Warren Petryk

State Representative • 93rd Assembly District

Date: June 6, 2019

To: Members of the Senate Committee on Health and Human Services
From: Representative Petryk

Re: Testimony regarding Senate Bill 103 – Hours of Instructional Program for Certified Nursing Aids.

Good morning Chairman Testin and members of the committee. I appreciate this opportunity to come before you today to speak in favor of Senate Bill 103 which I authored with Senator Rob Cowles to help alleviate our state's rising shortage of skilled works in our long-term care facilities. I also want to thank Chairman Testin, Senator Kooyenga, and Senator Jacque for their support of this important piece of bipartisan legislation.

The lack of Certified Nursing Assistants or CNAs has been long felt in nursing homes and care facilities alike in my Western Wisconsin Assembly District and across the state. Certified Nursing Assistants or CNAs provide essential daily care to our veterans and the vulnerable aging population. With at least 1 in 5 caregiver positions currently unfilled in our state, this is a serious issue than needs to be addressed immediately.

Senate Bill 103 very simply brings Wisconsin's CNA instructional requirements in line with federal standards and those of our surrounding states of Michigan, Minnesota and Iowa. The bill does this without costing the state extra dollars in expensive incentive programs and is supported by the Mayo Clinic.

Federal law requires CNAs to have at least 75 hours of training. Currently, Wisconsin requires 120 hours of training. This has placed our state facilities at a significant disadvantage, especially with our border states which mirror the federal standard of 75 hours.

You will hear today how this bill would prohibit the Department of Health Services from requiring an instructional program to exceed the federal required minimum total training hours; this is quite untrue. Individual programs may choose to provide instruction in excess of the federal standards; however, that is up to the facility and facilitators.

You will also hear that the bill will lower the quality of care CNAs will provide. There is no evidence that longer training has impacted quality of care. Without an adequate workforce, it is very difficult for facilities to focus on advancing. With adequate staffing, I would argue that the quality of care offered will only increase.

Capitol Office: Post Office Box 8953 • Madison, Wisconsin 53708-8953 • Rep.Petryk@legis.wi.gov • (608) 266-0660 • **Toll-Free:** (888) 534-0093

It is important to note that the 2017 AARP State Scorecard Summary of Long-Term Services and Supports System Performance Report showed that our border state of Minnesota who abides by the federal CNA training hours is ranked 2nd highest for quality of care among all 50 states.

This small change to state statute will get these students into our facilities earlier, and help to fill the ever-growing demand for excellent, high-quality, caring professional men and women in the field of healthcare.

Let me make this perfectly clear, in order to practice as a Certified Nursing Assistant, you must pass the nurse aide competency examination, a federally required exam given in each state. The test remains the same regardless of if you have 75 hours of training or 120+ hours of training. The test sets the minimum requirements.

The Assembly version of this bill, Assembly Bill 76, has already passed the Assembly on a bipartisan vote of 66-31 on May 15, 2019.

Senate Bill 103 is a positive and much needed step toward addressing our state's skilled nursing shortage. I humbly ask for your support on this very important piece of legislation. Thank you for your attention to this important matter.

STANDING COMMITTEES:
Natural Resources & Energy, Chair
Transportation, Veterans, & Military Affairs

ROBERT L. COWLES
Wisconsin State Senator
2nd Senate District

JOINT COMMITTEES:
Audit Committee, Co-Chair

Testimony for 2019 Senate Bill 103

Senator Robert Cowles
June 6, 2019
Senate Committee on Health and Human Services

Thank you, Chairman Testin and Committee Members, for holding a hearing today on 2019 Senate Bill 103 (SB 103) regarding the hours of instructional program for Nurse Aides. I appreciate the opportunity to share my testimony on the importance of this legislation.

Certified Nursing Assistants (CNAs), or Nurse Aides, provide indispensable services to our disabled and elderly residents living in Wisconsin communities. Despite their value in the medical community and elder care, employers are finding it more and more difficult to recruit these workers for long-term care facilities, like nursing homes, for a variety of reasons.

As a result, some nursing homes are forced to turn away residents due to the lack of staffing necessary to provide the care for this vulnerable population. SB 103 will help address the shortage crisis of CNAs here in Wisconsin. This bill aligns Wisconsin's CNA training requirements to the federal requirement of 75 hours of instructional training for nurse aides, a reduction in training for Wisconsin CNAs of about 60 hours.

We have many unfilled caregiver positions in long-term care facilities here in Wisconsin. By mirroring the federal training requirements, SB 103 will help to introduce new CNAs in recruitment, training, and retention of Nurse Aides in Wisconsin. While the state has an interest in ensuring qualified CNAs enter the workplace, employment experts at the federal level and throughout many other states feel this instructional training requirement is sufficient. This legislation will also keep Wisconsin at a competitive advantage with our neighboring states of Michigan, Iowa, and Minnesota which all align their training standards with the federal standards. Additionally, no licensing instruction is more valuable that the training provided in the workplace, and this legislation does nothing to impact that crucial training outside of licensing.

Senate Bill 103 is supported by many long-term care facilities and home health care groups across Wisconsin. This bill is an important step forward to help the shortage crisis for CNAs in Wisconsin.

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disabilityrights | WISCONSIN
Protection and advocacy for people with disabilities.

Date: June 5, 2019

To: Senator Patrick Testin, Chair, Senate Committee on Health and Human Services, and Committee Members

From: Disability Rights Wisconsin – Barbara Beckert, Director, DRW Milwaukee Office

Re: 2019 SB 103

Disability Rights Wisconsin is the protection and advocacy system for people with disabilities in Wisconsin. In that capacity, we work with people with disabilities who rely upon well-trained certified nurse aides (CNAs) to assist with personal cares and daily tasks of living, while also providing emotional support.

We oppose SB 103 because we are concerned that lowering training requirements for certified nurse aides will affect the quality of care for people with disabilities in long-term and residential care facilities. Studies have demonstrated that increased training reduces job turnover while increasing job satisfaction.[1] Over half of the states in the U.S. have elected to require training over the minimum 75 hours required by the federal government, and the Institute of Medicine recommends expanding federal training requirements to 120 hours.[2]

Reducing the number of training hours is also unlikely to alleviate the long-term care workforce shortage in Wisconsin. Contributions to the workforce shortage may include but are not limited to: low pay, lack of or limited benefits, long and/or difficult hours, residents with more complex physical and behavioral health needs, and diminished availability of family caregivers.[3] These all place a strain on CNAs and may contribute to the workforce shortage.

We are encouraged by the establishment of a new Wisconsin Task Force on Caregiving. The Task Force on Caregiving is charged with analyzing strategies to attract and retain a strong direct care workforce, finding strategies to support families providing caregiving supports and services, and improving the quality of caregiving in Wisconsin. It is premature to move forward with such a significant change, reducing by nearly 40% Wisconsin CNA training requirements, prior to the convening of the Caregiver Task Force. At a minimum, we recommend that you delay consideration of this training hours change until after the Task Force issues its recommendations.

Thank you for considering our concerns regarding the reduction of required training hours. DRW remains committed to working with policy makers on solutions to Wisconsin's long-term care workforce shortage.

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[1] Han, K., Trinkoff, A.M., Storr, C.L., Lerner, N., Johantgen, M., Gartrell, K. (2014). Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis. International Journal of Nursing Studies, 51 (8), 1135-1141.

[2] Paraprofessional Healthcare Institute (PHI) (2016). Raise the Floor: Quality Nursing Home Care Depends on Quality Jobs. https://phinational.org/sites/default/files/research-report/phi-raisethefloor-201604012.pdf

[3] Paraprofessional Healthcare Institute (PHI) (2016). Raise the Floor: Quality Nursing Home Care Depends on Quality Jobs. https://phinational.org/sites/default/files/research-report/phi-raisethefloor-201604012.pdf

MADISON	MILWAUKEE	RICE LAKE	
131 W. Wilson St. Suite 700 Madison, WI 53703	6737 West Washington St. Suite 3230 Milwaukee, WI 53214	217 West Knapp St. Rice Lake, WI 54868	disabilityrightswi.org
608 267-0214 608 267-0368 FAX	414 773-4646 414 773-4647 FAX	715 736-1232 715 736-1252 FAX	800 928-8778 consumers & family

INTEGRO HEALTH

Waunakee, WI 53597

June 3, 2019

Dear Members of the Senate Committee on Health and Human Services,

Thank you for taking the time today to hear public testimony on Assembly Bill 76, legislation which would match Wisconsin's CNA hourly training requirements with the federal standard of 75 hours, including 16 clinical hours. We are administrators from long-term care facilities in your districts and we write today to encourage you to support this important legislation.

As administrators in Wisconsin nursing facilities, we are committed to providing excellent care to our frail elderly and disabled residents. But right now, providers across the state face a serious caregiver workforce shortage which, if left unaddressed, could severely limit access to care.

Many facilities are feeling the pinch as we are unable to find CNAs to fill needed shifts. This has led to many providers having to rely on current staff to work overtime to meet the needs of our residents, which can lead to burnout and more rapid staff turnover. Many providers also are forced to limit admissions – even though beds are available – because we don't have the CNA staff we need to care for more residents. It is never easy to tell a senior in need of care who has lived in the same community their entire life that they must look for care the next town over, or in some instances, hours away.

As administrators, we are responsible first and foremost for the health and quality of life of our residents. We care deeply about their wellbeing and we work to earn their trust during a period of their lives which is often difficult and emotional – for residents and their families. As Wisconsin's population continues to age, the legislature must act now to help address the CNA workforce shortage and ensure Wisconsin's seniors and disabled citizens are able to live with dignity and respect, receiving the care they need. Assembly Bill 76 is an important measure to help long-term care providers bring more CNAs on staff. The bill eliminates a current barrier for many applicants who may not be able to afford to pay for Wisconsin's current training hours and who certainly cannot afford to go many additional weeks without a paycheck for training classes.

As constituents and employers in your districts, we respectfully ask you to support this bill to help protect the vulnerable residents we serve. Thank you for your consideration.

Sincerely,

Integro Health

June 2, 2019

TO: Health and Human Services Committee

FROM: Kathy Hansen, RN, MSN Kathy Hansen

RE: Senate Bill 103 Reducing Nursing Assistant education to a minimum of 75 hours

I wish I could be present for the public hearing. Thank you for reading my position statement.

I am a RN with 36 years of experience, including 18+ years in nursing education. Although I am currently in a nursing faculty position at MATC, I am writing on my own behalf.

This bill falls dramatically short of accomplishing the goal the bill sponsors propose. It would not begin to solve the CNA recruitment and retention crisis; the loss of 45 hours of instruction would exacerbate the poor staffing situation. More importantly, decreasing the preparation for this challenging work would lead to diminished quality of care for vulnerable patients and residents, particularly the elderly. Who do you want taking care of your parents or yourself?

The state of Wisconsin continues to place over 750 people on the Wisconsin Nurse Aide registry each month. Nursing assistant programs, including the Wisconsin Technical College system, are getting the job done – we are offering nurse aide programs in many formats, students are passing their course and the competency exams, leading to placement on the nurse aide registry. There is not a "shortage"; there is a "recruitment and retention crisis". If employers could recruit and retain even 50% of the 750 newly qualified CNA's each month, their staffing crisis would end in very quickly.

Potential nurse aides have many options to complete the 120 hours of training. There are record numbers of students becoming a CNA while in high schools with grant funding at no additional cost to the student. The WisCaregiver program is funding the full cost for students with guaranteed employment following completion; the WTSC offers the lowest cost tuition; private programs continue to fill their seats with students. Wisconsin State health care facilities, for example Mendota Mental Health and Central Wisconsin, hire students as employees and provide all training and competency testing in paid employee status. Work Force Development and Centro Hispano offer tremendous financial and academic support for success. These programs may include online learning; evenings and weekends hours, and accelerated formats to choose from, which allow students to meet their current job, family, and other school commitments.

The challenge for employers is to recruit and retain them in their facility. Senate Bill 103 offers nothing to support the real barrier issues, such as salaries and

working conditions. Salaries of $11-15/hour (or less) are insufficient for the physically and emotionally demanding work of the nursing assistant. Students do take the nurse aide training for pre-requisites for other programs, BUT then do not take on a CNA position because other employment options are much more lucrative and accommodating to their school schedules. Retention is challenging with the revolving door of all levels of nursing staff, creating a constant stream of new people without strong resources to guide them as they transition into their new role. CNA's are commonly forced to work double shifts and work short staffed. These are the "burdensome" issues; not the 120 hours of educational training.

Proponents of the bill state the exiting of nurse managers from long term care facilities is at an all time high; yet they also indicate nurse managers are pivitol to provide the critical support to new CNA's (and can replace education). It doesn't make any sense. The CNA needs to enter the employment facility as best prepared as possible, because the demands and conditions of the job are not conducive to replace 45 hours of education.
The majority of states require over the federal minimum of 75 hours. This minimum of 75 hours was established back in 1987, because prior to that there were no standards. Health care was very different in 1987 – I was there! Experts on care of the elderly indicate we should have been ***steadily increasing*** the minimum number of hours over the decades.

CNA's from any state requiring less than 120 hours have several options. They may complete a 45 hour bridge program to meet the 120 hours; they can demonstrate they have worked for 2088 hours in the previous 24 months and be placed on the Wisconsin Nurse Aide Registry. There are viable options; this is not the defining cause of the staffing crisis in nursing.

People in Wisconsin invest in the Wisconsin Nurse Aide training program and employment as they also realize our 120 hour standard increases their options for the unpredictable future when they may find themselves moving out of state. No one wants training that leaves you ineligible for employment in other states.

Decreasing the number of hours required will not increase the number of CNA's ready for work. It will not contribute to solving the staffing crisis. A reduction of 45 hours will most likely result in (1) fewer people passing the required competency testing (the written and performance tests will be the same) (2) decreased preparedness to care for the elderly and cope with mandated double shifts and short staffing, (3) continued turnover of staff.

To the members of the Senate Committee on Health and Human Services:

Thank you for the opportunity to submit testimony for this public hearing. My name is Gale Barber. I live in Middleton, WI and am writing in opposition to Senate Bill 103, which would reduce the minimum required number of training hours for CNAs from 120 to 75. I understand this would be in line with a federal requirement that dates back to 1987.

I speak from the consumer side of services provided by CNAs. I currently have Healthcare Power of Attorney (POA) for two seniors:

- My mother, aged 97, who suffered a hip fracture approximately 2 years ago, had major surgery, 7 weeks of rehabilitation, and now lives in assisted living in Madison;
- A friend and former colleague, aged 86, who has heart disease, memory loss, and significant eye disease.

I also had health care POA for my aunt aged 90 who was undergoing rehabilitation in Illinois following 10 days of hospitalization for an infection and newly diagnosed heart disease; she then transitioned to hospice care in late March and died in a care home at the end of April.

The reality of the situation is that I spend hours a week managing their affairs and have witnessed first hand the impact well-trained, clinically competent CNAs can have on their well-being across the care continuum – in the hospital, in rehab and hospice, in assisted living, and in home care.

You well know that patients spend very little time in the hospital. My mother, then aged 96, was released to rehab within four days of breaking her hip and having a hip replacement. While in the hospital and in rehab, CNAs were the ones providing the first level of care. My mother was quite confused initially and in a great deal of pain. The CNAs were the ones who answered her call light, transferred her delicately from the bed to the wheel chair when she needed to use the restroom or have meals. These individuals probably made a little over what a barista makes and yet they were responsible for her care and for noticing and reporting any new signs and symptoms of deteriorating health status. I would invite you to complete two shifts of care (the clinical requirement in the proposed bill) to witness first hand what these individuals are called upon to do every day.

In the case of my dear aunt, there was the added element of preparing for death. CNAs are the ones with eyes on the patient 24/7 and are the ones noting changes in health status at end of life. This is a most precious time and needs staff who are educated and experienced in life changes.

Because costs of assisted living and nursing home care have skyrocketed so many seniors who require a lot of care opt to remain at home. Family and CNAs are again the ones on the front lines managing the health status of these individuals. All you have to do is spend time in a so-called "independent living facility" and you will see the level of independence of many of the residents. In the case of my friend who lives in independent living, home care assistants come to her home several times a week to set out her medications, record her vitals, prepare meals since she can not use the stove or oven because of her visual impairment, and take her out to run errands and buy groceries. Each client that a CNA cares for in the home has a unique set of illnesses and requirements. Seventy-five hours of training is not enough preparation. Again I would invite you to shadow a home care CNA for a day.

If anything, the way health care is going we should be putting much more education and clinical training in place for CNAs, not reducing their preparation. CNAs are an undervalued, critical component of health care institutions. They benefit from enhanced training and education to fulfill their role. I urge you to reject this bill.

Debora B. Klatkiewicz, NHA
Park Manor Quality Consultant
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TO: Members of the Senate Committee on Health and Human Services

FROM: Debora B. KLatkiewicz, NHA and Park Manor Quality Consultant

RE: Assembly Bill 76 relating to: Hours of instructional program for nurse aides.
SB 103

June 6, 2019

Thank you for the opportunity to speak with you today. My purpose here involves the provisions of this proposed legislation to match Wisconsin's Certified Nurse Aide (C.N.A.) hourly training requirements with the Centers for Medicare and Medicaid (CMS) federal standard of 75 hours.

Personal Background:

- Thirty-eight (38) years of experience in long term care at Park Manor Nursing Home. Until my retirement from day –to-day operations at the end of 2018, I served twenty-five (25) years as the Administrator of Personnel and Regulations. I currently serve as a quality consultant to Park Manor in areas similar to those I was responsible for during my active employment.
- Twenty-three (23) years on the Wisconsin Health Care Association Board including five (5) years as President. Extensive networking and contact with peers in the nursing home profession across the State of Wisconsin.
- An abiding and committed interest in the quality of care and quality of life provided to the residents of Park Manor and across the State of Wisconsin.
- I list my background not to be self-serving, but rather, credible.

C.N.A. Training Requirements:

In 1987 CMS enacted the first major revision of federal nursing home requirements of participation (ROP). Eventually that document provided requirements of instruction of C.N.A.'s of 75 hours. That requirement has not been changed since inception despite several revisions including a massive re-write initiated in 2016 with full implementation in 2020.

In 2008 the State of Wisconsin Department of Health Services chose to change that requirement for instruction to 120 hours. Many objections were raised at this time to no avail. To my recollection there was no empirical evidence that more hours of instruction would equate to a higher quality of care.

My professional objections at the time primarily were:

1. In my experience the 75 hours of instruction plus testing requirements were more than adequate to prepare C.N.A.'s for employment in long term care. The extensive – 10 days or more – one-on-one training the C.N.A.'s received in the employing facilities provided the hands on instruction with real life experience to solidify the class training. The one-on-one training occurs regardless of the length of instruction hours.

2. Workforce issues were already problematic in 2008. Attracting and retaining qualified C.N.A.'s was difficult. My overriding concern was that the increase in training hours would provide even more barriers to individuals who had an interest and an aptitude in being a C.N.A. attached to the increase in 35 hours of training requirements was a corresponding increase in costs and thus another barrier. In the past 11 years this has only become exponentially more difficult.
3. The outcome for existing nurse aide programs at the time was honestly in my opinion adding, "padding" if you will the existing and required areas of training to meet the 120 hour requirement.

Additional Information:

- Facilities strive and struggle to attract, train, and maintain qualified C.N.A.'s to provide the quality of care our residents both expect and deserve. The 120 hour instruction requirement does nothing to improve employment opportunities for facilities or individuals with potential to be incredible and dedicated caregiver. In fact a serious argument could be to the contrary.
- The training component of new employee C.N.AS.'s continue in skilled rehab and nursing facilities regardless of whether an employee is a newly certified C.N.A. or an experienced C.N.A. new to the facility, and regardless of the length of their instruction as a C.N.A. This training remains a critical and equally important part of employment as a C.N.A.

Conclusion:

I speak both for Park Manor and for my peers in the Wisconsin Health Care Association who have shared for years and at length their concerns regarding the instructional program for nurse aides and workforce issues as well. While we are all advocates and proponents of education and training for all of our employees, this particular development has proven to be onerous, costly, but more importantly unnecessary.

The dedication of the State of Wisconsin – caregivers, regulators, and legislators – is well known and respected. This legislation in its entirely promotes that dedication and reputation while bring fairness back to the table.

Thank you in advance for your support.

Respectfully,

Debora B Klatkiewicz NHA

Debora B. Klatkiewicz, NHA

WI Director *of* Nursing Council

WHCA / WiCAL
Wisconsin Health Care Association | Wisconsin Center for Assisted Living

LeadingAge Wisconsin
Better Services for Better Aging

WALA
Wisconsin Assisted Living Association

wamd The Wisconsin Society for Post-Acute and Long-Term Care Medicine

WACH
Wisconsin Association of County Homes

Disability Service Provider Networks

SUPPORT AB-76 / SB-103 – THE CNA TRAINING BILL

Wisconsin's long-term care providers request your support for legislation aligning the state's Certified Nursing Assistant (CNA) hourly training requirements with the federal standard of 75 hours

WHAT:

Last session, a bipartisan coalition of legislators introduced a bill to align Wisconsin's CNA hourly training requirements with the federal standard of 75 hours. The bill passed the Assembly with bipartisan support but did not pass the Senate before session adjourned.

