So, we took a ratio to see how they were related to outcomes. And for nursing home outcomes as I indicated, low is good and the lower the better is reflective of better care.

We selected... Now, I know there's some controversy about what's nursing-sensitive, what's CNA sensitive, and we look for things that had at least some intersection between the two. We used ADLs, falls with injury, and pain and I have the definitions on here, but the idea was that you don't want

might have to interface with a nurse at some kind of medication is needed, but it's uninvolved...

It's a CAN-involved function, not necessarily to fully assess it and treat it, but to identify Mr. So-and-so is distressed or whatever the basic characteristics are. So, we felt that these would be a good reflection of quality. Now, for the nursing home control variables, these are things that can affect the relationships that I'm studying, the training hours and the outcomes.

These are things that have been shown to affect outcomes by themselves and potentially, could be ity size, which is usually done as bed size and case mix. So, if you have a much sicker population, you might have some more of the outcomes and the idea is to smooth these all out so we don't have to say, "Well those nursing homes, you know, were having very, very difficult kinds of populations and this way, we kind of, can say we took care of those things in the models."

So, here's some sample data. The total hours, I talked about how they were very diverse across the groups. The total hours ranged from 75 to 180. So, 75, again, is that minimum. And states have increased it, you know, over twice. The average was 100 hours for the initial training.

The clinical hours were averaged 40 hours. So, even though 16 is required, I think what has happened is many states have recognized that just more is needed, especially if you think about nursing homes having sicker and sicker people that they're taking care of in many instances. While I'm looking at the long-term care population with significant nursing needs, in many cases, they've gotten more ill over time and there's more complexity and comorbidities than there used to be.

Now, I'm not talking about the short-stay people that might have, say, heart surgery and come into a nursing home, it's still that long-term care population, but they have shifted. They're also older on average than they used to be as well. So, the second chunk I have here is talking about how the nursing homes fell in terms of the regulations. So, one-third of the nursing homes were in states that had minimum training hours and that 19 states were the minimum for either the clinical or total.

I think 15 states now have the minimum for to(7(7(s) think 15 stes noesh

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So, I think I did see one that was 85 and went back to 80, but that was not so recent. So, it seems like there is an impetus to increase it. Yes. - [Woman 4] I'm not sure. The question you're asking is how do you do it and generally it's through the rules process.

- Yeah. Well, kind of I mean there's a [inaud - Yeah. I don't see that changing very soon. - [Crosstalk]

- Yeah. That over 87, it's been there, well, since '87, so.

- Is that so? How do you make that happen, I guess, is my question. - [Crosstalk]

- It's mostly going on at the state level, I think. Yeah, but that's not to say, it shouldn't.

- On the federal level, what...the requirement is, the 20% of the 75 hours?

- Yeah, it is. The requirement is a 75, at least. They're both minimums and 16 must be clinical. And then there's some competencies that go along with it. There's a set of things you have to cover and there is a curriculum.

- So, when that was instituted, it was in the '80s, you said? Nineteen-eighty-seven.

- Nineteen-eighty-seven.

- Nineteen-eighty-seven. I was thinking on the federal level, somebody should look at that patient that went into a nursing home in '87and the complexity of that patient compared to the complexity of the patients...

- 've continuously advocated for that.

- It's a lot different.

- It is.

- No one even looks at that or cares about that?

- Oh, I think people do and I don't think I've ever written anything without continuously advocating for that and in person as well. But the way I look at it is, from what I understand, it's not something that's going to be changing soon at that level, but I feel like by putting it out there, a lot of states have

has.

You know, it's far enough along now. So...

- receive federal funding only. Those are the minimums that I understand.

- Medicare and [inaudible].

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- Most of the programs that we have in Washington are not nursing home. They're private. So, we can do that through rules.

- So, for Illinois, a CNA must have 40 clinical hours and 80 didactic hours. In order to be on the CNA register.

- So, that would be, you know, one of the higher. That's 120, so that's considered one of the higher ones.

- Yeah, it's not enough.

- Yeah. Well, everybody feels like it isn't enough. Many do see the European examples and they're way higher, so...

- I was just wondering if we had thought about using the current [inaudible].

- We did, but I have used the high-risk pressure ulcers in a number of hospital studies. It doesn't seem to work as well for us in the nursing home. I'm not exactly sure why. It doesn't always show a clear-cut relationship, but obviously, those are dreadful things to occur.

I'm not sure why, I don't know if anyone.

- It is more infrequent.

- It isn't it? Well, they have the high-risk category. It isn't the frequency... There's just something about it does not always relate as one would think it. I've had some studies where those have been higher with less care. So, they're kind of paradoxical. I'm not really sure what it is with that particular indicator, but that's why.

And I have used it in some of the hospital data, though, and we just basically didn't find support for the hypothesis. They're included in the data and the table, but they don't seem to ever go that way. So, interesting. Now, the other thing that comes up with pressure ulcers as an outcome in nursing homes, is a lot of times people come to the nursing homes with it or because they have it and it's not healing.

So, you get these issues of, well if they came in with it, sort of like the present on admission and then, that to me, is my sense of why it is all muddled. But I don't know for sure. It's just a guess. -

[Man] I think I have [inaudible] question about your issue. Do you think that that's driven primarily by [inaudible], like, positive association increase in clinical hours? Or are you even curious to why that is?

- It could be, but I think there were enough places that have that, the clinical preponderance and that oking at

something that, you know, looks a little different, but I think that's what I came down to. Is that it really