

Staffing Ratios in a Workforce Crisis

Why Nursing Facility Policy Must Move Beyond Headcount

EXECUTIVE SUMMARY

Nursing facilities are operating inside a structural staffing crisis. The aging population is growing, resident acuity is rising, and the available workforce is not expanding fast enough to meet demand through traditional hiring alone. In that environment, it is not serious policy to say only: hire more staff.

The federal ratio mandate has been vacated, suspended by Congress, and slated for rescission. The decisive policy choices now move to the states. The question those states face is not whether to repeat the federal formula. It is whether to build something better.

This brief proposes the answer: a *Care Capacity Framework*—an eight-point model that preserves staffing as an essential measure of quality while recognizing that resident care depends on more than raw headcount. The goal is not to abandon accountability. It is to build accountability that produces care.

About the Aging Services Institute

The Aging Services Institute (ASI) is a think tank dedicated to driving policy reform, challenging conventional narratives, and advancing sustainable solutions across the senior care sectors.

The Workforce Crisis Is Structural, Not Temporary

The nursing facility sector is not dealing with a temporary staffing inconvenience. It is facing a structural workforce problem, and the evidence is not ambiguous.

Turnover alone makes the point. CMS payroll-based data show the average nursing home experiences total nurse staff turnover above 53 percent a year, with registered nurse turnover near 52 percent.¹ For certified nurse aides—the most common caregivers in nursing homes—peer-reviewed research using CMS payroll data found mean annual turnover exceeding 129 percent.² A facility that replaces most of its direct-care workforce every two years is not understaffed by accident. It is operating inside a broken labor market.

Turnover is not just a symptom of the crisis. It is itself a driver of poor quality—and the evidence shows it operates independently of staffing volume. A CMS-funded study using auditable Payroll-Based Journal data found that, after adjusting for staffing levels and other facility factors, nursing homes with high total nurse staff turnover were significantly more likely to hold a one-star quality rating and significantly less likely to hold five stars.³ Retention, not raw headcount, is the more reliable predictor of quality.

The supply side offers no rescue. An estimated one million nurses are expected to leave the workforce by 2030 as the baby-boom generation retires. Meanwhile, in 2025, the American Association of Colleges of Nursing reported that more than 93,000 qualified applications were turned away from U.S. nursing programs—not for lack of interest, but because of faculty shortages, limited clinical placements, and budget constraints.⁴ The supply pipeline cannot be expanded by regulatory command.

Providers themselves report the strain in stark terms. A 2024 national survey found that nearly all nursing homes continued to face staffing shortages, with nearly half reporting high-level shortages and more than a quarter of residents at risk of displacement if the federal mandate had taken effect.⁵ A mandate to hire workers who do not exist does not produce care. It produces noncompliance, agency dependence, wage inflation, access restrictions, facility closures, or administrative gamesmanship.

A Ratio Counts Hours. It Does Not Count Care.

A staffing ratio assumes the central question is how many staff hours appear on a report. But a nursing facility is not a spreadsheet. It is a 24-hour care environment, and two facilities with the same ratio can produce very different resident experiences.

At one facility, nurses and aides may spend substantial time on duplicative documentation, manual reporting, inefficient communication, supply searches, redundant compliance tasks, and workarounds forced by outdated infrastructure. At another, modern workflows and better building design let staff spend that same time with residents. A ratio treats those two facilities as equivalent. They are not. One has more friction. The other has more care capacity.

The serious position is not “more staff” as an abstract demand. It is this: use every available tool to increase the amount of timely, human, resident-facing care actually delivered. A modern quality system should examine whether a facility has built a system that converts available labor into meaningful resident support.

The ratio model compounds this problem by drawing the boundaries of “staffing” too narrowly. Residents experience care through a full ecosystem of daily touchpoints: nursing, aides, therapy, dietary, housekeeping, social services, activities, maintenance, transportation, pharmacy, medical direction, respiratory therapy, behavioral health, and administrative support.

That ecosystem also includes outside providers physically present in the building: hospice nurses and aides, dialysis providers, therapy contractors, wound care consultants, behavioral health clinicians, mobile diagnostic providers, podiatrists, dentists, optometrists, pharmacy consultants, and lab personnel. Their work does not eliminate the facility’s responsibility to provide nursing care, but it does shape the real care environment residents experience.