WHY:

Workforce Crisis: Long-term care providers continue to struggle with an ongoing long-term care workforce crisis in Wisconsin. A recent provider survey found that 1 in 5 caregiving positions remains unfilled – a number that has gotten worse since two years ago, when a study found 1 in 7 caregiving positions unfilled.

In Wisconsin, facilities need individuals to come into the CNA profession. This proposal to align Wisconsin's CNA training requirements with the federal standard would be a significant step to addressing the long-term care workforce crisis through eliminating a barrier in the path to becoming a CNA.

Regional Fairness: Federal law has a minimum requirement of 75 hours of instructional training to be certified as a CNA. However, Wisconsin requires 120 hours of training. Wisconsin facilities are at a significant disadvantage; Michigan, Minnesota, and Iowa all mirror the federally-authorized standard of 75 hours.

Long-term care providers urge you to support legislation which would help alleviate the long-term care workforce crisis with no cost to the state.

BACKGROUND ON THE CNA TRAINING BILL

Federal law has a minimum requirement of 75 hours of instructional training to be certified as a CNA. However, Wisconsin requires 120 hours of instructional training. Wisconsin facilities are at a significant disadvantage with neighboring states; Michigan, Minnesota, and Iowa all mirror the federal standard of 75 hours.

Changing the CNA training requirement is an important step toward helping providers **address our state's long-term care workforce crisis.** The CNA Training Bill earned support from stateline border legislators on both sides of the aisle who have heard directly from providers that Wisconsin's current training requirements often serve as a barrier to employment, as employers across the border can offer a less burdensome training program for CNA prospects.

Aligning the Wisconsin CNA training standard with the federal requirement creates a clear standard for Wisconsin regulators and providers, as the bill's language aligns Wisconsin's standards with federal standards. If federal hourly requirement standards change, Wisconsin's hourly requirements must also change.

By helping address Wisconsin's long-term care workforce crisis, this proposal will help ensure quality advancement within provider facilities. Without an adequate workforce, it is very difficult for facilities to focus on advancing quality. This policy will help Wisconsin facilities have the staff to maintain quality care. Establishing a 75-hour training standard will address current personal time and resource barriers for prospective CNAs, resulting in more individuals becoming interested in pursuing a CNA opportunity. There clearly is a correlation between adequate staffing and the quality of care provided.

Consider neighboring Minnesota, which uses the 75-hour requirement: in certain quality measures, Minnesota long-term care providers outperform Wisconsin providers; in other measures, Wisconsin providers outpace their Minnesota counterparts.[1] The fact is, no single prevailing factor serves as a single solution for care quality, and each state has unique needs and demands that require different approaches.

Every CNA has to go through eight subject areas as a part of training and a certification test, and that will not change as a result of this proposal. Many facilities care for specific patient populations that require specialized care, and allowing CNAs to get on the floor sooner will help them receive the exact training they need while on the job and through continuing education training requirements.

Further, nothing about this proposal will force CNA training programs across the state to change their curricula. Programs that wish to provide additional training hours will still be allowed to do so; the bill simply prevents the Department of Health Services from *requiring* more than the federal standard.

Providers agree that aligning Wisconsin's CNA hourly training requirements with the federal standard will help address the workforce crisis, which will benefit residents by providing more CNAs to provide the care they need and deserve.

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[1] WI Department of Health Services Division of Quality Assurance – Bureau of Nursing Home Resident Care 2017 Data. View at https://www.whcawical.org/files/2019/02/2018-NH-Survey-Statistics.pdf.

Homme
Inc. of Wisconsin

Date: Thursday, June 6, 2019

To: Senator Patrick Testin, Chairperson
Members, Senate Committee on Health and Human Services

From: Stephen H Seybold, NHA
Executive Director, Homme Inc. of Wisconsin

[redacted]

Good afternoon Mr. Chairman and members of the Senate Committee on Health and Human Services. My name is Stephen Seybold, and I am the Executive Director of Homme Inc. of Wisconsin, a Northcentral Wisconsin provider of services to the elderly on two continuum of care campuses which are located in Wittenberg and Wausau. Our campuses include a wide variety of services including skilled nursing, short term rehab care, memory care for individuals with dementia, and assisted living services in both Community Based Residential Facilities and Resident Care Apartment Complexes. I have served in my current position with Homme since 1992 and served as a licensed Nursing Home Administrator since 1980. Prior to that time, I worked as a Certified Nursing Assistant (CNA) in a long-term care facility. My career has been developed and focused on serving the needs of the elderly, in both skilled nursing facilities and assisted-living facilities. Key to meeting the needs of those we serve is the ability to recruit and retain a sufficient number of trained staff. I am here to speak to the merits of Senate Bill 103,

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which is known as the CNA Training Bill. I urge you most strenuously to approve this bill and recommend it for passage. Please let me explain why that is.

For those of you that may be unfamiliar with the job duties of a CNA, please let me put it simply: your job is to help meet the physical, emotional, and psychological needs of elderly individuals, individuals who look to you to provide them care and treatment. To some of those residents you become their "family". To some, you become the focus of their anger, the reminder of all they have had to give up in their life. You become the arms, the legs, and the muscles they need to perform a variety of tasks of daily living. It is an unglamorous, completely necessary, and totally fulfilling (at times) job. It is hard physical labor, and it is mentally challenging as you deal with individuals who are sick, handicapped, and potentially dying. You are exposed to the potential for blood borne pathogens, the flu, and other illnesses, and you are sometimes struck by a resident who no longer understands what they're doing. You are a part of their lives 24 hours a day, seven days a week, 365 days a year.

Certified Nursing Assistants (CNA's) perform their jobs in many types of living arrangements and settings: acute care hospitals, long-term and short-term skilled nursing facilities, CBRF's and RCAC a person state's. They may work in adult family homes, clinics, and doctors' offices. None of those settings or job responsibilities are particularly glamorous. Yet the presence of a CNA is critical to the success of these providers.

In my over 40 years of working in long-term care I have seen other workplace shortages come and go. The physician shortage, the registered nurse shortage, the therapist shortage, these are just a few. In each case, recognition of the shortage, the marshalling of the right resources, offered relief in a relatively short period of time. None of these shortages has come anywhere near the scope and depth of the shortage the State of Wisconsin is currently undergoing in the recruiting and retaining of certified nursing assistants. Thus far, relief has not been forthcoming to the CNA shortage. Right now, close to one in four CNA positions in this state is currently vacant. This is not a six-month crisis: this crisis has been deepening for years. In addition to individuals choosing to leave the field for other opportunities, the effect of retirements and non-renewals is dramatically reducing the number of CNAs in the State of Wisconsin. The effect of this shortage is causing facilities like mine to limit admissions and turn away

hours of additional training once they're on site. New employees work closely with seasoned professionals, and students may in fact work with us while they are in school, in order to allow them to begin working in healthcare, earning a wage, while learning and demonstrating competency in new tasks. We will pay for an individual to take the class, we will pay for their tuition.

Any barrier to potential employees which can be lowered must be evaluated, and if possible removed. Anything that can be done to help someone enter the healthcare field can help solve this workforce crisis. The more barriers there are to a potential new employee, the more likely they are to end up working at Kwik Trip, Walmart, or in some other industry.

I will not try to argue the merits of having a threshold or standard which is consistent with other states. I will argue the merit of being able to get someone interested in the field of healthcare, get them trained and bring them in and get them working, and continuing to train them so that they can become the best caregiver there is.

I happen to be one of those pesky baby boomers, someone who will more than likely feel first-hand the effects of a rapidly shrinking workforce in healthcare. If, as a state, we fail to continue looking at ways to focus on bringing people into the healthcare field we will find more and more providers limiting services or going out of business. As I said earlier, Senate Bill 103 is not the only thing that can and must be done. But it is one thing that can be done and done with bipartisan support in both the Senate and the Assembly.

Please allow me to thank you all for the opportunity to speak today, and for your thoughtful consideration of Senate Bill 103. I hope the healthcare industry can count on your committee's assistance in helping to address health care crisis which we are in.

Stephen H. Seybold, NHA

Executive Director, Homme Inc. of WI

those in need of services, services which are critical to the health and well-being of an individual.

Our nursing home is in Wittenberg Wisconsin, a village with a population of approximately 1300 people. For us, 1300 people is not enough to create a consistent labor pool. As such, I have staff members who commute up to 30 miles one way, to work at Homme. I am competing for CNA staff with four hospitals, 10 nursing homes, and countless assisted-living facilities within a 30-mile radius. I am not aware of a single facility within that 30-mile radius which can boast that they have all their positions filled for CNA's. That's how bad the situation is. Our organization over the course of the last three months has turned away 42 persons in our skilled nursing facility, in part because we do not have a sufficient number of staff to meet their needs for care. At the present time our organization has openings for 10 full-time equivalent CNAs on our Wittenberg campus, and for 4 full-time equivalents of CNAs on our Wausau campus. To reiterate: that is 14 people that we would be happy to hire immediately, were they available.

Senate Bill 103 is not the Lone Ranger's silver bullet. It is not a single solution to the workforce crisis in the state of Wisconsin. It is a positive step to helping healthcare providers in this state. This bill would allow two things to occur: it would make the certification standard in the state of Wisconsin the same as federal regulations. It would also allow people to become certified and begin working sooner in the healthcare field. There are concerns from advocates and others that lowering the standards does nothing to assure the quality of care. As a committee, you need to understand that CNA certification, standing on its own, is not the only training requirement that a new person must meet. CNA certification is the floor, the starting point. As a provider we are obliged under state and federal regulations to assure that any employee is properly trained to provide care and services. That mandate does not carry a specific number of hours of training – it requires that a competency be demonstrated.

While it may sound counterintuitive to lower the standard to 75 hours, by doing so it gives providers the opportunity to compete fairly with our surrounding states for staff. Obviously, in North-central Wisconsin competing with other states is less of an issue than it is for those who are located closer to our state's border. More importantly, it allows someone who has an interest in becoming a CNA to do so sooner, and to be able to begin working in their new position and earning a wage. Once working and receiving a wage, they will receive further training in their chosen profession. New employees in our facilities receive significantly more than 40

Waunakee Manor Health Care

Waunakee, WI 53597

June 3, 2019

Dear Members of the Senate Committee on Health and Human Services,

Thank you for taking the time today to hear public testimony on Assembly Bill 76, legislation which would match Wisconsin's CNA hourly training requirements with the federal standard of 75 hours, including 16 clinical hours. We are administrators from long-term care facilities in your districts and we write today to encourage you to support this important legislation.

As administrators in Wisconsin nursing facilities, we are committed to providing excellent care to our frail elderly and disabled residents. But right now, providers across the state face a serious caregiver workforce shortage which, if left unaddressed, could severely limit access to care.

Many facilities are feeling the pinch as we are unable to find CNAs to fill needed shifts. This has led to many providers having to rely on current staff to work overtime to meet the needs of our residents, which can lead to burnout and more rapid staff turnover. Many providers also are forced to limit admissions – even though beds are available – because we don't have the CNA staff we need to care for more residents. It is never easy to tell a senior in need of care who has lived in the same community their entire life that they must look for care the next town over, or in some instances, hours away.

As administrators, we are responsible first and foremost for the health and quality of life of our residents. We care deeply about their wellbeing and we work to earn their trust during a period of their lives which is often difficult and emotional – for residents and their families. As Wisconsin's population continues to age, the legislature must act now to help address the CNA workforce shortage and ensure Wisconsin's seniors and disabled citizens are able to live with dignity and respect, receiving the care they need. Assembly Bill 76 is an important measure to help long-term care providers bring more CNAs on staff. The bill eliminates a current barrier for many applicants who may not be able to afford to pay for Wisconsin's current training hours and who certainly cannot afford to go many additional weeks without a paycheck for training classes.

As constituents and employers in your districts, we respectfully ask you to support this bill to help protect the vulnerable residents we serve. Thank you for your consideration.

Sincerely,

Dominique Kittle
Waunakee Manor Health Care

Sun Prairie Health Care

228 W. Main Street
Sun Prairie, WI 53597

June 6, 2019

Dear Members of the Senate Committee on Health and Human Services,

Thank you for taking the time today to hear public testimony on Assembly Bill 76, legislation which would match Wisconsin's CNA hourly training requirements with the federal standard of 75 hours, including 16 clinical hours. We are administrators from long-term care facilities in your districts and we write today to encourage you to support this important legislation.

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As constituents and employers in your districts, we respectfully ask you to support this bill to help protect the vulnerable residents we serve. Thank you for your consideration.

Sincerely,

Susan M. Ohm
Sun Prairie Health Care

June 6, 2019

Dear Members of the Senate Committee on Health and Human Services,

Thank you for taking the time today to hear public testimony on Senate Bill 103, legislation which would match Wisconsin's CNA hourly training requirements with the federal standard of 75 hours, including 16 clinical hours. We are administrators from long-term care facilities in your districts and we write today to encourage you to support this important legislation.

As administrators in Wisconsin nursing facilities, we are committed to providing excellent care to our frail elderly and disabled residents. But right now, providers across the state face a serious caregiver workforce shortage which, if left unaddressed, could severely limit access to care.

Facilities are feeling the pinch as we are unable to find CNAs to fill needed shifts. This has led to many providers having to rely on current staff to work overtime to meet the needs of our residents, which leads to burnout and staff turnover. Providers also are forced to limit admissions – even though beds are available – because we don't have the CNA staff we need to care for more residents. It is never easy to tell a senior in need of care who lived in the same community their entire life that they must look for care the next town over, sometimes hours away.

As administrators, we are responsible first and foremost for the health and quality of life of our residents. We care deeply about their wellbeing and we work to earn their trust during a period of their lives which is often difficult and emotional – for residents and their families. As Wisconsin's population continues to age, the legislature must act now to help address the CNA workforce shortage and ensure Wisconsin's seniors and disabled citizens are able to live with dignity and respect, receiving the care they need.

Senate Bill 103 is an important measure to help long-term care providers bring more CNAs on staff. The bill eliminates a current barrier for many applicants who may not be able to afford to pay for Wisconsin's current training hours and who certainly cannot afford to go many additional weeks without a paycheck for training classes.

As constituents and employers in your districts, we respectfully ask you to support this bill to help protect the vulnerable residents we serve. Thank you for your consideration.

Sincerely,

The undersigned:

Senate District 24

Cayla Piehl
Administrator
Edenbrook of Wisconsin Rapids

Jessica Maurer
Administrator
Nekoosa Court

Senate District 5

Ben Mallon
Administrator
Care-Age of Brookfield
Brookfield, WI

Angela Willms
Administrator
Brookfield Rehab and Specialty Care
Brookfield, WI

Kris Sprtel
Administrator
Congregational Home
Brookfield, WI

Brandon Luke
Administrator
St. Camillus Health Center
Wauwatosa, WI

Senate District 1

David Mueller
Administrator
Sturgeon Bay Health Services
Sturgeon Bay, WI

Luke Schubert
Administrator
Rennes Health Center-De Pere
De Pere, WI

Senate District 27

Paul Fiscus
Administrator
Maplewood of Sauk Prairie
& Maplewood Village
Sauk Prairie, WI

Leah Perras
Administrator
Ingleside Manor
Mt Horeb, WI

Susan Ohm
Executive Director
Waunakee Manor Health Care Center
Waunakee, WI

Lynn Howard
Administrator
Four Winds Manor
Verona, WI

Senate District 3

Lauren Beaumont
Administrator
Sunrise Health Services
Milwaukee, WI

Tricia Plate
Administrator
Mercy Health Services
Milwaukee, WI

WI Director *of* Nursing Council

March 26, 2019

Dear Committee Members:

The Wisconsin Director of Nursing Council is a state organization representing nursing leaders in long-term care and post-acute care continuum. Our mission is to educate and support long- term care professionals as they enhance the quality of lives of the residents and staff. Part of our job during this testimony is to assure the committee understands what an important piece of legislation this bill is in the effort to remove one more barrier to increasing the number of individuals choosing to become a Certified Nursing Assistant (CNA) or work in Wisconsin as a CNA.

Our organization supports the passage of SB 103.

The federal government minimum requirement for nursing assistant training is 75 hours covering these basic areas: basic nursing skills, personal care skills, mental health and social service skills, caring for cognitively-impaired residents, basic restorative skills, and Residents' rights. The requirements prepare the nursing assistant to pass the competency test and begin performing duties as a novice CNA.

The Council would like to dispel three myths about passage of this bill:

Myth #1 All nursing assistant training courses will be required to be 75 hours.
That is incorrect. This legislation will set a minimum hour not a maximum. Prior to the passage of the legislation increasing the minimum hours to 120 hours there were classes of varying hours across the state. The minimum 75 hours would allow CNAs that have completed training in other states where 75 hours is acceptable to work in the state of Wisconsin without extraordinary requirements and barriers. This opens opportunities for CNAs trained in our neighboring states of Minnesota and Michigan. Attachment shows the decreasing numbers of CNAs in the state of Wisconsin from 2016- 2017.

Myth #2 Decreasing nursing assistant training hours will decrease quality of care.
The second myth is that lowering the CNA training hours to the federal standards will somehow decrease the quality of care to our residents. There is no evidence that increasing CNA training actually increased the quality. There is a perception that more education somehow equates to quality but it is leadership of those novice CNAs by qualified nurse leaders improves quality. The table attached shows states rated using the 5 Star rating system from the Centers for Medicaid & Medicare Services (CMS). The second table shows those states training requirements. It is pretty evident that training hours does not impact quality. What we know will improve quality is consistent nursing leadership. Directors of Nursing Service number one reason for leaving their job is staffing according to the American Association of Director of Nursing Service accounting for 73% of turnover. This affects quality.

Myth #3 Facilities will put inadequately trained nursing assistant into positions.
The third myth is that nursing homes will simply put ill prepared CNAs into care giving positions. The nursing assistants will all still need to pass the very same certification process which involves both a written and skills competency testing. This would not change. This testing is provided by a third party. Nurse leaders right now are obligated to federal regulations that require the facility to provide competent and qualified staff. The new mega rule phase 3 puts in place additional regulation requiring competency based education and training.

Respectfully,
Mindy Meehan, President
Joey Pettis, Executive Director

Nurse Aide Training and Registry: Statistics

https://www.dhs.wisconsin.gov/caregiver/nurse-aide/statistics.htm

Nurse Aide Registry Statistics

Listed below are the number of active nurse aides on the Wisconsin Nurse Aide Registry by month for 2016 and 2017.

Month	2016	2017
January	63,342	61,057
February	63,179	60,892
March	62,992	60,865
April	62,880	60,592
May	62,624	60,374
June	62,356	59,935
July	62,376	59,897
August	62,227	59,784
September	62,106	59,754
October	61,716	59,709
November	61,640	59,582
December	61,644	59,550

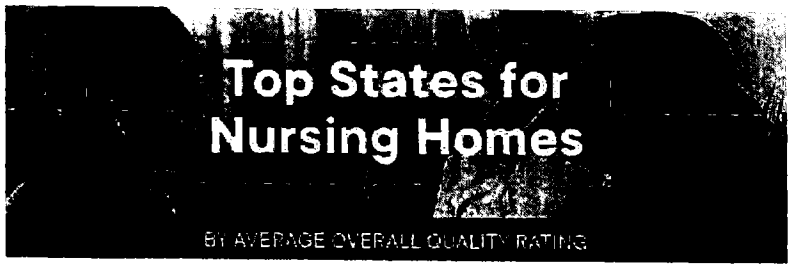
- A total of 7,508 individuals in 2016 and 7,066 in 2017, successfully completed the Wisconsin-approved standardized competency test and were added to the Wisconsin Nurse Aide Registry.
- A total of 22,946 individuals in 2016 and 19,364 in 2017, renewed their nurse aide status making them eligible to work in federally certified long-term care facilities, home health agencies, hospices, and hospitals.

Note: A nurse aide candidate has up to one year to take the nurse aide competency test after successfully completing their training. For example, a candidate who completed their training in 2017 may wait until 2018 to take the test.

Nurse Aide Training Program Statistics

Listed below are the number of nurse aides who have graduated from each type of training program in 2016 and 2017.

