residents with physical or cognitive impairments, ensuring their safety is a major concern for states. States require background checks for RCS staff, although the requirements vary greatly regarding the extent of checks required. States most often require background checks for administrators and direct care workers, and some also require checks for volunteers and contractors who work in the facility.

Many states require a criminal background check (often with fingerprinting) and the checking of statewide nurse aide abuse registries, but some states provide more extensive requirements specifying how the check is to be conducted. For example, in Florida, all assisted living facility owners (if individuals), administrators, financial officers, and employees must have a criminal history record check, including a fingerprint search through the Florida Department of Law Enforcement and the FBI to determine whether screened individuals have any disqualifying offenses. An analysis and review of court dispositions and arrest reports may also be required to make a final determination. All individuals who are required to have an initial background screening must be rescreened every 5 years. New Jersey also has extensive background check requirements.

The timing of criminal background checks is of concern because an employee without a criminal history could acquire one during his or her employment tenure. Some states require periodic criminal background checks on current employees. Additionally, several states, including Georgia, require owners, administrators, and other employees to self-report criminal charges and convictions to the licensing agency. The effectiveness of this approach is unknown.

Some states permit exceptions to criminal background screening requirements. For example, Missouri RCSs may hire individuals with certain felony convictions if the facility obtains verification from the Department of Health and Senior Services that a good cause waiver has been granted. Wisconsin has a Rehabilitation Review process by which caregivers convicted of certain offenses may request a formal review that may result in their being permitted to work in a community-based residential facility (Wisconsin Department of Health Services, 2016).

Staffing Provisions for Residents With Dementia

Policymakers, researchers, and providers recognize that persons with dementia require specialized care (Lines, Ahaghotu, Tilly, & Wiener, 2014). Regulatory requirements for dementia care in RCSs are of major policy interest because nearly 40 percent of RCS residents have Alzheimer's disease or another form of dementia (Harris-Kojetin et al., 2013).

RCSs have developed and promoted separate units or programs designed to meet the special needs of persons with dementia. In 2010, 14 percent of people in RCSs lived in special care units or in facilities that only served people with Alzheimer's disease (Wiener, Feng, Coots, & Johnson, 2014). States have developed rules and regulations for such units and programs, including dementia care staffing and staff training requirements, although the level of detail varies widely among states.

Dementia Care Unit Staffing Requirements

The majority of states have very general or nonspecific staffing provisions for their dementia care units. Several states' provisions simply reference the state's general residential care staffing requirements and do not require additional staffing for these units; several states' only specific requirement for their dementia care units is the presence of at least one awake staff person or staff "sufficient" to meet resident needs. However, seven states specify that an RN must be available a minimum number of hours,[3] and seven states require an additional manager or administrator for a dementia care unit that is not a stand-alone facility.[4] A few states have detailed requirements for dementia care units. For example, North Carolina

[3] The seven states that do specify that an RN must be available a minimum number of hours are Alabama, Arkansas, Mississippi, New Jersey, Rhode Island, West Virginia, and Wyoming.

[4] The seven states that require an additional manager or administrator for a dementia care unit that is not a stand-alone facility are Alabama, Illinois, Indiana, Massachusetts, Nevada, Oregon, and Texas.

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specifies minimum staff-to-resident ratios and a resident care manager. West Virginia requires that

> [s]pecial care units and programs must have a staff person with experience and training in dementia care to coordinate outside services, offer monthly educational and family support meetings, and advocate for residents. Staffing patterns must enable the facility to provide 2.25 hours of direct care time per resident per day. At least two staff must be present for units serving more than five residents. An RN must be available if residents require nursing procedures. Appropriate activities must be provided by a therapeutic specialist, occupational therapist, or activities professional. (Carder, O'Keeffe, & O'Keeffe, 2015, p. 37)

Dementia Care Unit Staff Training Requirements

People with dementia require staff who are trained to address their specific health and behavioral care needs. All but six states have staff training requirements for dementia care units (Table 4).[5] Most training requirements—including orientation, initial training, and continuing education—are for unlicensed direct care staff, but some states also require training for other staff, including licensed professionals and administrators.

[5] The six states that do not have specific staffing training requirements for dementia care units are Alaska, Arizona, District of Columbia, Hawaii, Michigan, and North Dakota.

Twenty-three states specify the number of hours of initial training or orientation required for staff who work in dementia care units; the number of hours ranges from 2 to 30; of these, 18 states require at least 6 hours of initial training. Most of the states that specify the number of training hours also specify continuing education, ranging from 2 to 12 hours annually.

The specificity of required training topics varies across the states. In Illinois, training must cover the following topics: encouraging independence in and providing ADL assistance; emergency and evacuation procedures specific to the dementia population; techniques for successful communication and minimizing challenging behaviors; residents' rights and choice for persons with dementia; and caregiver stress and working with families.