From the resident's perspective, the question is not whether a caregiver is on the facility payroll. The question is whether that person is present, qualified, coordinated, and contributing to the resident's care.

There is a useful way to name what this fuller ecosystem produces: *observational capacity*—a facility's real capacity to monitor residents, detect changes in condition, and intervene before a decline becomes a crisis. Skilled nursing facility 30-day all-cause readmission rates held near 19 percent—across 16,631 facilities—for three consecutive years, with mean rates of 19.8, 19.5, and 19.4 percent in 2013, 2014, and 2015 respectively.⁶ A rate that stable across that many facilities is not random variation. It is a structural result—a measure of the gap between the level of care a resident needs and the observational capacity a facility is funded and equipped to provide.

CMS then proved the point. When CMS launched the SNF Value-Based Purchasing program, it withheld 2 percent of SNF Medicare payments—effectively widening the reimbursement gap—and required facilities to earn those dollars back through performance scores. The program was not an incentive. It was a cut with a conditional rebate. The predictable result: readmission rates did not fall further. They rose. A policy built around payment penalties, without addressing the structural gap in observational capacity, produced exactly the outcome the gap predicts.

The Regulatory Framework Consumes the Capacity It Claims to Protect

Every unnecessary administrative task is a tax on care capacity. When nurses, aides, department heads, and facility leaders feed documentation systems, reconcile duplicative reports, complete low-value paperwork, or work around inefficient processes, that time comes from somewhere. Often, it comes from residents.

The scale of this tax is now well documented. The U.S. Surgeon General's Advisory on health worker burnout reports that nurses spend, on average, roughly 40 percent of every shift on documentation.⁷ A 2025 study at NYU Langone Health found nurses spent an average of 31 percent of a 12-hour shift documenting in electronic flowsheets alone—before narrative notes, handoffs, or charting that spills past the end of the shift.⁸ A large and growing share of scarce clinical labor is consumed before it ever reaches a resident.

That burden is not fixed. When one health system streamlined its documentation requirements, it cut documentation time by 15 percent for intensive-care nurses and 22 percent for medical-surgical nurses—recovering roughly 30,000 hours of nursing time for direct patient care in a single year.⁹ Those hours were not hired. They were freed.

Technology and artificial intelligence are the mechanism for freeing them at scale. Real deployments now produce measured results:

- Intermountain Health's pilot of ambient documentation with nurses set out to cut documentation time per patient from eight minutes to four, with the explicit goal of raising nurses' time at the bedside from 37 percent to 41 percent.¹⁰
- At Bon Secours Mercy Health, nursing leaders reported time savings of roughly 20.6 minutes per nurse across a 12-hour shift after deploying automated documentation.¹¹
- A 2025 JAMA Network Open study found that clinicians using ambient AI documentation spent 8.5 percent less total time in the electronic health record and more than 15 percent less time composing notes; self-reported burnout fell from roughly 52 percent to 39 percent.¹²
- Over one year, The Permanente Medical Group's ambient AI scribes produced documentation time savings of more than 15,700 hours among users—the equivalent of 1,794 working days.¹³

The lesson for policy is not that any technology purchase deserves reward. It is that technology which demonstrably frees clinical time effectively creates care capacity—and a regulatory framework that ignores these tools while adding documentation mandates is not protecting residents. It is taxing the people who care for them.

Physical Plant Is Also a Workforce Strategy

Infrastructure affects staffing. A poorly designed building consumes labor: long corridors, poor sightlines, shared rooms, inefficient bathrooms, inadequate storage, outdated mechanical systems, and difficult resident-flow patterns all make care harder to deliver. In an outdated building, staff must overcome the physical environment. In a modern building, the environment supports care.