Training Program Type	2016	2017
High School	201	136
Home Health Agency	69	70
Hospital	264	201
Nursing Home	694	525
Private	1,233	1,294
State Center	221	317
University	144	71
Wisconsin Technical College	6,206	6,067
Total	**9,032**	**8,681**



On a scale of 1 to 5, with 5 being best

1.00 — 5.00

TOP 10

1.	Hawaii	3.93
2.	Washington, D.C.	3.89
3.	Florida	3.79
4.	New Jersey	3.75
5.	Colorado	3.74
6.	Delaware	3.73
7.	Connecticut	3.73
8.	Minnesota	3.72
9.	North Dakota	3.71
10.	Idaho	3.71

BOTTOM 10

1.	Texas	2.58
2.	Oklahoma	2.76
3.	Louisiana	2.90
4.	Kentucky	2.98
5.	Georgia	3.01
6.	New Mexico	3.02
7.	North Carolina	3.07
8.	Missouri	3.12
9.	West Virginia	3.15
10.	Illinois	3.18

Source: Med.care.gov, 2017

Care.com

Nurse Aide Training Hours Required In the Top 10 and Bottom 10 Performing States

Top 10 States	Training Hrs.	Bottom 10	Training Hours
Hawaii	100	Texas	100
Washington DC	85	Oklahoma	75
Florida	120	Louisiana	80
New Jersey	90	Kentucky	75
Colorado	75	Georgia	85
Delaware	150	New Mexico	75
Connecticut	100	North Carolina	75
Minnesota	75	Missouri	175
North Dakota	75	West Virginia	120
Idaho	120	Illinois	120

WI Director *of* Nursing Council

Nursing Assistant Shortage Complicated by Wisconsin Regulation

The Wisconsin Director of Nurse Council, (WDONC) represents nursing leaders in Skilled Nursing, Assisted Living, Hospice and other Long-Term Care Facilities. Our members are Directors of Nursing, Assisted Directors of Nursing, Staff Development, Nurse Managers, Administrators, Suppliers and Consultants, among others who are looking to advance nursing in the continuum of care.

Our purpose in sharing a position paper on the healthcare worker crisis facing the long-term care industry is to heighten awareness specifically on the Certified Nurse Aide (CNA) shortage. Our organization believes that this shortage has been directly impacted by the rules and regulation imposed by the State of Wisconsin through it's regulation of nurse aide training requirements. Although according to studies this staffing crisis is multifaceted the WDONC has chosen to focus on revised legislation to positively impact this issue. Indirectly this will also decrease the cost to the Wisconsin Medicaid program. Impacting the availability of nursing assistants will in turn assist us in resolving the turnover of nursing leadership in long term care which can directly be tied to the quality of care that is delivered to the states most vulnerable citizens.

The WDONC is proposing **the elimination of the 120 hours nursing assistant training requirement and a return to the federally mandated 75 hour requirement.** This change will increase the financial ability of individuals interested in healthcare careers to enter the field in a time frame that is comparable to other entry level positions, will decrease the financial burden on the individual and still adequately prepare them for entry as a health care worker providing basic cares to Wisconsin citizens in need of care in long term care continuum due to illness and/or disability.

Training programs should still be allowed to determine the hours that they wish to train nursing assistants as they were prior to the implementation of the legislation requiring the 120 course. But the legislation should only mandate the federal requirement of 75 hours.

History:

In 1987 the federal government enacted the Omnibus Reconciliation Act or OBRA. In that regulation 75 hours of training were mandated for nursing assistants before they could work in federally certified nursing homes. This mandate was to assure basic training for entry level healthcare workers.

Wisconsin's statutory regulation related to nursing aide training is DHS Chapter 129. In 2008 the Wisconsin Rule was changed to require 120 hours of training as opposed to the federally mandated 75 hours. In 2013 Act 357 was passed in an effort to bridge the ability of CNAs from other states to obtain certification in Wisconsin if they were already certified it other states. It provided direction to accept certification from other states if the individual had been trained; competency tested and worked 2088 hours. It also provided for the ability to created a shortened training course consisting of an additional 45 hours allowing CNAs from other states that did not have the work experience to gain the additional hours without having to take an entire 120 hours course.

Facts:

The healthcare worker shortage that encompasses both licensed nurses and CNAs has well documented with studies dating back to 2008. The study completed in 2008 projected a continue need for additional workers secondary to the increased demand for long term assistance by the aging of America. The Wisconsin Hospital Association in 2014 reported vacancies in hospitals at 7.1 percent for CNA positions. Today, 2016 a study conducted by Leading Age, Wisconsin Healthcare Association, Wisconsin Assisted living Association and Residential Services Association of Wisconsin reported vacancies of 14.5 percent in the caregiver category. This report also notes that the CNAs entering the healthcare career is continuing to decline with statistic showing 24% less individuals applying for certification and a decline of 5.431 in individuals renewing their CNA certification.

There is no doubt the staffing problem exists. Finding solutions for these shortages in the long term care environment is complicated by poor wages, underfunding of the Medicaid program and workforce numbers in total but it is further crippled by self imposed regulatory requirements above the minimum standards set forth by the federal government.

DHS 129 requires 120 hours of training to become a certified nursing assistant in the state of Wisconsin. Our neighboring states of Minnesota, Michigan and Iowa require only the 75 hour course for certification. Individuals from these neighboring states are not recognized as being adequately prepared to work in Wisconsin unless certain other criteria are met. This criteria is so burdensome that many trained individuals work in fields other than healthcare due to wage disparity, difficult entry into the healthcare workforce due to regulatory issues surrounding certification and the need to earn a living immediately.

To enter the healthcare industry as a Certified Nursing Assistant the individual must apply and be accepted into an approved nursing assistant course. These courses are approved and

monitored by state of Wisconsin to assure compliance with the standard set forth in DHS 129. The applicant is paying on average $700 for this course. If the course is offered through the technical college environment there is often additional student fees incurred. The applicant then must successfully complete the course by attending and then passing both a written and skills test. The courses are offered in an accelerated fashion with completion within a month attending classes full time, may be conducted by semester or other offering to meet the individual needs. After the course is completed a state approved competency test is conducted costing $110.00 plus approximately $8.00 in additional fees. This evaluation consists of both a written and skills test. Wait time for testing times varies throughout the state but is reported by the State of Wisconsin to be in an acceptable range of on average 2 weeks. This leaves the individual seeking an entry level position out of the healthcare industry for a minimum of 6 weeks.

Points of Discussion:

The implementation of an increase in training was with the good intention of improving the quality of care to the elderly and disabled in Wisconsin. Through federally reported quality indicators there is no documentable impact on the quality provided that can be linked to increased staff training in the state of Wisconsin. There is no evidence that longer training has impacted the quality of care. What is documented is that nursing leadership retention directly impacts the quality of care.

Citations in nursing homes at the highest level called immediate jeopardy are at record levels with only 2008 being higher. Therefore, the intended purpose of the increased training hours for nursing assistants has failed.

Entry level positions in other fields are often associated with no time commitment for training and better wages. Therefore the employable seek jobs that provide income immediately, especially if their primary reason for being in Wisconsin seeking employment is to supplement them as they complete their education in one of Wisconsin Colleges.

Nursing homes in particular are already mandated through regulation to assure that care is being provided by properly trained and qualified individuals. The responsibility to meet this regulation is on the employer not the State of Wisconsin.

The long term care industry needs every individual interested in healthcare career to be able to enter that career with reasonable training and financial expectations.

The Directors of Nurses in long term care have an unacceptable turnover rate which directly impacts the residents they care for. The WDONC in a study of 79 leaders in long term care found that 63% of them identified staffing as their number one challenge.

Recommendations:

The WDONC supports the return to the 75 hour nursing assistant federal training requirement. This simple regulatory change from the required 120 hours to the 75 hour course:

- Will improve the ability of providers of Wisconsin's long term care to attract, hire and retain the much needed Certified Nursing Assistant.
- Will allow long term care facilities to provide the training that is necessary to meet the needs of their particular resident/client population.
- Will allow regulators to hold nursing homes accountable to well trained and qualified staff through existing federal regulations.
- Will decrease both the financial and time investment by the potential healthcare worker interested in entry level career opportunities.
- Will allow individuals certified in neighboring states to become certified and work in Wisconsin long term care without additional cost and time to the worker. It allows properly trained and willing workers to provide services to our elderly and disabled instead of seeking employment in other industries.

This move will not resolve the entire healthcare worker shortage we are facing. Since 2008 we have done little to significantly impact the ability to attract healthcare workers we have only watched the crisis develop. Now that crisis is upon us, we must take action. Returning to the federally mandated training requirement of 75 hours can be that one thing that has an impact on both increasing the numbers of available trained and certified nursing assistants with the indirect effect of nursing leadership retention.

This proposal does not ask for additional Medicaid dollars but make as reasonable request for less regulation.

AARP® Real Possibilities
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Testimony of Pauline Sneath, RN, BSN and Volunteer Advocate for AARP
Committee on Health and Human Services
Regarding: AB76 and SB103.
June 6, 2019

Good Morning

My name is Pauline Sneath, and I am currently from Columbus, Wisconsin. I bring to the discussion my background in health care and as a Volunteer Advocate for AARP Wisconsin.

AARP Wisconsin has over 850,000 members over the age of 50. We advocate on their behalf before the legislature and other policy groups.

My career started as a CNA at 18 years old, married, and with a new baby. In those days, the CNA program was very hands-on with small classes. The program was run by the Hospital over about a 12-week period. There was lecture, instructional reading, and testing. Lots and lots of hands-on, directly supervised care -- we even practiced on each other. I cannot imagine being turned loose into the profession after having completed training in less than 2 weeks with only 16 hours of hands-on care, passing the test and being placed on the registry.

After 3 years as a CNA, I went to school for my BSN spending 3 years at IUPUI (Indiana University and Purdue University at Indianapolis) and 1 year at Vanderbilt University as an Independent student. My degree is from IUPUI. Since then I have spent 20 + years in hospitals mostly in all types of Critical Care and practicing in different States. The last 15 years have been spent in Hospice working in different capacities: a Clinical Manager for a 32-bed acute and 18- bed residential in-patient unit, on the Management Team, a Team Leader, and a Case Manager for an In-Home team and a Facility team. Census of this Hospice was 350+. I have been in every county surrounding Dane, Jefferson and some of Fond du Lac.

I have observed CNA care in every type of setting from hospital, group homes, RCAC and Assisted Living to even CNA's in private practice in homes. I also have personal experiences.

The goal of this bill is to have more CNAs to fill the CNA shortage. This bill would cut the requirements for CNA training of 120 hours, including 32 clinical hours (hands-on care) to the **minimum** required by Medicare and Medicaid of 75 hours training and only 16 of those hours required to be clinical. Cutting training nearly in half!

This is not just a state crisis but a national crisis and a very distressing situation. We are not the only ones. Why would lowering training Standards bring more CNAs to our State? Statistics show a very small percent of trained CNAs move to our state and they have moved for other reasons than a job.

How can a candidate afford to move? What quality of candidate will this attract? What quality of care will this provide?

In many settings CNAs are the eyes and ears for the nurse. They are part of a care team and they do need to make judgements. Their role has become, like all healthcare, more challenging, and expanded with more complex patients at a hectic pace. This is very emotional and physically challenging work – hard work! It is also stressful work, but it can be very rewarding for the right person.

CNAs provide care that on the outside may look task-oriented but indeed requires judgement and knowledge to provide safe and effective care. They operate autonomously in a room or home with the patient who is competent or not. They provide bathing, oral hygiene, hair and nail care, feeding, observe swallowing ability, change beds, get patients up, and walking with support. They need to have knowledge of what to do in an emergency and how to maintain and clean equipment to name a just a few responsibilities. They may even be trained to pass medications in some instances. They see the patient more regularly to provide continuity, to know and report any changes in function, skin, mentation and spirituality. This can make a real difference in recovery, suffering, further treatment, re-hospitalization and it saves money. CNAs are an important part of a team, not just another body.

What I have observed in health care is a universal truth. Dig deeper! Nothing is as it appears on the surface. The answer to the CNA shortage is not so simple as to cut training from 120 hours including 32 hours clinical or hands on care to 75 hours including 16 hours clinical or hands on care. This is the **minimum** training requirement for a Medicare or Medicaid approved facility or organization. This means they get paid.

It is easy to cut training thinking that this would attract more people to CNA programs. Again, this is very physically and emotionally taxing work, and the pay is not very good! It can be a thankless job with no social prestige. What quality of candidate will this attract? How long will they stay?

According to The Bureau of Labor Statistics and Occupational Employment Statistics Program: CNA pay ranges from $21,840 to $37,320 per year in Wisconsin. Higher pay is for the more experienced CNAs. The Federal poverty level for a family of 4 in Wisconsin $25,750 and for a family of 3 it is $21,330.

This reminds me of the Critical Care RN shortage in the early 80's. I was lucky as I had experience in a Critical Care Unit as a CNA. Otherwise one was mostly birthed by fire. No training. What changed the shortage were classes to prepare one well for the specialty, lots of hands-on care with training, reducing burnout and better pay (differentials). The specialty became well-prepared to do a job worth being proud of and it became a prestigious position.

Another concern is an applicant for CNA training does not, by state requirements, have to have a GED or High School diploma and can be as young as 16 years old. Many programs currently have their own requirements which do require High School Diploma or GED and that applicants be 18 years old. Less training means less money for program funding, and possibly less programs. Maybe even going to minimum requirements for quality of trainee.

I have been participating in care for my own aged parents and have experienced this care firsthand. My mother is in Memory Care with other physical needs. The Director of Nurses there says she has so many no shows or no call for sick, starting or quitting the job. They just do not show up. She has started showing them the hard work and ask if they cannot handle it, that they should apply to something else. She would rather have good quality help rather than no help and no shows.

What will this cost in the long run? As my management experience has taught me one change has many other affects not thought of or foreseen. Will lack of quality bring more cost, suffering, pain, disability, or death? I don't know about you but I do not want to be cared for or have my family members cared for by less prepared CNAs. Someone who potentially has had only 16 of hours of hands on training, who should know how to do everything they are taught to know in 75hrs.

Orientation with employers vary. We have had testimony from the cream of the crop of Long-Term Care Facilities. Where are the testimonies from the Hospices, Home Health, Hospitals and the many Facilities providing care for those who cannot afford the better facilities? What kind of on-boarding will they provide? Better facilities will afford better on-boarding and training, but the others providing care for those who cannot afford those facilities, will do just what is regulated.

I have seen much great care, good care, and some not so good and even awful care by CNAs with the current requirements.

Wisconsinites need and deserve the best and safest quality of care that can be provided. Rather than reducing the required total training hours for CNAs and potentially putting the health and safety of those needing care at risk, I encourage you to bring the various stakeholders together to find solutions that will alleviate the work force shortage without endangering the care of vulnerable citizens. I and AARP encourage you to vote NO on this bill!

Thank you for the opportunity to comment on this important issue impacting the job satisfaction and retention of valuable and much needed direct care workforce providing health and safety for our vulnerable Wisconsinites.

Thank you again.

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Testimony of Helen Marks Dicks, State Issues Advocacy Director for AARP WI
Committee on Health and Human Services
Regarding: SB103/AB76
June 6, 2019

AARP continues to oppose SB103/AB76. We continue to believe that limiting the hours of instruction for certified nursing assistants is a bad idea. After the assembly hearing on this bill AARP Wisconsin provided the members of this committee and the Assembly Committee on Aging and Long Term Care additional information about the state of play in Minnesota. We did this because much of the hearing in the assembly was about how our neighbor had reduced training requirements which did not affect the quality of care in that state.

However, the much lauded quality of care in Minnesota's long-term care system is more myth than reality. In 2016 alone, the Minnesota Department of Health received 25,226 allegations of neglect, physical abuse, unexplained serious injuries, and thefts in state-licensed elder care facilities. The crisis of elder abuse in elder care facilities was highlighted in a series of articles in the Minneapolis Star Tribune in November of 2017. In response Governor Dayton asked AARP Minnesota to convene a Consumer work group and named the following organizations to the work group: The Alzheimer's Association, The Minnesota Elder Justice Center, Elder Voices Family Advocates, and the Mid-Minnesota Legal Aid. The group was asked to develop recommendations to improve the care and safety of older and vulnerable Minnesotans in nursing homes and assisted living and to submit a report to the governor. I have enclosed a copy of that report.

You will note that the report includes recommendations for greater regulation and oversight by the state of facilities serving the elderly and an increase in training for people dealing with patients with dementia. This is not an endorsement or validation of the glowing reports we heard at the hearing about the wonders, safety and quality of care in the Minnesota Long Term Care system. Rather it is a cautionary tale of what happens when regulation is light and/or nonexistent and staff is not adequately trained to deal with the type of patients they interact with. Wisconsin takes pride in the quality of care and the strength of our long term care system. We are better than Minnesota in this area and we should not emulate their failures by lowering our standards.

Today I am providing you with additional information about training requirements in Minnesota for people of all job classifications who work with patients with dementia. This is the direction we should be moving in. It also shows that Minnesota provides and requires training beyond the limited hour CNA training. Currently there is more legislation pending in Minnesota around the issues of elder abuse and care of those in various types of residential settings. I have attached those requirements to this testimony. You will note it even includes housekeepers, maintenance and food service workers who come in contact with people with dementia. If we wish to retain and keep CNAs it would be wise to provide them with this kind of training and a supportive work environment where their coworkers can also deal with issues.

As we are moving through the budget process many suggestions and proposals have been advanced to improve the pay of CNAs. This is a much more realistic approach to the challenges of recruitment and retention.

The equipment and treatments are more complex, and the level of care expected to be provided by a CNA is greater than ever. This is not the time to be lowering the training requirements. Those of us in the field that work with and value CNAs urge you to vote no on this bill. It is bad for CNAs. It is bad for the Care team. It is bad for the patient.

AARP WI urges a no vote on SB103/AB76.

IF you work in a Registered Housing with Services (HWS) establishment that has a special care unit for tenants with dementia or markets/promotes the HWS as providing services for tenants with dementia (regardless if the dementia services are in a segregated unit);

Care Providers of Minnesota

OR you work for the arranged home care provider in a Registered Housing with Services (HWS) establishment that has a special care unit for tenants with dementia or markets/promotes the HWS as providing services for tenants with dementia (regardless if the dementia services are in a segregated unit);

THEN, effective January 1, 2016, you will have new dementia training requirements applied to you.

What type of job do you have?	New Hire (Initial) Training Requirement	Annual Training Requirement
Maintenance, Housekeeping, Food Service, or other job that does not provide direct care or supervise those who provide direct care to tenants of the HWS	4 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 160 work hours after your first day of employment. You may satisfy the initial 4 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.
Supervisor of direct care staff	8 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 120 work hours after your first day of employment. You may satisfy the initial 8 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.
Direct care staff	8 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 160 work hours after your first day of employment. You may satisfy the initial 8 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.

The HWS must make available to consumers a description of the dementia training programs, the category of employees trained, the frequency of training, and the basic topics covered.

IF you work in a Registered Housing with Services (HWS) establishment that does NOT have a special care unit for tenants with dementia or does NOT market/promote the HWS as providing services for tenants with dementia, but the establishment DOES use the term Assisted Living or DOES provide Assisted Living services;

Care Providers of Minnesota

OR you work for the arranged home care provider in a Registered Housing with Services (HWS) establishment that does NOT have a special care unit for tenants with dementia or does NOT market/promote the HWS as providing services for tenants with dementia, but the establishment DOES use the term Assisted Living or DOES provide Assisted Living services;

THEN, effective January 1, 2016, you will have new dementia training requirements applied to you.

What type of job do you have?	New Hire (Initial) Training Requirement	Annual Training Requirement
Maintenance, Housekeeping, Food Service, or other job that does not provide direct care or supervise those who provide direct care to tenants of the HWS	4 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 160 work hours after your first day of employment. You may satisfy the initial 4 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.
Supervisor of direct care staff	4 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 120 work hours after your first day of employment. You may satisfy the initial 4 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.
Direct care staff	4 hours of training that includes: 1. An explanation of Alzheimer's disease and related disorders 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills This training must be completed within 160 work hours after your first day of employment. You may satisfy the initial 4 hour training requirement if you can produce written proof that you have received the training within the last 18 months.	2 hours of training are required on topics related to dementia care for each 12 months of employment after your initial training.

The HWS must make available to consumers a description of the dementia training programs, the category of employees trained, the frequency of training, and the basic topics covered.

MDH Enforcement of Staff Dementia Training Requirements

The 2015 Minnesota Legislature passed the following clarifications to the dementia training requirements previously passed in 2014 (effective 1-1-16):

"Direct-care staff" means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.

Note: 144A.471 Subdivisions 6 and 7 list the following home care services:

Under a Basic Home Care License: assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing; providing standby assistance; providing verbal or visual reminders to the client to take regularly scheduled medication, which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication; providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises; preparing modified diets ordered by a licensed health professional; and assisting with laundry, housekeeping, meal preparation, shopping, or other household chores and services if the provider is also providing at least one of the activities noted above.