Arkansas has very detailed dementia staff training requirements, including 30 hours of training on the following topics: (a) policies (1 hour); (b) etiology, philosophy, and treatment of dementia (3 hours); (c) stages of Alzheimer's disease (2 hours); (d) behavior management (4 hours); (e) use of physical restraints, wandering, and egress control (2 hours); (f) medication management (2 hours); (g) communication skills (4 hours); (h) prevention of staff burnout (2 hours); (i) activities (4 hours);

Table 4. General orientation/initial training requirements for dementia care unit staff, by state

No training requirement	Hours unstated		1–5 hours	6–10 hours	11+ hours
Alaska	Alabama	New York	Florida	California	Arkansas
Arizona	Delaware	Oklahoma	Maryland	Connecticut[a]	Colorado[b]
District of Columbia	Georgia	Oregon	Missouri	Iowa	Idaho
Hawaii	Kansas	South Carolina	Nevada	Louisiana[a]	Illinois[a]
Michigan	Kentucky	South Dakota	Ohio	Massachusetts	Indiana[b]
North Dakota	Mississippi	Tennessee		Minnesota	Maine
	Montana	Utah		Pennsylvania	North Carolina
	Nebraska	Vermont		Virginia	Rhode Island
	New Hampshire	Washington			Texas[a]
	New Jersey	Wisconsin			West Virginia
	New Mexico	Wyoming			
Total: 6	**Total: 22**		**Total: 5**	**Total: 8**	**Total: 10**

[a] Reflects orientation/initial training requirements for direct care staff in dementia care units.

[b] Reflects orientation/initial training requirements for administrative staff in dementia care units.

Source: RTI analysis of the *Compendium of Residential Care and Assisted Living Regulations and Policy, 2015 Edition* (Carder, O'Keeffe, & O'Keeffe, 2015).

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(j) ADLs and individual-centered care (3 hours); and (k) assessment and individual service plans (3 hours).

Conclusions

RCSs provide an important type of congregate community-based care for people with physical and cognitive impairments. RCS staffing is an important policy issue because staff are expected to meet residents' functional and health needs and thus, have a significant impact on their health and well-being (Stone & Harahan, 2010). Because states regulate RCSs, staffing requirements vary considerably across the states. Consumers and regulators need to be aware of the state variance in staffing requirements and to assess whether licensed nursing and unlicensed aide staffing requirements are adequate to meet residents' needs. Of course, RCSs may provide staffing levels above those a state requires, but state requirements set important minimums for the type of staff, the level of staffing, and staff training. These minimum standards are the basis for state monitoring of RCSs.

This analysis of state licensure standards raises several important issues about staffing in RCSs that predominately serve older adults and working-age people with physical disabilities. Although a substantial number of people with disabilities and chronic conditions live in RCSs, about a quarter of states do not require these settings to hire or contract with RNs. In 2013, the National Study of Long-Term Care Providers found that fewer than 50 percent of RCSs employed an RN (Harris-Kojetin et al., 2013). Although the expertise of RNs is not necessary to provide the direct care required by most RCS residents, RN oversight of tasks such as medication administration can help ensure quality care (Young, Sikma, Reinhard, McCormick, & Cartwright, 2013).

Closely related to the issue of the availability of nursing personnel are states' approaches to ensure adequate staffing levels. Only 19 states specify minimum staff-to-resident ratios—usually for direct care staff—that require a certain number of staff or staff hours per resident. The other states have less specific requirements, generally stipulating only that staffing be "sufficient" to meet residents' needs. Despite such imprecise and subjective requirements, research indicates that more disabled residents reside in RCSs with higher staffing to resident ratios, although the mechanism by which this sorting occurs is not clear (Khatutsky et al., 2013). Importantly, there are no studies that provide an empirical base for setting minimum staffing ratios in RCSs, especially standards that would be linked to the RCS casemix.

Of course, high-quality care depends not only on an adequate number of staff but also on adequate skill. Thus, training—especially of direct care workers—could be a key strategy for ensuring quality of care in RCSs, as well as other LTSS settings (Institute of Medicine, 2008). States' training requirements for direct care workers in RCSs are much less stringent than federal standards for certified nurse assistants in nursing homes or home health aides in home health agencies, which require a minimum of 75 hours of training. Twelve states require 11 hours or more of training. The other states require either (1) no initial training, (2) some training without specifying a number of hours, or (3) 10 or fewer hours of training. The widespread lack of training requirements raises the question of whether direct care workers have the knowledge and skills needed to provide high quality care to residents. High staff turnover, especially among direct care workers, adds to the difficulty of maintaining a trained and experienced workforce (Zuckerbraun et al., 2015).

Training is particularly important because of the high percentage of people in RCSs who have cognitive impairment and dementia and who live in dementia special care units (Wiener et al., 2013). While all but six states have some training care requirements for dementia care units, only a few have detailed requirements. Generally, states use the same approach they use for overall staff training requirements: lacking in specificity and requiring less training than is required of certified nurse assistants and home health aides.

A final staffing issue relates to the need for states to ensure the safety of vulnerable residents with physical and/or cognitive impairments and chronic health conditions. Many states require background checks for RCS staff, although the extent of these requirements—the type of staff for which they are

required, the use of state and national criminal databases, and the frequency of checks—vary greatly.

As the population ages and more people need LTSS, RCSs are likely to play an increasingly important role as the LTSS delivery system shifts from the provision of care in nursing homes to home and community-based services. State licensure standards regarding staffing will play a major role in determining whether these settings are able to meet their residents' needs.

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