A large body of research demonstrates that single-occupancy rooms reduce the risk of acquiring and spreading infection, are associated with improved sleep and reduced agitation among residents with dementia, and correlate with fewer medication errors and adverse outcomes.¹⁴ A retrospective cohort study of 687 long-term care facilities in Germany found that a higher proportion of single-occupancy rooms was a statistically significant protective factor against resident infection.¹⁵ One review estimated that 31 percent of COVID-19 deaths in Ontario long-term care facilities could have been prevented had all residents been in single-occupancy rooms.¹⁶

Building design is also a staffing variable. Nursing staff report that single rooms support greater efficiency and make it easier to examine and care for residents.¹⁷ A facility that modernizes its building can increase effective care capacity without adding the same number of workers an inefficient building would require.

This is precisely the principle underlying ASI's *Structural Quality Standards (SQS)* framework, which treats the private room with a private bathroom as the non-negotiable entry condition for a modern facility. SQS is the mechanism through which physical-plant capability becomes an explicit, reimbursable component of quality. A care-capacity framework and a structural-quality framework are two halves of the same argument.

Government Must Modernize Alongside Providers

Government cannot impose outdated administrative burdens and then complain that facilities lack resident-facing staff. If the state wants better care, it must examine its own role in consuming care capacity.

Survey processes, reporting requirements, reimbursement rules, duplicative submissions, manual documentation expectations, and fragmented oversight systems all determine how staff time is used. The administrative state should adopt the same modernization principles it expects from providers: smarter data systems, automated reporting, risk-based oversight, reduced duplication, elimination of low-value paperwork, and a focus on outcomes rather than process accumulation. A modern staffing framework cannot operate inside an outdated regulatory machine.

Toward a Modern Care Capacity Framework

The alternative to crude staffing ratios is not the absence of accountability. It is better accountability. A Care Capacity Framework would evaluate how a facility converts available resources into actual resident support, preserving staffing as an essential component of quality while recognizing that resident care depends on more than raw headcount.

That question leads to an eight-point framework.

1. Require Workforce Availability Analysis Before Imposing New Mandates

A care-capacity model should begin with labor-market reality. Before adopting new staffing requirements, policymakers should analyze whether the relevant labor market can realistically supply the nurses, aides, therapists, and other personnel the mandate assumes.

A staffing mandate that ignores workforce availability can drive agency dependence, wage inflation, access restrictions, selective admissions, or closures—without producing a stable care workforce. The federal experience of 2024 and 2025 is the cautionary case: a national formula adopted without a credible workforce-supply pathway did not survive contact with the labor market or the courts.

2. Treat Administrative Burden Reduction as a Staffing Strategy

A care-capacity model should treat administrative burden as a direct threat to resident-facing care. Policy should require an administrative burden review before new staffing, quality, or reporting mandates are adopted, identifying which existing tasks can be eliminated, automated, consolidated, or reassigned.

A workable policy architecture emerges from this principle. Start with a baseline administrative burden assumption for the facility type — then apply structured credits: documented deployment of technology that reduces clinical documentation time; AI tools with demonstrated resident-facing time recovery; physical-plant configurations that reduce wasted staff movement; and ecosystem partnerships that expand onsite care coverage. The result is a *care-capacity score* — a facility-level measure of how effectively available labor converts into resident support. That is a fundamentally different question from how many staff appear on a roster. It is also the right question. Building policy around it requires real work. But it cannot be built at all without first accepting that headcount is the wrong unit of analysis.

A near-term funding pathway already exists. Civil Money Penalty (CMP) reinvestment funds—penalties collected from facilities and returned to states for projects that benefit residents—can support workforce enhancement, staff training, and technical-assistance projects. CMS’s September 2025 restructuring of the program expanded per-project funding limits and added workforce enhancement as a project category.

3. Reward Technology and AI That Increase Resident-Facing Capacity

A care-capacity model should recognize technology and AI as workforce strategies when they reduce administrative burden, improve communication, support clinical decision-making, or increase resident-facing time.

States should consider payment or quality credit for technology, automation, and workflow redesign — whether commercially licensed, custom-built, or developed in-house — that demonstrably expand care capacity. Here too, CMP reinvestment funds offer a proof-of-concept pathway. The September 2025 program restructuring updated the parameters for allowable technology projects, allowing states and providers to pilot care-capacity-expanding technology and measure its effect before that effect is built into payment or quality policy.¹⁸

4. Recognize Physical Plant as Part of the Workforce Equation

A care-capacity model should account for the building in which care is delivered. Policy should recognize infrastructure investments that improve care delivery—private rooms, better sightlines, efficient layouts, modern bathing and toileting areas, improved infection-control design, and configurations that reduce wasted staff movement.