Under a Comprehensive Home Care License: services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker; tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice; medication management services; hands-on assistance with transfers and mobility; assisting clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or providing other complex or specialty health care services.

ENFORCEMENT OF DEMENTIA CARE TRAINING REQUIREMENTS.

Subdivision 1. **Enforcement.**
(a) The commissioner shall enforce the dementia care training standards for staff working in housing with services settings and for housing managers according to clauses (1) to (3):

(1) for dementia care training requirements in section 144D.065, the commissioner shall review training records as part of the home care provider survey process for direct care staff and supervisors of direct care staff, in accordance with section 144A.474. The commissioner may also request and review training records at any time during the year;

(2) for dementia care training standards in section 144D.065, the commissioner shall review training records for maintenance, housekeeping, and food service staff and other staff not providing direct care working in housing with services settings as part of the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year; and

(3) for housing managers, the commissioner shall review the statement verifying compliance with the required training described in section 144D.10, paragraph (d), through the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year.

(b) The commissioner shall specify the required forms and what constitutes sufficient 334.7 training records for the items listed in paragraph (a), clauses (1) to (3).

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MDH Enforcement of Staff Dementia Training Requirements

(continued)

Subd. 2. **Fines for noncompliance.**

(a) Beginning January 1, 2017, the commissioner may impose a $200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance. For violations of subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care provider, and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and the fine will be imposed on the housing with services registrant and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior to imposing the fine, the commissioner must allow two weeks for staff to complete the required training. Fines collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The housing with services registrant and home care provider must allow for the required training as part of employee and staff duties. Imposition of a fine by the commissioner does not negate the need for the required training. Continued noncompliance with the requirements of sections 144D.065 and 144D.10 may result in revocation or nonrenewal of the housing with services registration or home care license. The commissioner shall make public the list of all housing with services establishments that have complied with the training requirements.

Subd. 3. **Technical assistance.**

From January 1, 2016, to December 31, 2016, the commissioner shall provide technical assistance instead of imposing fines for noncompliance with the training requirements. During the year of technical assistance, the commissioner shall review the training records to determine if the records meet the requirements and inform the home care provider. The commissioner shall also provide information about available training resources.

Addressing Elder Abuse in Minnesota Long-Term Care Settings

Public Policy Actions Necessary to Prevent and Deter Abuse

January 29, 2018

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Table of Contents

Executive Summary

Elder abuse is intolerable and an affront to human rights. While years in the making, the scale and gravity of this crisis began to take shape for policymakers during the 2017 legislative session when the Office of Health Facility Complaints ("OHFC") at the Minnesota Department of Health ("MDH") reported a 600% increase in maltreatment reports since 2010 and an ability to investigate only 1% of the 20,791 reports from providers and 10% of the 3,491 reports from individuals.[1]

The magnitude of the crisis was revealed further in the Minneapolis Star Tribune's shocking and sobering series ("Left to Suffer," November 2017) that described a broken system of care and regulatory oversight that has failed to protect Minnesota's older and vulnerable adults[2] from horrific abuse[3] in nursing homes and housing with services and assisted living settings (HWS/AL").[4]

In response, Governor Dayton asked AARP Minnesota to convene a Consumer Workgroup and named the following other organizations to the group: Alzheimer's Association, Minnesota Elder Justice Center, Elder Voice Family Advocates, and Mid-Minnesota Legal Aid. The group's charge was to develop recommendations to improve the care and safety of older and vulnerable Minnesotans in nursing homes and assisted living and to submit a report to the Governor by January 26, 2018. AARP requested an extension and submitted this report on January 29, 2018.

The Consumer Workgroup recommendations call for far-reaching policy and agency practice changes to prevent and deter abuse. The recommendations reflect the experiences of our organizations and a belief that older and vulnerable adults and their families should be at the center of any reform. They further reflect and incorporate feedback the group received from victims, family members, experts, providers, direct care workers, and advocates who responded to the request to convey their concerns and offer recommendations.

The problems in the regulatory system demand immediate and dramatic fixes. We recognize the joint steps already taken by the Minnesota Department of Human Services and the

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[1] *See* FY18-19 Biennium Budget Plan from OHFC.

[2] For the purposes of this report, we use the term "older and vulnerable adults" to generally mean those who are advanced in age and receiving services from a licensed health care provider, particularly in a nursing home or in assisted living. The term "vulnerable adult" is given the meaning as defined in the Vulnerable Adult Act. *See* Minn. Stat. § 626.5572, subd. 21.

[3] For the purposes of this report, we use the term "abuse" generically to include "abuse," "neglect," and "financial exploitation" as those terms are defined in the Vulnerable Adult Act. *See* Minn. Stat. § 626.5572, subds. 2,17, and 9, respectively.

[4] In Minnesota, regulation of residential settings that offer or allow a spectrum of needed care and services is confusing to the public and, most importantly, to older and vulnerable adults, and their families and advocates. Under the convoluted statutory construct in Minnesota, the commonly known term "assisted living" is actually a subset of the broader residential setting called "housing with services," a term few recognize or understand. In this report, we use the term "assisted living" or the abbreviation "HWS/AL" interchangeably to describe residential settings into which older and vulnerable adults move that are registered under Chapter 144D of Minnesota Statutes or have assisted living "title protection" under Chapter 144G of Minnesota Statutes.

Minnesota Department of Health (MDH) to address the backlog of complaints. Regulatory oversight is a critical element in ensuring appropriate care for older and vulnerable adults. The public needs assurance that the Minnesota Department of Health is enforcing state laws and administrative regulations. The Consumer Workgroup has examined where public regulation and enforcement have failed in their mission and recommends measures that improve both the licensing function of the MDH's Health Regulation Division and the investigative function of the OHFC.

However, regulatory agency reform does not provide the entire answer. An equally important response to the crisis entails giving older and vulnerable adults – and their families[5] – stronger consumer protection tools. Consequently, many of our recommendations are designed to strengthen and expand rights and address the sizable imbalance of power, knowledge, understanding, and sophistication between older and vulnerable adults who need care and those entities that provide that care. A significant number of our recommendations address gaps in rights and their enforcement.

Further, the exponential growth of HWS/AL and Memory Care units demands an overhaul of definitions, requirements, and consumer protections. Today, many older Minnesotans living in such residential settings have more complex care needs – including dementia – than when assisted living options first became available more than two decades ago.

Demographics show that this vulnerable population is expected to continue to rise over the next decade, placing greater demand and pressure on this already faltering system.[6] Comparatively few protections exist for vulnerable adults in these settings, although the frailty of residents in the HWS/AL setting often closely resembles that of people living in licensed nursing facilities.

Minnesota is an outlier in comparison to other states when it comes to regulation of assisted living. All other states require licensure or similar public oversight for these settings.[7] The Consumer Workgroup calls for Assisted Living licensure and Dementia Care Certification to establish clear and necessary standards of care and services.

Many of the comments we received expressed concerns about insufficient staffing levels in both nursing homes and assisted living settings. Research shows that understaffing contributes

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[5] For the purposes of this report, we use the term "family" or "families" to include, broadly, those who represent and advocate on behalf of the older or vulnerable adult on the basis of kinship. We recognize that legal definitions and restrictions affect the basis and extent of families' authorities to act in place of the older or vulnerable adult in specific situations.

[6] *See, e.g.*, Minnesota State Demographic Center, *Aging* (stating that the 285,000 "Minnesotans turning 65 in this decade will be greater than the past four decades combined" and that, by 2030, "more than 1 in 5 Minnesotans will be an older adult"); at https://mn.gov/admin/demography/data-by-topic/aging/.

[7] *See* Paula Carder, Janet O'Keeffe, and Christine O'Keeff, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition* (2015); at https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition#states

to serious care-related violations, including abuse and neglect.[8] Undeniably, staffing issues must be addressed. While there are ongoing efforts to address complex staffing issues, this issue must be addressed as part of the AL Licensure Stakeholder process as well. Stakeholders must be creative and cooperative and develop private/public incentives to improve staffing levels, retain today's dedicated caregivers, and find ways to recruit, train, and support future caregivers.

Summary of Key Action Recommendations:
The Consumer Workgroup's recommendations are divided into four key action areas:

- **Strengthen and Expand Rights of Older and Vulnerable Adults and Their Families**
  To address the significant power and knowledge imbalance, the State must strengthen and expand the rights of older and vulnerable adults and their families. These rights include allowing access to reports of allegations of abuse; establishing stronger anti-retaliation laws for vulnerable adults and their families; enacting new laws that give victims the same rights to appeal a maltreatment finding as perpetrators have; clarifying a resident's right to place a camera or electronic monitoring device[9] in the room[10]; and providing better access to information to assist consumers to assert and vindicate their rights.

- **Enhance Criminal and Civil Enforcement of Rights**
  To enforce these rights, the State must strengthen the Criminal Code to allow prosecutors to charge perpetrators of abuse with a gross misdemeanor for terrorizing assaults that do not result in physical injuries. Under current law, prosecutors are unable to bring that charge in the absence of demonstrable bodily harm. Further, because there is no statutory right for vulnerable adults and their families to enforce their rights in court and, where appropriate, receive compensation for rights that are violated, the Consumer Workgroup recommends establishing a private right of action for the violation of the vital rights granted under Minnesota law.

- **Develop New Licensure Frameworks for Assisted Living and Dementia Care Across Residential Settings**
  To address the complexity and confusion in the market today, the State must develop an AL license designed to create clear standards for providers and older and vulnerable adults alike. Input from a broad stakeholder group will be needed to develop standards for staffing, training, admission and discharge[11] criteria, as well as definitions of and certification for dementia care and protections to preserve access for individuals who rely on the Elderly Waiver Program. We propose immediate institution of termination appeal

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[8] See, e.g., the federal Elder Justice Roadmap and collateral research to support the connection between understaffing and preventable abuse, at https://centerjd.org/content/fact-sheet-epidemic-nursing-home-abuse-and-neglect.

[9] For the purposes of this report, we use the term "camera" broadly to include other electronic monitoring devices. Such devices may include video camera, web-based camera, devices with one or two-way communication, devices with audio and/or video, devices that record or stream images and/or sound over the internet or cell phone signals, or other systems that utilize technology as a means of communication or to monitor care needs.

[10] For the purposes of this report, the term "room" is used in the context of camera placement to mean the private living space of the resident.

[11] For the purposes of this report, the term "discharge" generally refers to no longer residing in a nursing home while the term "termination" generally refers to no longer receiving housing and/or health care services in HWS/AL. The terms may be used interchangeably in this report, depending on the circumstances.

rights, and new protections against arbitrary discharge. Displacement is traumatic for older and vulnerable adults who suddenly find themselves homeless, including those who rely on the Elderly Waiver Program to pay for care.

- **Improve MDH Licensing Regulation, OHFC Enforcement and Investigative Process, and MAARC Reporting**
  To restore confidence in our regulatory system, MDH and OHFC must use existing licensing and other authority to order corrections for violations and employ an effective investigative process that holds abusers accountable, including the use of fines. With respect to Home Care licensing inspections, the three-year cycle must be shortened, and to accomplish those more frequent inspections, adequate staffing is necessary. Further, we encourage the use of a wide array of tools to combat violations, including provisional licenses and increased fines in the HWS/AL settings. Also there must be continued efforts to improve the reporting system for vulnerable adults, families, and mandated reporters to the Minnesota Adult Abuse Reporting Center ("MAARC")

In sum, Minnesotans deserve a system that provides optimal care and services, and maximum protection against abuse. Elder abuse is not an inevitable consequence of the system of care and services provided by nursing homes, HWS/AL, or home care providers. Our recommendations focus on both prevention of and responses to older and vulnerable adult abuse.

We thank Governor Dayton for the opportunity to develop and present these recommendations and recognize the many lawmakers, consumers, care workers and providers who also have been working to improve Minnesota's long-term care system. Addressing the tragedy of elder abuse in this system is a shared Minnesota value. We urge lawmakers and regulators to take swift action to enact these recommendations.

The information contained in this Executive Summary and Report represents the collaborative discussion of the Governor's Consumer Workgroup and does not represent the views, platform or agenda of any individual organization on the Consumer Workgroup.

About this Report

Elder Abuse Consumer Workgroup Charge

Governor Dayton's letter of November 30, 2017 asking AARP to convene a Consumer Workgroup requested guidance for state leaders focused on the needs of seniors who are cared for in nursing home and assisted living settings, including:

Protecting the rights of residents and families and connect them to resources

- Review the current state and federal regulatory, licensing, compliance, and enforcement requirements, and recommend changes if these requirements are insufficient to deter potential abuse and protect seniors and families from retaliation from providers.
- Clarify and strengthen the statutory definitions of memory care, assisted living, and housing with services so consumers and families can make informed decisions on proper placement for seniors.
- Recommend changes to current law to ensure that family members are informed about how to report suspected abuse and neglect, including the Minnesota Vulnerable Adults Reporting Center and the Ombudsman for Long Term Care.

Improving communication with family members and law enforcement about allegations of abuse

- Recommend changes to current law to remove barriers and improve communication with family members when there is alleged abuse, including the complaints and investigations processes within the Office of Health Facility Complaints and self-reports from providers.
- Recommend changes to current law to ensure proper reporting to law enforcement about potential abuse.

Elder Abuse Consumer Workgroup Process

The Consumer Workgroup met frequently to discuss and develop recommendations that call for far-reaching policy and agency practice changes to prevent and deter abuse. To garner input from the public and other interested stakeholders, we developed and a distributed a survey based on the questions posed to us by Governor Dayton to workgroup members and the organizations, providers and individuals who contacted us.

We received more than 100 survey responses and more stories of elder abuse. A summary of responses to the survey and stories are attached in the appendix of this report along with the names of organizations and individuals who contacted us. Upon request, AARP can make available the full survey responses.

Organization of this Report

Given the breadth of issues facing older and vulnerable adults, organization of this report presented challenges. The broad scope and level of detail that the Workgroup was able to achieve for the recommendations in this report in a relatively short amount of time are both a testament to the intricate knowledge of those on the Workgroup but also to the magnitude of the crisis. For readability, and given the level of detail, this report is divided into two main sections: 1) Background of the Problems and Summary of Recommendations; and 2) Recommendations with Statutory Changes Needed. Each of the sections is broken down into the four action areas for reform listed in the Executive Summary. The Workgroup trusts that this organizational structure allows for readability of complex issues followed by fine-tuned recommendations and statutes.

Consumer Workgroup Participants

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STRENGTHEN AND EXPAND RIGHTS OF VULNERABLE ADULTS AND THEIR FAMILIES

BACKGROUND

Critical Gaps and Inequalities Exist in Current Law

Critical gaps and inequalities exist in current laws designed to safeguard Minnesota's older and vulnerable adults from abuse and to provide other vital consumer rights. These gaps exist despite the fact that there are many laws already on the books designed to protect older and vulnerable adults -- including, but not limited to, the Health Care Bill of Rights, the Home Care Bill of Rights, and the Minnesota Vulnerable Adult Act.

First, distressingly, as the system is set up, families – and those who care about and are responsible for the well-being of older and vulnerable adults in residential settings – are often completely in the dark that abuse, neglect, maltreatment, or violation of rights is occurring. Under current law, neither the victim nor the family has a right to know about the filing and content of reports of abuse.

Second, under current law, not all older and vulnerable adults who receive care at home or reside in nursing homes, boarding care homes, or in Housing with Services/Assisted Living (HWS/AL) settings, have the same rights. The Health Care Bill of Rights today does not apply to persons residing in HWS/AL settings. In most cases, it should not matter whether the older or vulnerable adult lives and receives care and services in a nursing home, a boarding care home, in HWS/AL, or at home. Most likely because these laws were stacked on top of one another over time, rights that should apply universally to all apply only to some. In addition, where a right does exist, it is often limited and insufficiently clear and protective.

Third, certain essential and longstanding rights, such as the expressed right of an older or vulnerable adults to place a camera or electronic monitoring device in their rooms, are unclear or absent from existing bills of rights. The Health Care Bill of Rights should be updated to include the right to place a camera and electronic monitoring devices both for abuse detection and for communication and make certain all other rights are clear and unequivocal.

Additionally, many stories we heard were from families that felt they were subject to deceptive marketing or alleged "bait and switch" practices after admission. There are no prohibitions against these practices in laws governing HWS/AL, and the one reference to it in the nursing home statutes has no associated enforcement right for the older or vulnerable adult, or for his or her family or advocate. All too often they report being given misleading information prior to, at, and after admission – or not receiving important information at all. For example, some of the misinformation is related to the nature and level of care offered; whether the older and vulnerable adult will have to move or share a room; or whether they will receive inferior services if forced to relocate if they switch from private pay to public pay are only some of the reported concerns.

Fourth, older and vulnerable adults and their families need stronger protections against retaliation for asserting rights, filing grievances or otherwise complaining about care or services. Further, the law should delineate the types of behaviors that constitute retaliation. Under current law, there is no meaningful protection against retaliation when either the older or vulnerable adult or a family member reports maltreatment or other violations of rights. It is essential that Minnesota law provide protection against retaliation.

Finally, the statutes and rules governing the provision of care and services to older and vulnerable adults, as well as to all persons with physical, developmental, or mental disabilities, are a tangled maze of confusion, rife with inconsistency, ambiguity, and cross-references to repealed statutes or rules. They cry out for harmonization, reorganization, consolidation, and recodification.

In this section, we outline the gaps in the current law regarding the rights of older and vulnerable adults and their families as well as point out where they need to be strengthened and expanded. In the next section, under criminal and civil enforcement, we outline new protections that are necessary to enforce these rights.

SUMMARY OF RECOMMENDATIONS

The Consumer Workgroup makes a set of recommendations to strengthen and expand the rights of older and vulnerable adults and their families, including adding the right to know about abuse; affirming the right to placement of a camera or electronic monitoring device in the room; enacting stronger anti-retaliation laws for vulnerable adults and their families; ensuring that, where appropriate, older and vulnerable adults all have the same rights and protections, regardless of the residential care setting in which they live; and ensuring that the services marketed are provided as promised and purported.

A. The Right to Know About Abuse

Disclosure of information in maltreatment/abuse reports must be allowable to the victim and those acting on their behalf. The state law should also be amended to mirror federal law by allowing release of medical records to authorized agents after the death of an older or vulnerable adult.

B. Affirming the Right to Placement of a Camera and Electronic Monitoring Device[12]

Technology plays an integral role in the lives of older and vulnerable adults and often operates as an important tool in their quality of life and connection to their support system beyond the care setting. Older and vulnerable adults need the explicit right to allow for use of a camera or other electronic monitoring device in their own room. The Workgroup recommends that such a right be added to the Health Care Bill of Rights.

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[12] For further information on this topic, see Minnesota Elder Justice Center, *Residential Care and Services Electronic Monitoring Work Group Final Report* (January 16, 2017) (presented to the Legislature pursuant to 2016 Minn. Laws, ch. 179, s. 39); available at http://www.health.state.mn.us/divs/fpc/rcworkgroup/finalreport.pdf.

C. Addressing Retaliation

Minnesota law needs to be clear and provide meaningful protection against retaliation when either the older or vulnerable adult or a family member reports maltreatment or other violations of rights. Certain acts that are currently not defined as "retaliatory" under the Vulnerable Adult Act should be added, including, among others, restriction of use of or access to amenities or services; termination of services or lease agreement; sudden increase in costs for services not already contemplated at the time of the maltreatment report; and deprivation of technology, communication, or electronic monitoring devices.

D. Ensuring Equal Rights and Expanding Rights

Currently, there is one Bill of Rights (the "Health Care Bill of Rights")[13] for older and vulnerable adults who live in nursing homes and boarding care homes, and another Bill of Rights (the "Home Care Bill of Rights")[14] for older and vulnerable adults who receive home care or live and receive services in a HWS/AL setting. As currently constituted, important and relevant rights granted in one Bill of Rights are not granted in the other, and vice-versa. There is no reason why older and vulnerable adults, regardless of the setting in which they live, should not be entitled to the same rights.

Moreover, there are significant gaps in both these Bills of Rights. Additional rights are needed. For example, while an older or vulnerable adult has the right to appeal a discharge from a nursing home, an older or vulnerable adult living in a HWS/AL or home care setting has no comparable right to appeal a termination of a lease or services. Finally, with one narrow exception, older and vulnerable adults can be asked or required to waive any or all of their rights. Waivers of rights generally is problematic, but it is especially worrisome in this setting because the people these rights are meant for are our most vulnerable. These rights should never be waivable. Laws already exist to allow necessary exceptions when the safety of the person or others is at stake. No further limitation of these rights should be allowed.

E. Identifying and Prohibiting Deceptive Marketing and Business Practices

Laws must be strengthened to specifically prohibit deceptive marketing and business practices across all care settings including HWS/AL. In addition, older and vulnerable adults and their families must have the statutory right to enforce these laws.

F. Making Sense of Our Confusing Laws Governing Care and Services to Vulnerable Minnesotans

Currently, the statutes governing the provision of care and services to persons receiving home care services, assisted living clients, and persons residing in nursing homes, boarding care homes, housing with services establishments, and residential facilities – as well as persons with physical, developmental, functional, or mental, functional impairments receiving services – are in varying degrees confusing, overlapping, redundant, inconsistent, ambiguous, and extremely difficult to navigate.

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[13] Minn. Stat. § 144.651 (providing rights for residents in nursing homes and boarding care homes, among other facilities).

[14] Minn. Stat. § 144A.44 (providing rights for persons receiving home care). The "Assisted Living Addendum" extends, with one exception, those rights to assisted living clients. *See* Minn. Stat. § 144A.441.

Further, there are five separate "Bills of Rights" that provide the same or similar rights to (and impose the same or similar provider responsibilities regarding) different types of recipients of the same or similar care and services.[15] They cry out for harmonization, reorganization, consolidation, and recodification.

In addition, the Uniform Consumer Information Guide – which was designed to provide a clear statement of promised services and provide an apples-to-apples comparison among competing providers – is not adequately fulfilling those originally intended purposes. It requires updating and editing for clarity.

Finally, while there are already legal requirements for providers to post and inform older and vulnerable adults about where to report suspected abuse, the reality is that this information cannot be fully absorbed during the complex admissions process. A separate mailing - developed by an independent victim services organization – should be distributed to new residents and their families no later than a month after move-in.

[15] *See* Health Care Bill of Rights (Minn. Stat. § 144.651); Home Care Bill of Rights (Minn. Stat. § 144A.44); the Assisted Living Addendum (Minn. Stat. § 144A.441); Hospice Bill of Rights (Minn. Stat. § 144A.751); and Patient Rights (Minn. Stat. § 144.292).

CRIMINAL AND CIVIL ENFORCEMENT

BACKGROUND

Criminal Enforcement: Prosecutors Need More Tools to Hold Abusers Accountable

Minnesota's criminal code does not allow prosecutors to charge perpetrators of abuse in the fourth degree with a gross misdemeanor if the older or vulnerable adult does not experience "demonstrable bodily harm." As a result, when an older or vulnerable adult is assaulted and terrorized by threats or other physical abuse where the legal standard cannot be met, prosecutors' hands are tied, and it is impossible for equally egregious – but less physically manifest – abuses and harms to be punished. The criminal code needs to be strengthened to give prosecutors the ability to charge assaults against older and vulnerable adults as gross misdemeanors.

Further, policymakers and prosecutors should undertake a thorough review of statutes enumerating crimes against vulnerable adults in other portions of the Criminal Code that apply in vulnerable adult cases. For example, the definition of criminal abuse of a vulnerable adult has limited application to aversive and deprivation procedures in a licensed facility or to sexual contact by a facility caregiver. Alternatives include expanding the definition of criminal abuse of a vulnerable adult to encompass a broader range of physical and sexual assault and/or prosecuting any sexual assault of a vulnerable adult under the sections of law governing sexual assault generally.

Civil Enforcement: Older and Vulnerable Adults Need a Statutory Right to Judicial Enforcement of Their Rights

There is a critical gap in Minnesota's civil statutes that for the most part leaves older and vulnerable adults, and their families and advocates, without a realistic avenue to obtain justice, redress, and compensation in a court of law for physical or other harms inflicted by abuse perpetrated or for other violations of the rights granted under the statutes. In many other sections of Minnesota law where vital rights are violated, or serious harms are inflicted, victims are statutorily empowered to seek the help of the courts to enforce their rights and receive compensation and their legal fees if they prevail. Without this statutory authority, all the critical rights provided for older and vulnerable adults are merely paper rights.

Currently, the right to civil enforcement is minimally mentioned in the Health Care Bill of Rights – and that right is severely limited. Since it resides in the Health Care Bill of Rights, it is available only to older and vulnerable adults residing in nursing homes, boarding care homes, and limited other settings. It appears further restricted to only those persons with guardians or conservators. Critically, this right does not even exist in the Home Care Bill of Rights and thus does not extend to older and vulnerable adults living in HWS/AL settings.

The narrow private enforcement right in the Health Care Bill of Rights is not at all helpful to the victim or the victim's family since there is no teeth to the law, and no right to compensation for wrongs included. And since the populations for whom these rights are intended are often

older and vulnerable adults with limited and rapidly diminishing financial resources, without inclusion of legal fees, few can afford lawyers to help them fight for their rights and justice.

Moreover, where a family can afford a lawyer to go to court when a perpetrator causes physical injuries to a vulnerable adult, if the older or vulnerable adult victim dies while the case is in progress, the case effectively dies with her or him; families get no closure or relief. This limitation provides a disincentive for perpetrators to resolve matters while the older and vulnerable adult is alive and sends the wrong message.

Older and vulnerable adults and their families cannot rely solely on the providers themselves or on government agency oversight, especially in the HWS/AL setting, where regulatory agency authority and oversight is statutorily and otherwise weak or nonexistent. Even if the public enforcement system were optimal, there is still no existing meaningful right for older and vulnerable adults and families to enforce their rights and receive compensation for harms done. Civil remedies must be strengthened.

Finally, there is an anomaly in the law that gives perpetrators of abuse greater appeal rights than victims of abuse of a maltreatment finding. Under current law, a perpetrator has the right to appeal an administrative finding of maltreatment to either an administrative tribunal or to district court, but the victim does not have that same right when the lead investigative agency does not find maltreatment. The victim's only appeal is back to the same agency that made the finding with which the victim disagrees in the first place. Only a paper review is conducted by a Maltreatment Review Panel composed, nearly exclusively, of lead investigative agency representatives. It is illogical that perpetrators have greater rights and access to our courts than older and vulnerable adult victims.

SUMMARY OF RECOMMENDATIONS

Criminal Enforcement

A. **Strengthen Criminal Code to Hold Perpetrators of Assault Accountable**
Prosecutors must be given additional authority to file a gross misdemeanor charge against a perpetrator committing assault in the fourth degree against a vulnerable adult without needing to prove "demonstrable bodily harm" when the assault was committed with the "intent to cause fear in another of imminent bodily harm or death."

B. **Review the Criminal Code with Respect to Crimes Against Vulnerable Adults**
The Criminal Code sections that address crimes against vulnerable adults should be reviewed to evaluate whether definitions of criminal abuse and neglect should be updated and whether some or all sexual assault crimes against vulnerable adults should be prosecuted, with enhancement for vulnerability.

Civil Enforcement

A. Allow Older and Vulnerable Adults to Go to Court to Enforce Their Rights
Older and vulnerable adults and their families and advocates need a statutory right to obtain redress and compensation for harms inflicted by the violation of consumer rights granted under Minnesota law, including but not limited to, rights contained in the Health Care Bill of Rights and the Home Care Bill of Rights.

B. Give Family Members and Others Advocates Authority to Enforce Rights Granted to Older and Vulnerable Adults
Currently, enforcement of the Health Care Bill of Rights is severely limited – appearing to extend to only those persons with guardians or conservators. Nowhere else in law are family and advocates given statutory authority to enforce the rights of older and vulnerable adults on their behalf.

C. Allow Court Actions Involving Abuse to Proceed After Death of the Vulnerable Adult Plaintiff
Families or an advocate should be able to proceed to the conclusion of the case, without limitations, on behalf of the deceased victim of abuse.

D. Give Victims of Abuse the Same Appeal Rights to Challenge a Maltreatment Finding
Victims of abuse should have the same rights as perpetrators of abuse to judicial appeal of an administrative determination of maltreatment.

NEW LICENSING FRAMEWORK FOR ASSISTED LIVING & DEMENTIA CARE

BACKGROUND

Regulation Not Keeping Up with Complex Care Needs of Residents

There has been an exponential growth in facilities in Minnesota called Housing with Services (HWS) or Assisted Living (AL). Approximately 60,000 elders[16] currently live in AL compared to fewer than 28,000 living in nursing homes.[17] In 2014, 58% of residents in AL were over age 85 and 39% had dementia.[18] In addition, the medical needs of those living in AL have steadily increased and are more complex.

Today, Minnesota does not currently license HWS/AL residential settings, making us an outlier compared to all other states. Instead, Minnesota regulates housing services separately from home care services and does not license the HWS/AL residential setting as a whole. The state requires a registration for "Housing with Services Establishments" and separately licenses home care providers who provide services to residents in these settings. However, the registration has no connection with or carries no authority over the home care provider(s) operating within the building.

Further complicating this scheme is that an HWS can call itself "assisted living" using title protection under Chapter 144G of Minnesota Statutes as long as it complies with other requirements, such as 24/7 awake staff. Not all HWS seek AL title protection and again the title protection does not provide a framework for oversight of the residential care setting. See graph 1 on page 17.

This complicated structure means older adults must enter into two contracts – one for the building/services and one for the home care services – each with important differences[19] that

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[16] *See,* Minnesota Department of Health, *Regulation and Oversight of Long Term Care* (2017) (reporting 1,474 HWS registrations and 1,144 Assisted Living designations); at http://www.senate.mn/committees/2017-2018/3087_ Committee_on_Aging_and_Long-Term_Care_Policy/MDH%20Long%20Term%20Care%20 Provider%20Licensing% 20and%20Regulation.pdf; Minnesota Board on Aging, *Legislative Report - Housing with Services Assisted Living Medical Assistance Study* (2013) (reporting 970 Assisted Living designations; at www.mnaging.org/en/ News%20Archive/2013/MA-Study.aspx); Minnesota Housing Finance Agency, *Housing for Minnesota's Aging Population* (2010) (reporting 57,261 AL residents); at www.mnhousing.gov/ idc/groups/secure/ documents/admin/mhfa_010262.pdf; Minnesota House of Representatives, *Information Brief: Assisted Living/Housing with Services in Minnesota* (2001) (reporting 643 HWS registrations); at www.house.leg.state. mn.us/hrd/pubs/asstlvg.pdf.

[17] Charlene Harrington, Helen Carrillo, and Rachel Garfield, Henry J. Kaiser Family Foundation, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015* (finding 25,542 occupied beds in in Certified Nursing Facilities in Minnesota in 2015); at https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2015/.

[18] National Center for Assisted Living, *Minnesota: Fast Facts – State Profile for Assisted Living;* at https://www.ahcancal.org/ncal/facts/Pages/State-Data.aspx.

[19] Home care services in the HWS setting can be terminated with 10-day notice while AL clients are given a 30-day notice. Even 30 days is an insufficient amount of time to find new services for many AL clients, let alone 10 days.

creates confusion for older and vulnerable adults in understanding what entity has overall responsibility for their care and causes significant disruptions in care.

The two-contract system provides two means to remove a vulnerable adult from their care setting – through termination of housing or termination of home care services. Older and vulnerable adults in residential settings can face traumatic and health-threatening impacts when forced to move. Today, there are few protections when they are terminated from housing or home care services. Older and vulnerable adults have no appeal rights[20] and there is no requirement for providers to assist with discharge planning. These protections exist for nursing home residents and we believe these protections should apply equally to older and vulnerable adults across all settings.

Several other problems exist with the current system. Minnesota does not define minimum standards for dementia care in statute, whether in what is commonly called a "memory care" unit or in another long-term care setting. This lack of definition results in differing standards of care across settings, such as nursing homes and HWS/AL. The lack of definition is making it difficult for vulnerable adults and their families to make informed decisions. Minnesota only requires the disclosure of practices related to dementia care in a facility, and there is little or no regulation of that disclosure, let alone the practices outlined in the disclosure. Also, while training guidelines are required for those facilities offering dementia care, there is no measure of competency to determine if staff understands the curriculum. Those with dementia are among our most vulnerable and often cannot articulate when they are being harmed or their needs are not being met.

In addition, there are no minimum staffing requirements in HWS/AL settings that take into account the acuity level of residents beyond concepts of "sufficient numbers" under Minnesota law. Without clear standards it is difficult for consumers to understand what services are available and whether such services will meet their needs.

Finally, problems exist for vulnerable adults who have spent their life savings and then must enroll in the Elderly Waiver (EW) Program, Minnesota's Medicaid program. EW recipients are often no longer able to either keep their private room or are terminated altogether from HWS/AL settings. More protections are needed beyond disclosure of whether the setting accepts persons on the EW program. Additionally, given the significant confusion in the EW benefit process, more training and greater collaboration among county, providers, and the vulnerable adult or his or her family member is necessary.

Given the complexity of care needs of the frail elderly living in HWS/AL settings, it is time to recognize that these "clients" are not merely tenants, but rather older and vulnerable adults that cannot simply find a new apartment. Therefore, we call for major systemic changes in how we regulate these settings including the development of Assisted Living Licensure, Certification of Dementia Care as well as some immediate protections for vulnerable adults in these settings today.

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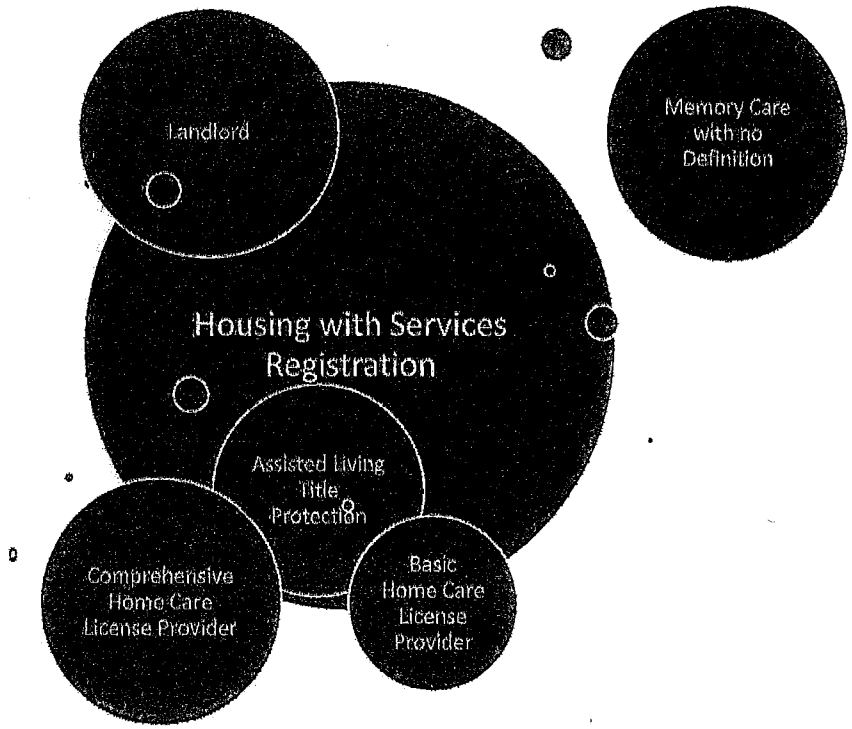
[20] If the HWS/AL wishes to formally evict the resident, housing court can become a venue for opposing the eviction from housing, but arguably not the termination of home care services.

Graph 1. Current framework of HWS and AL Title Protection that separates housing from and home care services creating a confusing regulatory scheme.



SUMMARY OF RECOMMENDATIONS

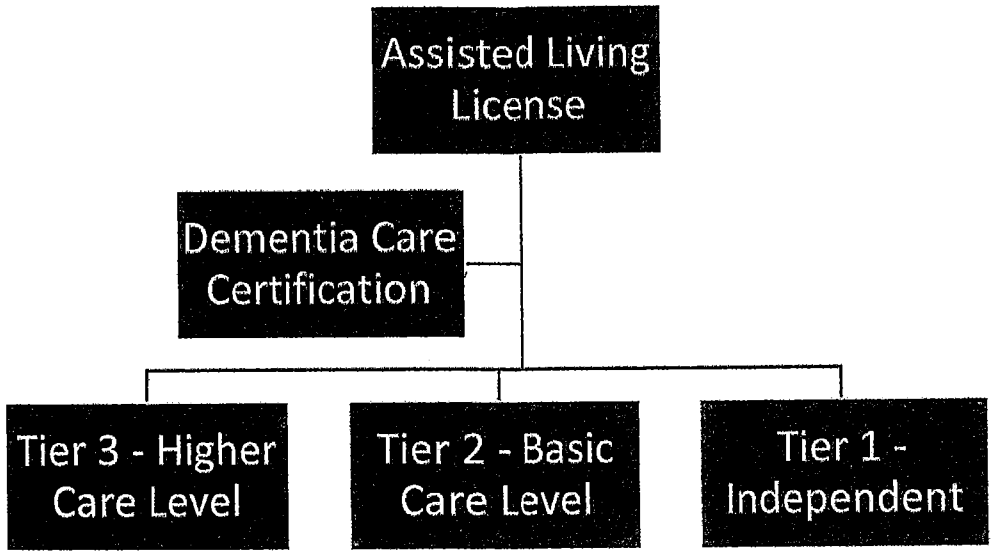
A. ***New Assisted Living Licensure Framework***
Direct the Commissioner of Health to create a new assisted living license during the 2018 legislative session to be implemented by January 1, 2020, with details of the license to be developed by a stakeholder group that includes significant consumer input. The main goal of licensing the AL residential setting is to join both housing and home care services under one license structure. The new licensing structure must recognize that landlord- tenant law under Chapter 504B still applies and additional standards that are currently outlined in law, in addition to new standards as discussed in this report. See graph 2 below for an illustration of the new framework.

B. ***New Dementia Care Certification***
Direct the Commissioner of Health to create a new Dementia Care Certification, including for Dementia Care Units, during the 2018 legislative session to be implemented by January 1, 2020 as part of the AL licensure development process. The details of the certification will be developed by the stakeholder group referenced above. The goal of the certification is to identify minimum safety and quality of service standards for dementia special care, including dementia training, assessment, care planning, therapeutic activities,

and physical design/environment.

C. *Improved Staffing Levels Required*
Current staffing requirements are not sufficient to ensure that proper levels of staff are available and adequately trained to care for residents with complex needs, especially on nights and weekends. Stakeholders must be creative and cooperative as well as and develop private/public incentives to improve staffing levels, retain today's dedicated caregivers, and find ways to recruit, train, and support future caregivers.

Graph 2: Recommended new AL and Dementia Care License Framework.



D. *Immediate Protections for Vulnerable Adults Needed in HWS/AL*

Create a Termination of Appeal Right for Residents in HWS/AL
Allow residents of HWS/AL to appeal terminations of housing and/or home care services to the Minnesota Office of Administrative Hearings, similar to the appeal rights available to nursing home residents.

Prevent HWS/AL from Redefining Statutory Terms in Admission Contracts
Establish that HWS/AL admission contracts cannot redefine the terms, including "responsible party," that are already defined under current law.

Immediate Needs for Elderly Waiver (EW) Vulnerable Adults
Immediate needs include protections of elders on EW by requiring the HWS/AL to accept EW residents after a period of private pay and establishing training and/or education for providers and residents (or their families) on the process of applying for EW benefits, focusing on greater collaboration between the county, the resident, and the provider to avoid gaps in payment for long-term care services.

IMPROVE MDH LICENSING, OHFC ENFORCEMENT AND OHFC INVESTIGATION PROCESS, AND MAARC REPORTING PROCESS

BACKGROUND:

Current Licensing & OHFC Investigations Laws are Not Being Adequately Enforced

Under current law, the Minnesota Department of Health has two units to carry out its mission to protect vulnerable adults: the Office of Health Facility Complaints (OHFC) and the Health Regulation Licensing Division. Minnesota law and rules enable numerous actions MDH can take when violations are found in either a licensing survey or complaint investigation. A unique opportunity presents itself now, with so much public attention to these issues, to reevaluate the effectiveness of correction orders, time periods for correction, re-inspection, the schedules of fines for both nursing facilities and home care providers, the adequacy of those fines, and other available means for penalizing violations (e.g. receivership, placement of a monitor).

During the 2017 legislative session, OHFC revealed a substantial need for additional resources to handle the dramatic rise in maltreatment reports. OHFC reported a 600% increase in maltreatment reports since 2010 and an ability to investigate only 1% of the 20,791 reports from providers and 10% of the 3,491 reports from individuals.[21] We recognize that steps are being taken to improve OHFC's processes, including: task force and engagement work done in the fall of 2017; the current work being done in conjunction with the Department of Human Services; and potential solutions that will be in the Office of Legislative Auditor's report due in early 2018. Therefore, our recommendations reflect recognition of the work already underway while acknowledging that more must be done.

MDH should be expected to meet standards and statutory timelines for inspections and investigations. The process under which OHFC must perform investigations of maltreatment complaints is largely prescribed by law but is not being followed. The current rate of OHFC investigating family reports is woefully unacceptable. Moreover, continued improvements in reporting practices and enforcement policies are needed to hold perpetrators of maltreatment in facility settings accountable.