Physical-plant modernization requires capital-scale financing tools—reimbursement policy, quality incentives, replacement-facility pathways, certificate-of-need flexibility, or structural quality credits. It is the direct point of intersection between this framework and ASI’s Structural Quality Standards: the building is not merely a capital question. It is a staffing variable.

5. Count—and Disclose—the Full Resident-Support Ecosystem

A care-capacity model should understand staffing holistically. Residents experience care through a full ecosystem of people—therapy, activities, dietary, housekeeping, social services, respiratory therapy, behavioral health, care coordination, hospice personnel, dialysis providers, wound care consultants, mobile diagnostics, pharmacy consultants, and others.

These personnel should not be invisible in quality policy. The workable mechanism is recognition and disclosure: facilities should report the onsite care partners involved in resident care so that regulators and families can see the full support picture. The dividing line is not the payroll. It is whether the person is present, qualified, coordinated, and contributing to the resident’s care.

6. Encourage Role Redesign Around Resident Need

A care-capacity model should encourage providers to redesign roles as technology and workflow improvements remove administrative work. If automation reduces documentation burden, facilities should be encouraged to redeploy that capacity into resident-facing support—mobility aides, hydration and rounding aides, family communication coordinators, resident concierges, or care navigators.

Policy should not freeze staffing models around legacy job categories when new roles can measurably improve resident safety, dignity, and quality of life.

7. Modernize Government Oversight Through Data and Risk

A care-capacity model should require the administrative state to modernize alongside providers. States should create regulatory modernization pilots allowing qualified providers to demonstrate compliance through automated data feeds, quality dashboards, and outcome reporting rather than duplicative manual submissions.

This does not mean less accountability. It means better accountability. The test is not how much paperwork a provider can produce, but whether regulators can identify risk, verify performance, and protect residents without unnecessarily consuming staff time.

8. Use Outcomes-Based Flexibility for High Performers

A care-capacity model should connect flexibility to performance. Facilities that demonstrate strong outcomes—stable workforce performance and low turnover, low complaint rates, low avoidable hospitalization where applicable, positive resident experience, and effective use of technology or infrastructure—should have flexibility to meet care-capacity expectations through multiple means.

Outcomes-based flexibility also does the framework's hardest analytic work. Role redesign, workflow change, and technology adoption resist direct isolated measurement. The solution is to measure what they produce: reduced administrative time and more direct, resident-facing care hours. Because low turnover is independently associated with higher quality, workforce stability is itself an outcome worth measuring and rewarding—not merely an input.

Conclusion: Residents Need Care Capacity, Not Ratio Politics

The nursing facility workforce crisis demands more than ratio politics. It demands honesty about labor scarcity and seriousness about care delivery. The country cannot meet the needs of an aging population by pretending that unlimited caregivers are available if government simply orders providers to hire them.

The federal ratio mandate has been vacated, suspended by Congress, and slated for rescission. That outcome is not a defeat for nursing facility quality. It is an opening. The real question—how to maximize resident-facing care capacity in a world where labor is scarce, acuity is rising, and administrative burden keeps growing—now belongs to the states.

State Medicaid agencies and legislatures should adopt the *Care Capacity Framework*: ground every mandate in workforce reality, treat administrative burden reduction as a staffing strategy, credit technology and physical-plant investment that demonstrably expand capacity, count the full resident-support ecosystem, modernize oversight, and reserve flexibility for facilities that prove their outcomes.

A staffing ratio in a vacuum is lazy policy. A care-capacity model is harder—but it is more honest, more modern, and more likely to improve resident life. Residents do not need policymakers to win arguments about inputs. They need a system that produces better care.

Sources and Notes

The notes below identify the sources for evidence cited in this brief. Several describe a source category rather than a single pinpoint citation; before publication, each should be resolved to a specific, linkable source with publication date and URL.

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