The current regulatory process is split between nursing homes on the one hand and Housing with Services (HWS) and assisted living (AL) settings on the other. OHFC for example, does not provide on-going monitoring for compliance for HWS/AL. Moreover, the fines for maltreatment in HWS/AL are generally believed to be less than the fines in nursing homes. While, both OHFC and MDH Licensing currently have the authority to issue fines for substantiated maltreatment, resident right violations, and violations of certain provisions in the Vulnerable Adults Act, such authority is not being utilized. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult in HWS/AL is $5,000. We believe this is not significant enough to deter poor care. Vulnerable adults are entitled to equal protection from maltreatment regardless of their care setting.

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[21] *See* FY18-19 Biennium Budget Plan from OHFC.

to sign due to HOH (hard of hearing). They didn't put his hearing aids in and they were laying on table. "Am I supposed to be in pain, but I'm not."

Mom doesn't remember any of these days because she was suffering from a urinary tract infection. So, I prayed with Dad and said I wanted the hospice nurse to check his lungs. She got short with me and said, 'your Dad's dying" and walked out. Adam (my son) can understand if Grandpa dies from CHF, but he can't understand how they would let him die without treating him for pneumonia.

I see no difference between this story and euthanasia...I'll never get over this.

Case 24 - Mental Abuse

I have a mother at a nursing home. I have had to work hard to get people (aides, nurses, nurse managers and directors) to realize that abuse constitutes more than something physical.

1). Mom does not want not go to the bathroom in front of men but she now has men late at nite because the female aide is either not there or is busy - and it takes a long time.....why can't a female nurse help?

This man also told my mother he was a doctor!!!!!!!!! These women are Catholic and have certain modes of modesty that they have followed all their lives - why are they forced to accept this? This is where physical abuse can occur and knowing their maladies can give them assurance that if they have the inclination towards aberrant behavior it probably will not be reported or they can lie. I have repeatedly called the Nurse Manager but she is only there on Monday, Wednesday, and Friday. They never get back to me, even when I leave message.

2). We just got done with a so-called "quarantine" because 3 people came down with flu symptoms and when tested, were positive. They required that all residents will be given the Tamiflu. It did affect Mom and so we discontinued it at day 8. Her frame of mind improved from that missing dose.

They do not let the first floor residents go anywhere - not to Mass, not to the atrium, but they are all expected to sit in their rooms and then go out to be together in small places where they can get sick - no fresh air, no sun exposure.

3). The refrigerators on the 1st floor are always dirty with dried on spills everywhere - I try to keep it spruced when I am there but at $6-8,000 /mo isn't that housekeeping's job? Not to mention the tables in the dining room. There is dried food on the sides, bottom of the table.

While these are no where near the horrible abuses that have happened to others, they are an opening of pandora's box that will lead to more serious abuses. Lincoln said, "you can judge a country by the way it treats it elderly." No abuses should occur at any time.

(2) One staff member would ram my uncle, legs first into the wall when she became frustrated with caring for him. This was reported through all the appropriate channels, but by the time an agency actually called the family to follow up on the situation (many months later), he was already dead.
(3) On another occasion, my uncle was taken to a doctor in a van. The wheelchair was not secured and during a quick stop, he toppled over backwards hitting his head on the floor. No action was taken by the staff regarding this injury.
(4) My uncle, early on his stay, was very motivated to walk and asked to receive physical therapy to help him. I repeatedly called the therapist and the facility manager requesting this therapy and offered to pay for the therapy privately. They refused and the doctor told me, "that would be like throwing money at a dead horse." He was confined to a wheelchair sometime after those requests failed.

Because their caretaker lived out of town and couldn't do weekly checks, she hired a private caretaker to visit the facility three times a week to check on and report the status of her aunt and uncle. This regular checking helped to get this couple some special attention; though during the stay there was a continual stream of little incidents.

Why didn't they just move to another facility? They were all full. Their niece had them on a waiting list for all the local facilities, but an opening never arose in four years. The aunt was eventually hospitalized due to the MRSA infection. The last insult was during her transport from the hospital to the hospice facility, her wedding rings vanished from her hand! And, of course, no one knew what happened to them.

Case 23 - Put in Hospice Against Will of Capable Resident

My Dad loved life to the full. He was 91 years young and living at home with my beautiful Mom, then 87, in August of 2016.

My twin sister and I were dedicated to helping them stay in their home, but my niece convinced my Mom to sign a hospice agreement back in about 2015 without consulting my Dad, who was still running errands, paying bills, and playing in the band. My Mom was trying her best to understand all this but what she didn't understand was that Dad could not be admitted to a hospital with this hospice agreement.

Dad ended up being transported to the hospital with pneumonia...my sister and I rushed to the hospital and told the doctors to please care for him...we'd be there in two hours from the Twin Cities to Albert Lea. The doctor said, "We have plenty of drugs to give him"...I said, "I bet you have morphine too." He said, "Yes , we do but he's on hospice so we can't treat him".

Dad said he wanted to be treated and he was signed into hospice. Dad said, "They know I want to live...Why isn't my word good enough." Dad had been released to a nursing home. The person in charge never liked Dad and she said, "I'll give him one chance to rehab and that's it." The administrators came and told her to leave. One of the medical nurses let me look at the records for my Dad and it said, "Wife signed benefit election form for Hospice, due to patient's declining

- I came to visit and found my mom in the bathroom on the toilet and she said she had no feeling in her legs because she had been sitting there so long. Again, she called out many times, but no one came. This would happen frequently. The aide's response would be "just go in your Depends and I'll change you, it's easier."

- My husband, son and I witnessed an aide pushing a resident in a wheelchair that had her foot wedged under the wheel, there were no foot rests. The resident was calling out that her foot was stuck and the aide responded, "pick up your feet, I am tired of your games." The resident cannot stand, walk and can hardly sit up straight.

- My mom had hospice care at the end and the day before she died hospice prescribed more pain meds. The facility nurse would not respond to the Hospice or the aide's calls to give approval for the aides to administer the new dosage. The aides were terrified that they would lose their jobs since the facility nurse did not give approval. The facility nurse stopped in 9 hours later, stating he had 24 hours to make a medication change and it didn't matter anyway!

- I was told the day before mom died that she had a large open sore on her back, pain meds would not be given sometimes for an entire day and she had fallen many more times than the staff reported. The few aides that came forward asked me to please speak up, that they did care but didn't want to lose their jobs.

Case 21 – Sexual Abuse in a Nursing Home

My grandfather was a resident in a nursing home. He had been living there for several months when suddenly he didn't want to take a bath. He had always looked forward to a whirlpool bath. I asked him why he didn't want to bath any longer and his response was "sex maniac." Clearly it had been hard for him to report what was going on. My husband and I contacted the administrator once we could identify the person responsible. The administrator was responsive about the situation and had called the individual to come into his office while we were there. The person never showed up for that meeting and never reported back to the nursing home. Hopefully, he's not working in another facility. I have heard talk about a database to track CNA's and nurses, but I don't know if that exists.

Case 22 – Physical Abuse, Cruelty and Theft

An elderly aunt and uncle (she 80 and he in his 90s) were residing in a care facility that included both assisted living in one part of the building and skilled nursing care in another. Their niece, the primary advocate and caregiver lived in another state and made regular, unannounced, visits to see them and check on their care. During a period of three years, the following things were observed:

(1) The aunt could not walk and/or transfer from her wheelchair to her bed without assistance. She had a MRSA infection in her hip from a hip surgery and sitting was painful for her. When she asked to lie down one time, they picked her up and threw her into the bed saying, "there, now you are where you want to be." Both she and her husband were afraid to comment on the abuse because they thought the staff would treat them even worse.

Mom never did recover from the ordeal. She passed away two weeks later.

The Department of Health never did an investigation even when other healthcare professionals verified the claims. The health department reviewed the records and determined there were no violations of state or federal regulations, even though they never met with hospital staff or interviewed the driver. Without a state investigation, we will never get a full understanding of what happened to mother.

Case 19 - Poor Hygiene Care

I'm a volunteer in the senior living community in the Twin Cities area. I was asked to leave the facility after cutting a resident's hair. While this was apparently an offense, the real offense was that her hair was matted like a cat's and clearly hadn't been brushed in weeks, if not longer.

I also witnessed nurses admonishing residents for complaining about their treatment. Mind you, the residents often times hardly understood what the nurses were saying!

Case 20 - Staff Neglect Led to Suffering and Painful Death

My mother had advanced Parkinson's and lived for 1 ½ years at a residential assisted living facility. She was mobile with a walker when she moved in, was of very sound mind and excellent hearing. Of course, the disease progressed but she remained quite sharp. She passed away due to aspiration, she was 75.

Unfortunately, the conversations I had with my mother regarding the incidents I personally witnessed or my mother told me about usually ended with her asking me not to say anything because it would just make it worse or that she was worried she would end up in a nursing home.

These are some of the many incidents:

- The facility advertises a specialized home environment and that all staff are fully trained in Parkinson's patients. Many aides I spoke with had never been trained. There was no specialized eating, drinking or personal care items designed for a person with Parkinson's and the bathroom hardly had room for an aide and a resident.

- They also said that an aide was always on the lower level of the house where my mom's room was. That was definitely not true. Many times I would visit and she would be sitting at the table alone trying to eat, her care plan clearly stated she was not to eat unattended due to high risk of choking.

- She was left fully clothed, with her glasses on and dentures still in, lying on top of the covers and the TV and the lights on from about 9:00 pm until the daytime aide came in to get her up for breakfast. Mom said she called out many times, but no one came. She was very cold and had wet herself. The aide did make a report and management said that the night time aide didn't notice anything.

yet. It was 4 hours later! She had not been seen, offered breakfast, or moved since the night before! During her short stay there, she also developed a decubitus ulcer on her coccyx. Even though we filed a report with the state regarding the neglect, there was no follow up by the facility or state.

Case 17 - Financial Exploitation and Theft, No Government Protections Available

We have evidence that my father's cash assets were mysteriously changing in favor of his attorney-in-fact (AIF). The financial institutions seemed to slam their books shut, and claimed undocumented changes were done "electronically". It's very hard to believe that the 89 year old senior was doing anything electronically.

My father had kept very meticulous, handwritten records. These records were claimed to have been destroyed by the personal representative (P/R), who had also operated as the AIF. All of this was done after he was determined to need help with banking. The power of attorney document on file, at the Credit Union, had a 3rd stipulation stating his AIF could NOT take ownership of any of his property. Yet, as P/R, she walked away with an undisclosed amount of the Elder's assets, including a $96,000 transfer to a "ghost" account. The financial institutions were able to seemingly slam their records shut, and claim the Elderly, vulnerable adult, with Alzheimer's/Dementia was "clear".

I have submitted reports and complaints to several authorities throughout the State of Minnesota, including the Attorney General's office. I have filed 3-4 complaints to Adult Protective Services (APS), to no avail. My latest report was to Consumer Protection to their Elder Abuse task force. From there, the investigator was to be forwarding the information to Adult Protection. I also spoke with Law Enforcement, who was later denied consent for a criminal investigation. Yet, apparently, in Minnesota, the laws are rather archaic, the standards are nearly as low as being able to fog a mirror and/or sign an X (this worked as a loophole, allowing the wrongdoer to walk away with the undisclosed amount of the Elder's cash assets). Aren't "electronic" changes, to elderly vulnerable adult's assets, without supporting documentation, a crime?

Case 18 - Improper Medical Transport Resulted in Severe Trauma, No Investigation

My mother was a victim of abuse from the employees. I have spent countless hours making phone calls and writing letters to plead my case and find resolution to what happened to her before she passed. In desperation I contacted Fox 9 Investigators and Jeff Ballion aired our story on May 2, 2017, 'Ride from hell.'

A few days after hip surgery, she was strapped to a gurney and loaded into a medical transport van for a 36-mile drive back to her nursing home. Because of her dementia, having had anesthesia and being with a stranger she was very scared and confused. She got very agitated and started thrashing around causing serious injury and trauma. It looked like a wild animal had gotten a hold of her hands. That lasted the entire ride and continued at the nursing home. I wanted to be with her, but they never let me know.

Case 13 - No Wellness Checks as Guaranteed, Body Left for One Week

An independent living facility that also offered assisted living and nursing home care, told the family that they would do a same day wellness check if the father didn't come to a meal. They didn't do this. His body was not discovered for one week, even though he hadn't been to one meal during that period of time, his newspapers were piling up outside his door and another resident asked them to check on him. The family doesn't know how long he laid there before he died but the condition of his body was horrible.

Assisted Living facilities have limited governmental oversight, therefore there was no recourse for the family to assure that the provider corrected their procedures to prevent this from happening in this facility or another provider facility.

Case 14 - Under Staffing and Pay Lead to Abuse

My Mom suffered neglect during her stay in a nursing home. "I think the issue that needs more attention is the staffing of nursing homes. Both the proper number of staffers but also staff pay. Better pay would mean better staffers.

Case 15 - Disregard for the Dignity of The Elderly and Devaluation of Their Life

I am a baby boomer who saw a parent through various stages of elder "care." My parents are both deceased but I care deeply for those currently facing this epidemic and for all of our future elders. The thing that keeps sticking in my craw is that, if people behaved with decency and respect in the first place, we wouldn't be having to work so hard to legislate it. Where is it written that at a certain age, you should start to be treated like trash?? This includes hospitals. I know it's mostly about administrative and money, but they are so eager to get rid of these old people before they spend too much time and money on them. I'm not the only one where their parent was trashed and let die without consent and before their time.

Case 16 - Neglect and Complaint Received No Follow-up

Mother was an elderly woman with mild dementia and we believed that the facilities' caregivers found it acceptable to neglect her because they didn't believe she had the capacity to relate what happened. Unfortunately, when she did report different episodes to us and demanded answers, the facility discounted her reports saying she was mistaken or confused.

One morning we found her in a wheelchair in the dining room, slumped over her untouched cold food and crying out in pain. The women at the table said she had been sitting there for a long time, crying, and with no one coming to help her eat or give her pain meds. We located a nurse who finally gave her medication and an aide then offered to help feed her.

Another day we came at 10 AM to find her in her darkened room, in bed, still wearing the shirt and bra we had dressed her in the day before. Upon pulling off the blanket, we saw no pants and only a bath towel stuck between her legs soaked in urine! Appalled, we immediately called for help. The aide informed us that she had come in to work at 6 AM but hadn't had time to help her

When the mother was transferred back to her long-term care center and the nursing staff gave her an exam they noted that her buttock area was enflamed and raw from being left in wet Depends®. They also noted her unclean skin and ordered medication to treat her buttock area. The nursing supervisor informed the daughter that she would be reporting the other senior care center to the MN Department of Health and that she was obligated to do so because of the obvious neglect.

The family also wrote a lengthy complaint and sent that to the MN Department of Health. They were told that the complaint would be investigated. It took one full year to receive the report on the complaint. The MDH investigator said there wasn't sufficient evidence to prove neglect but later noted on the report that there was concern regarding this facility.

Case 11 - Neglect, Abuse Resulting Hospitalizations and Retaliation

My mother was moved into a senior living facility. She was repeatedly admitted to the hospital with urinary tract infections, cuts and bruises over the next months. There were continual serious errors in giving her the medications or never giving them to her. Dietary orders were not followed by the staff. They ignored her and when she was sick or in pain, they often did not give her Tylenol or heart medication. One time she collapsed and was seriously injured because they hadn't been giving her the heart medication. Another time, my mom said that when she was having chest pain they refused to give her any Nitroglycerin. I gave her one. Another time my mom was complaining of tooth pain. When I got her in to the dentist the next day, we found out that she had 3 abscessed teeth. The oral surgeon said that she had been getting poor help with cleaning her teeth.

After repeated falls, medication mistakes and numerous other poor care that resulted in several hospitalizations in a year's time, I had a confrontation with the nurse. Soon after that I got a call from my brother stating that mom was acting up and could I go. I was there in 10 minutes. The police arrived because the facility wanted her to be taken out of the facility because of her behavior. The whole time this was happening my mom was calm and quiet. When I took her to a hospital it was found that she had narcotics in her system that were not prescribed to her. Then, when they tried to place her in the geriatric psych unit, they wouldn't take her because she was calm the whole time.

She was returned to the facility because there were no open beds elsewhere. They met with the family and they blamed me for the narcotics and I was not permitted to have any contact with her. Finally, after six months my beautiful mother succumbed to her injuries.

Case 12 - Theft and Pawning of Valuables

Instances were caught on camera showing aides stealing cash and valuables from a mother's room. In working with the police, it was learned they found that the aide took the valuables to sell at a pawn shop. Her case went all the way to the Attorney General. It was substantiated by MDH but the findings were never put on MDH website, so this information is not available to the public.

"Oh my god!" Her femur (leg), was broken in half. She ended up with a splint from hip to toe. When she went back, hospice came to "manage her pain." They were giving her far too much morphine and I ended up calling 911 again and she ended up back in the hospital because as the ER Doctor stated, "They were giving her far too much morphine, elderly people can't process drugs the way someone younger can, with that amount, she could OD."

I got her out of there and moved her to another facility. They would put her in a lift to move her into her wheel chair and back to bed because her leg was completely broken in half. Every time they did it, her femur started coming out of her knee. I went to see her and found her lying on the bed with a hospital gown just draped over her and blood coming through all the bandages around her knee. It was the bone coming through the skin and now she had an infection. I called 911 again. She was rushed to Fairview Southdale, one of the Orthopedic Doctors who was on duty said, "You should just have her leg amputated, she has dementia, she doesn't know what's going on, it's not going to heal." I basically told him to get out of the room.

In the end, I couldn't imagine putting her in another place after the horror she had already been through. Between my brother, my sister and myself, we brought her home and I did her care until she passed away. It was my biggest mistake to ever entrust any of these places to care for her and it will haunt me until I die. It is my deepest regret. If I can change things so that no one else has to experience the horror and pain that she experienced, I will do it.

Case 9 - Physical and Emotional Abuse at Memory Care Facility

A video in a "state-of-the-art" memory care facility shows this family member being given physical care which was unnecessarily rough and being verbally disrespected. Two complaint reports were filed with MDH. The first one was substantiated and the second one, which showed videos taken with a camera, was not. The facility nurse announced at the last family care conference that the latest filing with MDH had been denied. The family had not heard anything from MDH about this denial. The family then called MDH and they confirmed that the case had been denied. Why did they notify the provider of this denial and ignore the family?

Case 10 - Gross Negligence and Abuse

A family member's mother had fallen at her long-term senior care residence, fracturing her shoulder. It was determined that she should be transferred to another provider that could give the additional care required while recovering from her fracture. Almost no other local providers would accept the mother due to her dementia diagnosis. She was therefore transferred from the hospital to this temporary care center until she could return to her long-term care center.

The cleanliness of the facility was poor. The family often found the mother wearing the same rumpled clothing that she had on the day before. She was not being bathed and on several occasions the family found a meal tray left sitting in front of their mother for several hours. No one had stopped by to pick up the tray or to offer to help her eat—in spite of having a fractured right shoulder that left her unable to manage silverware or cut the food.

individual and their assets, this process often allows quite the opposite to take place. A ward of a guardian has fewer rights than a criminal. One can be stripped of his or her right to determine their residence, the right to marry, vote or apply for government benefits. The guardian decides where you live, who can see you, and who takes care of you to name just a few.

My 92-year old step-mother lived in her own home with a guardian as overseer. Her actual care was provided by a home health-care company for more than three years. During that time, multiple incidents occurred. One of the worst was when she fell and broke her ankle. She couldn't move around so the caretaker called me (instead of the guardian) to try and find a wheelchair. The caretaker's supervisor said that" since it was Friday, wait until Monday until they could reach a doctor." I went to her house, picked her up and put her in my car and took her to the ER where she was diagnosed with a broken ankle and admitted to the hospital for treatment.

Case 7 - Financial Exploitation

This is a case of the substantiated claim of financial exploitation in 2015/2016. Video evidence of the incident was provided.

The case determination was completed after 3 months. But the information was not available online for many months afterward. The facility was marketing itself as "voted best," yet the data from this substantiated claim and another from the same time period were not made available to the public.

Case 8 - Untreated Broken Leg Led to Recommended Amputation

My mother's experience in the first facility was horrific as it was for many other residents that I saw and witnessed. One of the many things that happened to my mother was that she ended up with a severe urinary tract infection, to the point that she passed out as a result of them not caring properly for her and regularly taking her to the bathroom. When I was helping her in the rest room, she passed out on the toilet. I was holding her up and pulled the cord for a nurse or aid to come in. No one came after several minutes, therefore I called 911. The paramedics arrived came into the room with a gurney and then the nurse and aids came running into the room. As a result, she spent a few days in the hospital. On another occasion, we found that they had shoved a dining room table cloth down the back of her wheelchair to soak up the urine so they wouldn't have to take her to the bathroom. They would leave her pants pulled down and use a sweater or a long shirt to cover her in front. She was only there for 3 months and something horrible happened almost every day. I got her out of there as fast as I could.

Next: we found another assisted living facility and it started out well. It is a family owned place, with the whole family involved, the wife/mother is the nurse there. As time went on, the staff started turning over and one evening, I went to visit my mom and an aid said, "I don't know what's wrong with your mom, she was screaming in pain and wouldn't let anyone touch her. She was pointing at her leg saying it hurts." The aid called the nurse and she told her to put a hot pack on it and they put her to bed. I got there and she was in horrific pain, I called 911 immediately. When she got to the hospital they took an X-ray of her leg, the technician yelled from the back,

One of the main reasons my sister and I are so involved in our parents' care at their assisted living facility is because of the many 'misses' – with basic medical care. One example is the administration of the wrong medication or non-administration of a required medication for both our parents.

However, these PALE in comparison to the following events. A resident entered my mother's bedroom, refused to leave and hit her more than 1 time on the head with a plastic bottle. She told me these blows hurt very much.

I thought we should report this incident as an assault and contact the Police Dept. The Director of the facility counseled me against doing so, as it "would be too disruptive". She promised she would take immediate action to stop/prevent the problem from happening again. I found out a few days later, the action was to install a temporary 'companion' with the resident who assaulted my mother, so he could not wander the hallways any more.

He again entered my mother's bedroom. A nurse confirmed he was "very restless last night and entered several other resident's apartments, prior to entering my mother's room." The nurse also told me she locked the doors of the residents' room that the resident had already entered, but did not feel the need to lock my mother and father's room because "I didn't think he would wander that far away from his own room."

After the 2nd event I hired a 'guard,' at my expense, to sit in front of my mother's room, during the evening times when the resident was often wandering and restless (7:30pm – 11:30pm for several days). During the guard's employment with me, there were at least 3 times the guard was required to chase him away from my mother's front door. Another task the guard was responsible for was to make sure the nurses or aides locked my mother's door when they left. There were at least 5 times the nurses or aides forgot to lock the door, and the guard then made sure her door was locked, to prevent a 3rd assault. On Sept 1, 2016, my mother moved away from the facility.

Case 5 - Sexual Assault in Memory Care Facility

In June 2014 a mother with dementia was the victim of sexual assault by another resident at the facility where she had lived. This assault was witnessed by staff and reported to MDH. Even after the report, the perpetrator (who had no diagnosis of cognitive deficit or dementia) was not removed from the facility for 5 days until the family secured a temporary order of restraint.

A maltreatment report was filed with the MDH. However, the family has yet to be informed of any investigation completed by the MDH.

Case 6 – Caregiving Company Authorized by County Appointed Guardian Fails On Many Fronts

Guardianship fraud seems to be absent from the conversation about elder abuse, but third-party, court-appointed guardians have total power over an individual. Though the intent is to protect an

The family first reported the abuse and neglect to the Vice President of the organization by showing him the videos. The family was promised that the organization would report themselves to the Minnesota Department of Health (MDH). After two weeks of silence by the facility and MDH, the family suspected the facility self-report was never filed, submitted their own report and sent it certified mail to MDH. Following up with MDH two weeks later the family learned the report had never been reviewed or recorded as being received. The facility continued to ignore emails and phone calls from the family after the video camera documented further neglect of their mother's care which included daily cares and escorts to meals.

Their mother was placed in hospice after significant weight loss that was undetected and/or ignored by the caregivers and the facility. The family made the decision not to use the hospice associated with the facility and went to another hospice provider. Within days of hiring the other hospice provider, an email was received from the executive director threatening continuation of substandard care.

MDH substantiated the complaints filed by the family and the results were published to the Minnesota Department of Health website four months after their mothers' death and almost 7 months after the complaint was initially filed by the family. No documentation of the report, the facility stated they filed was ever discovered.

Case 2 - Amputation of Legs Resulting from Neglect at Skilled Nursing Facility

A member's father lacked proper treatment at a skilled nursing home that resulted in the amputation of both legs below the knee. He was admitted to the hospital for blood sepsis and life-threatening bone infections in both of his feet/calves as a result of pressure wounds that were not properly treated in the skilled nursing care facility.

This case was reported to the Minnesota Department of Health (MDH). It was evident that very little time was spent on finding the truth and the department concluded that maltreatment was unsubstantiated. The finding was then appealed and solid evidence was provided to support the fact that each of the MDH reasons were NOT accurate. The factual evidence, including photos, supported the abuse and neglect.

Case 3 - Death from Untreated Emergency Condition in Assisted Living

This is a case of failure to get adequate medical care for an emergency condition, which resulted in death. The assisted living staff were aware of the emergency condition and the symptoms to look for, yet they did not assess him adequately or call 911 when there were clear signs of serious problems. His stomach was bloated and swollen; he was vomiting and had explosive diarrhea. He screamed for help in the morning and no one did a thing. The daughter came unexpectedly and found her father in extreme pain and in critical condition. 911 was immediately called and he died later that day.

He was in relatively good physical condition before this incident. The state found the assisted living provider was neglectful in their care.

Case 4 - Resident Repeated Attacks, Medication Errors

elder voice
FAMILY ADVOCATES

Member Experiences - Examples of Abuse and Maltreatment

The following are some of Elder Voice member experiences at various senior living, home care and long-term care facilities. Many members, however, have not felt they could contribute their story in any public manner because of fear of retaliation; legal action they are pursuing; or other family concerns.



These are photos of three family members who suffered from maltreatment and neglect at some of these facilities.

Case 1 – Death after Neglect

After months of concern for the care being given a mother at a memory care facility and numerous care conferences with the provider, the family installed a video camera. Within three days of installing the video camera the family had clear evidence of multiple incidences of gross neglect and abuse including not being fed, given water, cleaned or moved for 16 - 18 hours in a stretch.

chair. It should be my decision to protect myself. Let's use common sense. I know they were afraid a possible investigator might see it. I offered to sign a note stating I chose to belt myself in. But the reply was "no"."

Case 13 – Death after Neglect – Only in Facility for Twelve Days

"The facility employs young people with no training to take care of the elderly. My husband was there for 12 days and the intact person I talked to told me that every concern I asked about would be taken care of by the care taker. It was not. He never got a shower, his toilet was always full of feces and his teeth were never fixed so he could eat. We went to pick him up and he was unable to talk, walk or anything. He died a few days later. Bad place."

Case 14 – Family Member Financially Exploits Vulnerable Adult

"In the case of my mother, I checked the facility out myself and asked community leaders what they thought about the place. In this instance, it wasn't the facility staff that caused issues, but her financially-dependent verbally-abusive "boyfriend" (who wanted to take her back home and regain control of her checkbook) and a male client who was a bully at the dinner table. I took care of both situations by addressing the social worker on staff."

Case 15 – Staff within a Facility lists Examples of "Care"/Abuse Witnessed

- Staff repeatedly refused to give a pillow to a patient to elevate her foot. The patient had a pressure wound on her foot and protocol is to elevate the foot to prevent additional pressure.
- Staff refused to give water to patients. When water is provided, it is put in a place where the patient cannot reach it unassisted and there is no assistance. Staff will tell you that they withhold water to reduce the need to toilet. (Multiple Facilities)
- Staff put a patient in a disposable diaper that was far too large for the patient's size. The staff told the family they did that because the larger diaper "held more." The patient was left in the diaper so long he ended up with e-coli.
- Verbal abuse and humiliation of patients with dementia (Multiple Facilities).
- Patient was stripped and put naked on the toilet, handled roughly, doused with water. When the patient behaved badly during this "bath", the staff demanded that the patient's anti-psychotics be increased.

There are regulations and "standards of care" that would suggest that none of these things should happened and yet they are a common occurrence.

I have been sending a CNA over to help and teach them how to care and treat and meet my dad's needs. I had to act ugly, to gain much needed attention to my personal situation concerning his welfare, care and needs.

I spoke to my father one evening and I asked him "Daddy How Do You Feel?"

His response was "Baby, I Feel Good And I Look Good Too" those words touched my heart, because I sent someone to properly care for him in the manner his is accustomed to, the way I expect him to be cared for and treated."

Case 8 – Death after Poor Staffing – Facility did not Listen to Family Complaints

"My mother's experience with long-term care in a suburb of the Twin Cities consisted of eight years in assisted living, memory care, and, finally, the nursing home. My mother's care was provided by a very reputable non-profit organization, but the best of intentions was no match for the understaffing and high staff turnover which negatively impacted her care and quality-of-life in the nursing home. Our family grew to believe that no one listened to or cared about our concerns regarding the importance of quality-of-life at the end of life."

Case 9 – Decline in Health after Neglect – Family was not contacted after fall or Health Problems

"My Grandfather suffered a stroke after my Grandmother's death. As a result, we had to move him to an assisted living facility. When he went in, he had some difficulty with searching for words and was a little unsteady on his feet. His decline began gradually and then picked up speed. I was concerned about the changes and urged my mother to make an unannounced visit.

We found that my grandfather was being left alone in his room. If he didn't respond when it was time to eat, they just left him there. He had fallen but no calls were made to us when it happened and we likely would not have known if not for the sudden visit. By the time we moved him out of the assisted living, he was wheel chair bound and completely non-verbal. The nursing home worked one on one with him and made some progress, but he never was the same. It breaks my heart to think of people treating seniors in this way."

Case 10 – Abused by Caregiver – Limited Family Contact and Caregiver Threatened Resident to not Report Abuse

"My mother was a vulnerable adult and was abused be her caregiver. She was competent but so afraid of the consequences she refused to report it. She was cut off from all other family contact. The county provided prior notification of any visits which allowed her caregiver to scare her and prepare the home/responses before the visit. Sadly there was no help from any county or state group. She eventually died, most likely from neglect - not getting prompt attention to her health issues."

Case 11- Resident Shares First Hand Experience with Neglect in Facility

"I was in a facility in the Twin Cities for cardiac rehab after open heart surgery. I was only allowed a shower once a week even when I asked for daily showers. I didn't get clean towels & washcloths daily. I had wounds that needed to be cleansed daily, and proper soap wasn't provided, and I got an infection. Other residents had dirty hair, and weren't kept clean when they couldn't care for themselves."

Case 12 – Facility Limits Residents Decision to Use Self-Protection

"I was in a care facility and while sitting in a wheel chair I was getting sleepy. I knew if I fell asleep I would fall to the floor, so I put the body strap around the back of the chair too. They saw it and removed it and gave me a shorter belt that would not reach around the

Case 5 – Emotionally and Financially Exploited; Facility Denied Family Communication – Complaints Ignored by the State

"My 95 year old grandmother was emotionally and financially exploited over a 4 year period. I would hate to see it happen to other people in the future. I think many of my concerns and complaints were ignored by the state and county agencies that were designed to protect her and others like her.

The nursing home that had a financial interest in my grandmother's care actually did not allow family to speak to her. They set up a password and denied us access to speak to her. I called to talk to my grandmother and they said "do you have the password?" They also did not allow us to take her out for visits!

A system exists but nobody has any authority to enforce the rules. The county agencies I spoke to after filling out complaints did not return calls. They gave zero indication they were doing anything. Our complaints were repeatedly ignored. We later found out licensed healthcare providers (Registered Nurse) made the same complaints we did and they were not contacted by any agency after they reported. These vulnerable adult reports were ignored. This should actually be considered a crime. Agencies that fail to protect vulnerable adults should face criminal liability."

Case 6 – Death after Neglect – OHFC, Ombudsman, Law Enforcement and Multiple Lawyers reported substantiated neglect – No Repercussions to Deter Abuse

"My father was deliberately abused, neglected, and finally killed by his "guardian" and the facility, while the Office of Facility Complaints, ombudsman, law enforcement, and multiple lawyers stood by.

A Special Investigator from Office of Health Facility Complaint reported "substantiated neglect" of my father when she finally showed up February 5, 2017 and yet she left him there to be killed. He died February 11, 2017. She did not even call law enforcement. The guardian and facility were allowed the power to continue to punish/retaliate against Dad and me whenever I advocated for his wellbeing, not even letting me be with him except for a few hours.

My father was loved. He was a wonderful man who simply wanted to live a quality life with us, the ones who loved him. He needed me and I him."

Case 7 – Insufficient Care and Neglect at Memory Care Facility – No Notification of Incidents to Family

"My dad was sent to the emergency room for complete kidney failure only to find and learn that he had almost 3 liters of urine in his bladder that went up into his chest. He was wheezing and very confused. During his hospital stay, I learned that he was so constipated that he had bile coming from his mouth while having a bowel movement at the same time. He now has a permanent catheter which is causing much pain and anxiety, that leads to him pulling out the catheter and almost bleeding to death several times. He has dementia. The facility he is at now let me know that they didn't have the staff or man power to care for my dad in the manner I expected. I wanted them to treat his sores on his feet at least 3 times a day, he had bed sores on his feet after being there a couple weeks, this is new! I did leave the director a message with no response. I don't want to make it more difficult for my dad, or put him at higher risk of abuse by policing and complaining.

He was sent to the emergency room with the same clothing on from 4 days prior to his emergency room visit. He was so nasty and dirty!

months later they found my claim of financial exploitation to be unsubstantiated because the staff member in question said she had the card by accident and never actually used it. Mom's fast decline was met with staff that simply didn't have time for her. The Elderly Waiver she is on to pay for housing and services specifically lists tasks that the staff are to do and in return be compensated for by the State of Minnesota. Consistently for almost three months, my mom was missing meals and was unaccompanied to and from those meals, her medication was given hours later than it was supposed to be given. She was left out of activities and structured social gatherings, and lost in the elevator and walking the halls lost almost the entire time. They were paid to escort her, include her and make her feel safe. None of those things happened. There were doctors' orders for all of the mentioned above tasks that went unfulfilled."

Note: initially her mother was not put into memory care, even after staff advised her to do so. When her mother eventually did move her to memory care facility, she still was left alone wandering and going without meals.

Case 3 – Death after Neglect – Uneducated Staff Abused Resident – Cameras Could Have Proven Abuse

"Our mother was in three different facilities with many problems. Mom was neglected in all three facilities mainly due to a lack of training and/or understanding of Alzheimer's. Our mother was a hardworking person that was a nurse's aid herself for 20 years. The last place she was in was the very facility she worked at. Mom was a true giving person and did not deserve neglect and abuse. Most of which I could not prove, I was accused of having to high of expectations

We did hide one (camera) in mom's room at one point, it was difficult to watch! But if staff knew it was there it would change a lot as time went on I think. Many of our problems would have been witnessed and proven."

Case 4 – Harassed, Abused and Withheld Medication – MDH Investigation Delayed another Year

"I will continue to use my voice to draw attention to the fact elderly residents in the United States are continually being injured and dying. While the governor keeps his finger to his lips, sick old people such as this writer might be able to survive their feelings of anger and rage as they try to reach for handholds in life that may give them one more day, one more day, one more day. And in the meantime, one more old woman is ignored, threatened, physically or sexually assaulted, ridiculed , stolen from, or out and out killed. I asked a registered nurse on staff why it didn't bother her that she is violating the law and she shrugged her shoulders and said "PEOPLE GET OLD AND THEN THEY DIE ! " , AND THEN SHE TURNED HER BACK AND WALKED OUT OF MY ROOM.
I don't intend to die! THERE IS TOO DAMN MUCH LEFT TO DO!"

Note: Marjory has also been featured in the Startribune where an abusive nurse stopped giving her antibiotics that were prescribed to her. "She said she could feel fluid building up again in her lungs, and asked an aide about resuming her mediations. When she got no response, she asked that a nurse call a doctor to renew her prescription. She said the nurse reacted by slamming a phone against her check so hard she nearly passed out. I laid there for 20 minutes, too petrified to move." Last month, Aldrich received a letter form the Health Department informing her that the state's investigation into her case had been delayed until later this year.

AARP® Real Possibilities
Minnesota

Stories Submitted to AARP & Elder Abuse Consumer Workgroup

This document includes stories from families and victims who have shared their personal experiences of maltreatment and abuse to AARP anonymously.



Photos submitted from family members who expereinced maltreatment and abuse within these facilities.

Case 1 – Neglect and Insufficient Care – Moving to a Third Facility

"My father has been in a memory care facility since August 19, 2015. We are now working on moving him to his third facility. We have experienced grave concerns about care and competency in the first two facilities. I also have worked in higher education for the past 10 years. Through this experience I know just how important education is to help our care facilities find qualified and quality team members to serve this fragile and vulnerable population."

Case 2 – Left Wandering in Memory Care and Staff Theft of Valuables; Family Was Not Notified – State ruled unsubstantiated

"My mom escaped and was found outside for an undisclosed amount of time, and I had to follow up on my own for a month to find out what happened, and even then the response was vague and differed from the original explanation.

She had her debit card stolen by a staff member. Other staff told me who it was and that the CNA in question was homeless and staying with another staff member and it was that staff member that turned in the card (she found in her couch) and the CNA in question. The CNA in question admitted that she'd taken it to the Sanctuary staff and was fired immediately. A police report was filed and an elder abuse claim was opened with DHS. 9

Summary of Survey Responses

Submitted to the Elder Abuse Consumer Workgroup

Improve Enforcement of Maltreatment Violations through the OHFC and Licensing Regulation through MDH (135 total)

- Hold providers accountable – 13
- State established rating system for facilities – 10
- More frequent reporting/inspections/surprise visits – 26
- Timely investigations – 23
- Penalties assessed for providers on abuse, fraudulent advertising, not reporting – closure, loss of license, fines -26
- Legislative funding for regulation/enforcement – 24
- Post/advertise information on where to report/better info to consumers – 13

Strengthen & Expand Rights of Consumers and Their Families (127 total)

- Allowing cameras – 7
- Prohibit retaliation against residents – 3
- Process to bring case forward when patient has passed away – 1
- Increased public education campaign, hotline to report, etc.) on senior facilities/long-term care – 21
- Family involvement (frequent visits and monitoring)/patient advocates – 14
- Communication regarding complaint process – 26
- Improve access to home care – 4
- Consumer sign off on acknowledgement of rights/reporting process – 27
- More transparency on reports and incidents of abuse/inspection/report cards/consumer feedback – 24

Staffing Issues (74 total)

- Staffing shortage/wages/turnover/pay – 20
- Background checks/screening – 13
- No tolerance hiring offenders – 2
- Staff training on proper care/process for reporting abuse – 21
- Change work culture at facilities (i.e people feel safe reporting) – 8
- Timely reporting of abuse by facility staff – 10

Appendix

Addressing Elder Abuse in Minnesota in Long-Term Care Settings

Table of Contents

Conclusion

The Elder Abuse Consumer Workgroup respectfully submits this report and offers a comprehensive set of recommendations to address the many problems that undermine the system of care and services provided to older and vulnerable Minnesotans. Our paramount concerns and the heart of our recommendations are these: ensuring that those older and vulnerable adults are protected from abuse; that they have the rights they need and the ability to enforce them fully; and that the system of licensing, reporting, inspection, and public enforcement is effective in fulfilling its statutory and societal obligations.

While we made significant efforts to be comprehensive in our recommendations, we grant that multiple issues affecting older and vulnerable adults could not be addressed in the short timeframe allotted. Nor could we incorporate the entire span of public agencies who share the mission of combatting abuse, caregiver neglect, and financial exploitation in residential long-term care. We certainly recognize and appreciate that the Ombudsman for Long-Term Care and the Minnesota Department of Human Services, particularly Adult Protective Services, are key partners in improving quality of life and services for older and vulnerable adults.

The Workgroup also recognizes that issues discussed in this report may uniquely impact rural and outstate communities, given more limited options for care and workforce, and encourage consideration of these issues when focusing on recommended solutions.

We thank Governor Dayton for giving us the opportunity to develop and present these recommendations, and we recognize the many lawmakers, consumers, care workers, and providers who have been working to improve Minnesota's long-term care system. The Workgroup now looks ahead to working with others to enact legislation in 2018 and commit to the longer-term efforts to bring our recommendations to fruition. Minnesotans deserve a system that provides optimal care and services, and maximum protections against abuse. Addressing the tragedy of elder abuse is a shared Minnesota value. We urge lawmakers and regulators to take swift action to turn these recommendations into laws and into meaningful change.

given that the central common entry point is currently the MAARC, the contact information for MAARC should be posted for residents to know what number to call to report abuse.

Amend the Health Care Bill of Rights (Minn. Stat. § 144.651, subd.20)

investigation to assure the family member does not receive the results of the investigation later than the facility or perpetrator, under the Vulnerable Adult Act.[38]

5. **Require OHFC to Cross-Reference Reports for the Same Victim and Facility**
   The opportunity to add additional reports of abuse and neglect for the same victim in the same facility to a case already in the process of investigation should be allowed. In addition, multiple reports for the same vulnerable adult and/or the same facility for better tracking of maltreatment data should be cross-referenced.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

6. **Publish Completed Investigations to an Easily Searchable Website**
   Consumers and families need tools to help them as they search for a home care facility. They deserve a dedicated website, easy to search, which displays the current and historical investigative reports of abuse specific to each facility.

G. Improve Central Reporting of Maltreatment to MAARC

1. **Allow for Document and File Uploads to MAARC.**
   In order to allow federally certified providers to submit their five-day internal investigation report required by CMS, as well as for families and reporters to provide critical evidence when making a report, the MAARC intake process must be changed to allow for document and file uploads.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

2. **Direct all Reporters to MAARC**
   All reporters, including families, should be directed to make their initial report to MAARC and not OHFC.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

3. **Clarify Ability of Staff to Directly Report Maltreatment**
   Ensure that providers communicate to their staff that they are able to report maltreatment directly to MAARC, without fear of retaliation, and need not rely solely on an internal reporting process.[39]

4. **Define and Enforce Immediate Reporting**
   The term "immediate" should be defined to mean within 24 hours when referring to when a mandated reporter must submit a maltreatment report upon suspecting or having knowledge of abuse. Enforce the strict 24-hour reporting timeline for provider self-reports.[40]

5. **Post MAARC Contact Information.**
   The Health Care Bill of Rights currently states that notice of the grievance procedure to the Office of Health Facility Complaints shall be posted in a conspicuous place. However,

[38] *See* Minn. Stat. §626.557, subd. 9c(f).
[39] *See* Minn. Stat. § 626.557, subd. 4a(d).
[40] *See* 42 CFR §483.12, subd. (c)(1).

E. *Improve OHFC investigative Timelines*

Measurable outcomes should be developed to ensure a higher investigation rate and interventions when such rates fall below established guidelines. It is crucial that all required investigation timelines established by MDH under the Vulnerable Adult Act are met, including:

a. Immediate reporting to law enforcement in appropriate cases;[32]
b. In the nursing home context, reporting within two hours when the abuse results in serious bodily injury[33] to comply with federal law;
c. Assignment to the lead investigative agency with two working days;[34]
d. Communication the initial disposition of the report to the reporter within five days;[35]
e. Completion of the final disposition of the investigation with 60 calendar days;[36]
f. Completion of the public investigation memorandum within ten days of disposition.[37]

F. *Increase Communication to Families During the Investigation*

1. **Allow Disclosure of Reports and Records**

Older and vulnerable adults and their trusted family members should have the right to learn the details of suspected maltreatment. Disclosure of information in maltreatment/abuse reports received by MAARC must be allowable to the victim and those acting on their behalf, except in cases where those acting on their behalf is the suspected perpetrator of abuse.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

2. **Add Response Times and Guidelines for Relaying Information to Families and Advocates**

The investigator should contact the vulnerable adult's family for an introduction within five days after initiation of an investigation and communicate at a minimum every three weeks throughout the investigation. This recommendation does not extend to contacting a family member who is the alleged abuser.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

3. **Provide Investigator Contact Information**

The appropriate family member or designated victim representative should be provided with contact information for the OHFC investigator, as well as additional contact information for other OHFC personnel as needed, resources and appeal rights.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

4. **Enforce Timely Distribution of Final Report to Families**

It is necessary to enforce stricter guidelines surrounding final notification of the

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[32] *See* Minn. Stat. § 626.557, subd. 9(d).
[33] See 24 CFR §483.12 subd. (c)(1).
[34] *See* Minn. Stat. § 626.557, subd. 9a(a)(3).
[35] See Minn. Stat. §626.557, subd. 9c(a).
[36] *See* Minn. Stat. 626.557, subd. 9c(e)
[37] *See* Minn. Stat. §626.557, subd. 9c(f)

2. **Clarify OFHC Authority to Issue Fines for a Variety of Violations.**
   Clarify OHFC's statutory authority to issue fines under Minnesota law for substantiated maltreatment, and to issue correction orders and assess civil fines.[29] A facility or home's refusal to cooperate in providing lawfully requested information may also be grounds for a correction order.

3. **Increase Penalties for Violations by Home Care Providers.**
   We encourage MDH to, at a minimum, double the penalties for all levels of home care violations from the current structure of $0-$5,000. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult is $5,000. We believe this is not significant enough to deter poor care.
   Amend Minn. Stat. §144A.474

C. *Enforcement of Abuse Prevention Plans - Under the Vulnerable Adult Act*

1. **Direct Compliance and Correction Action Related to Abuse Prevention Plans**
   MDH should also be directed to require a corrective action for noncompliance and use its regulatory authority to fine facilities and services for failing to correct noncompliance with abuse prevention plans.[30]

2. **Increase Fines for Failure to Comply with Abuse Prevention Plans**
   Fines for compliance failures regarding the establishment and enforcement of ongoing written abuse prevention plans, as required under the Vulnerable Adult Act, should be increased from its current level of $100.[31]

3. **Change the Definition of Facilities to Include HWS/AL Settings**
   HWS/AL Settings should also be required to have an Abuse Prevention Plan for the physical plant.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557 or Minn. Stat. § 626.5572)

D. *Accelerate Reports to Law Enforcement and Improve Law Enforcement Response where Crimes are Suspected*

Amend Minnesota laws to clarify which is the lead agency when cases involve an alleged crime, whether law enforcement or protective services; clarify mutual reporting responsibilities from OHFC to law enforcement and vice versa, and notify and train lead agencies and law enforcement on clarified expectations.
Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

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[29] See Minn. Stat. §§ 144.653, subd. 6; 144A.45; 144A.53, subd. 1(f); 626.557 – 626.5573; and Minn. R. 4664.0014.
[30] *See* Minn. R. 4658.0193 (reporting maltreatment of vulnerable adults; fines)
[31] *See* Minn. Stat. § 626.557, subd. 14 (abuse prevention plans).

IMPROVE MDH LICENSING REGULATION, OHFC ENFORCEMENT AND INVESTIGATIVE PROCESS, AND MAARC REPORTING

A. *Improve MDH Licensing for Inspections Correction Orders/Fines*

1. **Increase Frequency of Surveys from Every Three Years to Annually**
   Surveys should be every year. The change to annually would require a significant commitment by MDH, but the ramifications of not doing so places older and vulnerable adults at unjustifiable risk.
   Amend Minn. Stat. §144A.474

2. **Remove the Requirement to Provide An "Opportunity to Correct" Before Issuing a Fine**
   MDH interprets the law to require it to allow facilities time to correct violations before it can issue a fine for a violation. MDH believes that its lack of authority under statute to issue fines unless it first provides an "opportunity to correct" not only makes it oversight less effective, but also reduces the effectiveness of fines.

3. **Impose Fine if New Violation Identified in Follow Up Survey**
   For providers that have Level 3 or Level 4 violations, as provided under Minn. Stat. § 144A.474, if a new violation is identified on a follow-up survey, a fine may be immediately imposed during the follow-up survey or during any subsequent survey.

4. **Require Assisted Living Entities to Submit Written Plan of Correction**
   Current practices of allowing providers to develop a "plan of correction" in residential settings should require that the plan is submitted to the department and on file. HWS/AL entities and home care providers should be required to submit a written plan of correction to MDH.
   Amend Minn. Stat. §144A.474

5. **Increase Home Care Fines**
   Fines under home care licensing statutes should be increased to deter violations.
   Amend Minn. Stat. §144A.474

B. *Strengthen and Equalize OHFC Fines and Penalties*
OHFC currently has the authority to issue fines for substantiated maltreatment, resident right violations, and violations of certain provisions in the Vulnerable Adults Act, but such authority is not being utilized. Also, some fines and penalties are not significant enough to be a deterrent for home care providers.

1. **Use Current Authority Enforce fines for Violations of Resident Rights and the Vulnerable Adults Act**
   Both OHFC and MDH's Health Regulation Division have authority to issue fines for violations of resident rights, the Vulnerable Adults Act, and other violations under Minnesota Rules.[28] Such authority needs to be utilized as intended to deter violations.

[28] *See* Minn. Stat. § 144A.53, subd. 1(f) and Minn. R. 4664.0014.

2. **Add Requirements to Termination of Lease and/or Services in HWS/AL**
   - Limit the reasons for termination of lease or health care services to non-payment or breach of contract; allow the resident 30 days from termination to cure the breach.
   - Include at minimum the following in a detailed written notice of termination: the reason for termination, time period to cure any breach, date of termination, and appeal process.
   - Assist the resident in developing a discharge plan to a safe location, including giving the receiving provider sufficient information for continuity of care and offering names to the resident of other providers and HWS/AL facilities.
   - Return any refunds, fees, money or property to the resident as well as provide a final account statement within 30 days of discharge.

   Amend Minn. Stat. § 144D.09

3. **Require a Minimum of 30-Day Notice for Termination**

   Currently there are two minimum notice requirements for termination of housing and services (30 days for assisted living and 10 days for health care services). Require a minimum of 30-day notice for termination of either housing or health care services in the HWS/AL environment.

   Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

4. **Address Improvements in Elderly Waiver**

   Establish training and/or education for providers and residents (or their families) on the process of applying for EW benefits, focusing on greater collaboration between the county, the resident, and the provider to avoid gaps in payment for long-term care services. The training should, at minimum, include the following:
   - That a MnChoices assessment is required prior to becoming eligible for EW;
   - That EW payments do not include three months of retroactive benefits;
   - That if EW benefits are not approved within 60 days of the MnChoices assessment, the resident must undergo another MnChoices assessment prior to becoming eligible for EW.

5. **Prevent HWS/AL from Redefining Statutory Terms in their Admission Contracts**

   Establish that HWS/AL admission contracts cannot redefine the terms, including "responsible party," that are already defined under Minn. Stat. § 144.6501.

   Amend Chapter 144D (HWS)

Create a license for AL Executive Directors/Administrators of assisted living, in consultation with the Minnesota Board of Examiners for Nursing Home Administrators.

B. New Dementia Care Certification

Commit to Create a Dementia Care Certification

The certification should:

- Apply across residential setting (i.e. nursing home, HWS/AL, or home care), with increased requirements for those providers operating a Dementia Care Unit within their residential setting.
- Meet minimum standards based on best practice recommendations for dementia care, like those developed by the Alzheimer's Association.
- Establish one place in statute to identify minimum safety and quality of service standards for dementia special care, including dementia training, assessment, care planning, therapeutic activities, and physical design/environment by combining concepts from current law governing improper disclosure, dementia training in nursing facilities and HWS/AL, and home care provider responsibilities. [27]
- Develop comprehensive dementia care training including evaluation of competency of the individual worker, continuing education, portability for workers across employers, minimum standards for trainers. Training curriculum should incorporate principles of person-centered dementia care including thorough knowledge of the person, their abilities and needs; advancement of optimal functioning and a high quality of life; and use of problem solving approaches to care. Training should be culturally competent, both for the provider and the care recipient.
- Grant authority to MDH to monitor and enforce such certification for compliance.

C. Improved Staffing Levels Required Through the Stakeholder Process

Create more detailed staffing guidelines and best practices based on acuity level and number of residents, specifically taking into account nights and weekends. Staffing requirements under state law (Minn. Stat. § 144A.4795) and federal law (42 CFR §483.30) should be consulted when setting such guidelines.

Amend Minn. Stat. § 144A.4795

D. Immediate Protections Needed in HWS/AL

1. **Create an Appeal Right for Terminations**

Create an appeal right for residents in HWS/AL to appeal termination of housing and/or services to the Minnesota Office of Administrative Hearings, similar to the appeal rights available to nursing home residents under Minn. Stat. §144A.135.

Amend Chapter 144D (HWS)

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[27] *See* Minn. Stat. § 325F.72 (improper disclosure); Minn. Stat. §§ 144.6503 (dementia training in nursing facilities); 144D.065 (dementia training in HWS/AL); and Minn. Stat. §§ 144.4791 and 144A.4796 (home care provider responsibilities).

- Investigate whether the current EW benefit program for AL residents meets the needs of EW beneficiaries, including under the new AL licensure framework.
  Amend Chapter 144D (HWS)
  Consult Minn. Stat. § 256B

D. Increase Training for Those Providing Services in HWS/AL

- Review recently implemented dementia training laws for efficacy.
- Improve training for all care providers employed by a facility or program and who are involved in the delivery of care, as well as those who have regular contact with, persons with Alzheimer's disease or related dementias, including training on behavioral approaches.
  Amend Minn. Stat. § 144D.065 (HWS)
  Amend Minn. Stat. §§ 144A.4795 & 144A.4796 (Home Care)
  Amend Minn. Stat. § 144.6503 (Nursing Facility)
  Amend Minn. Stat. § 144A.61 (Nursing Assistant)
- Require training for owners, financial officers, administrators, and management on the Minnesota Vulnerable Adult Act and best practices in standard of long-term care.
  Amend Minn. Stat. § 144A.472
- Require training for all staff and management in best practices for courteous treatment of residents, resolution of conflict, and collaboration between the residents and their families.
  Amend Minn. Stat. § 144A.4796

E. Establish New Notice and Financial Requirements

- Promptly provide a written notification to residents of a change in ownership or management, including contact information.
- Provide written notice to the resident under what conditions the contract may be amended.
- Prohibit charges for community fees, activity fees, or other fees that are not classified as rent or health care services charges, unless otherwise allowed under law.
- Prohibit relocation of a resident within the facility without proper notice and resident consent, even if going on EW.
- Notify residents of their right to request a reasonable accommodation for their disability, including for disability related behaviors.
  Amend Chapter 144D (HWS)
  Amend Minn. Stat. § 144A.472

F. Establish Resident and Family Councils

Ensure creation of resident and/or family councils in HWS/AL settings with the input from the Ombudsman for Long Term Care, based on similar rights found in the Health Care Bill of Rights and provisions in Minn. Stat. §144A.33.

Amend Chapter 144D (HWS)

G. Create a License for AL Administrators

NEW LICENSING FRAMEWORKS FOR ASSISTED LIVING AND DEMENTIA CARE ACROSS RESIDENTIAL SETTINGS

The Consumer Workgroup recommends a new assisted living license framework and a dementia care certification. The Consumer Workgroup also recommends immediate changes in HWS/AL.

A. *New Assisted Living License Framework*

1. Commit to a New Assisted Living License during the 2018 Legislative Session

A. Create a new assisted living license during the 2018 legislative session to be implemented by January 1, 2020, with details of the license to be developed by a stakeholder group that includes significant consumer input. The Consumer Workgroup recommends a new AL license framework be developed with a main goal of licensing the AL residential setting, including both housing and health care services, recognizing that landlord-tenant law under Chapter 504B still applies but that there are additional housing needs for the AL residential setting.

B. Replace "title protection" under Chapter 144G with an "assisted living license," separate and distinct from a basic or comprehensive home care license under Chapter 144A. Essentially home care licensure under Chapter 144A would remain intact as applied to care for clients in their own home.

C. Remove the "housing with services" registration concept under Chapter 144D from any association with AL and relocate any necessary or helpful HWS framework related to AL in new AL licensure under Chapter 144G.

2. Issues to be Addressed by Stakeholders Licensure Process

A. Confirm Responsibility for Coordination of Care

Confirm in law that the HWS/AL is responsible for the overall coordination of care among medical providers, based on the needs of the resident, including carrying out any medical orders.

Amend Minn. Stat. §§ 144A.4791 & 144A.4795

B. Clarify When the Residents Needs are Beyond the Scope of Care

Establish a brighter line for both residents and providers to know when the needs of a resident are beyond the scope of practice of the HWS/AL, mirroring the responsibilities of Home Care Providers as a basis for the definition.[26]

Amend Minn. Stat. § 144A.4791

C. Protections for Elderly Waiver Recipients

- Establish standards to meet the federal Home and Community Based Service requirements to preserve access for individuals who rely on the Elderly Waiver Program.
- That EW benefits do not cover housing costs under the current structure, including a discussion of Group Residential Housing benefits for housing.
- Designate at least 10% of beds for residents receiving EW benefits and notify residents of this requirement.

[26] *See* Minn. Stat. § 144A.4791, subd. 4.

behalf of the deceased victim. Such limitations that occur when the victim dies creates a disincentive for perpetrators to resolve matters while victim is alive and send the wrong message to our older and vulnerable adults.

Amend Minn. Stat. § 573.02

D. *Give Victims the Same Appeal Rights to Challenge a Maltreatment Finding*

Victims of abuse should have the same rights as perpetrators of abuse to appeal an administrative determination of maltreatment. Currently, victims can only appeal to the lead investigative agency and obtain paper review by the Maltreatment Review Panel. They are denied independent administrative hearings or access to district court, while perpetrators have both. Victims should have the same right to judicial appeal that perpetrators now have.

Amend Minn. Stat. § 256.045

ENHANCE CRIMINAL AND CIVIL ENFORCEMENT OF RIGHTS

Criminal Enforcement

A. *Strengthen Criminal Code to Hold Perpetrators of Assault Accountable*
Prosecutors must be given the authority to file a gross misdemeanor charge against a perpetrator committing assault of a vulnerable adult in the fourth degree, without needing to prove "demonstrable bodily harm" when the assault was committed with the "intent to cause fear in another of imminent bodily harm or death."[25]

Amend the Criminal Code (Minn. Stat. § 609.2231)

B. *Review and Assess the Criminal Code with Respect to Crimes Against Vulnerable Adults*
Policymakers should undertake a review of the Criminal Code sections that address crimes against vulnerable adults to evaluate whether definitions of criminal abuse and neglect should be updated and whether some or all sexual assault crimes against vulnerable adults should be prosecuted, with enhancement for vulnerability, under the sections of criminal law that govern those crimes generally.

Review the Criminal Code (in particular Minn. Stat. §§ 609.232, 609.2325, and 609.233)

Civil Enforcement

A. *Allow Older and Vulnerable Adults to Go to Court to Enforce Their Rights*
Neither older and vulnerable adults nor their families and advocates have adequate tools under current law to enforce their rights and protections in a court of law. They need a statutory right to obtain redress and compensation for harms inflicted by the violation of consumer rights granted under Minnesota law, including but not limited to, the Health Care Bill of Rights and the Home Care Bill of Rights.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)
Amend Chapter 144D (Housing with Services)

B. *Give Family Members and Other Advocates the Explicit Statutory Authority to Enforce Rights Granted to Older and Vulnerable Adults*
Currently, enforcement of the Health Care Bill of Rights is severely limited – appearing to extend to only those persons with guardians or conservators. Nowhere else in law are family and advocates given statutory authority to enforce the rights of older and vulnerable adults on their behalf. They should have that right.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

C. *Allow Court Actions Involving Abuse to Proceed After Death of the Vulnerable Adult Plaintiff*
Under current law, in cases involving physical injuries to a vulnerable adult from abuse, if the victim dies before conclusion of the claim, the claim is severely limited and effectively ends. Families should be able to proceed to the conclusion of the case, without such limitations, on

[25] See definition of assault in Minn. Stat § 602.224 subd.1

Laws specific to the provision of care and services to older and vulnerable adults should be strengthened to include explicit protection against, and definitions of, deceptive marketing and business practices.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

2. **Make the Additional Fine for Consumer Fraud Committed Against Older Adults and Persons with Disabilities Apply to Fraud Committed Against Vulnerable Adults**
Perpetrators who commit fraud against vulnerable adults should be subject to the same additional fine to which they are currently subject for committing fraud against older adults and persons with disabilities.

Amend Consumer Fraud Act (Minn. Stat. § 325F.71)

F. *Making Sense Out of Our Confusing Health Care Laws*

1. **Create a Resource List to Be Provided Separately from Admission Documents**
While there are already legal requirements for providers to post and inform older and vulnerable adults about where to report suspected abuse, the reality is that this information cannot be fully absorbed during the complex admissions process. A separate mailing -- developed by an independent victim services organization – should be distributed to new residents and their families no later than a month after move-in. Content should include explanation of the pertinent rights with clear directions about where to get help with problems and what to expect in the process.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

2. **Ensure Older and Vulnerable Adults Receive the Uniform Consumer Information Guide**
The Uniform Consumer Information Guide was developed and required by lawmakers to be made available to older and vulnerable adults to help them understand their rights and comparison shop among potential residential settings. Many prefer paper copies, but they only made available through a link to an electronic copy. Older and vulnerable adults and their families should have the right to have a paper copy. Further, the Legislature should direct MDH to update and clarify the required content.

Amend Minn. Stat. § 144D.08 (Housing with Services)
Amend Minn. Stat. § 144G.06 (Assisted Living)

3. **Harmonize, Reorganize, Consolidate, and Recodify Statutes Governing Care and Services Provided to Vulnerable Minnesotans**
The Revisor of Statutes, in consultation with stakeholders including industry and consumer advocates, should be directed to recodify the statutes that govern consumer rights and provider responsibilities for health care consumers to ensure consistency of rights and language, address ambiguities, and update cross-references to repealed laws and rules.

1. **Extend the Protections of the Health Care Bill of Rights to Persons Residing in HWS/AL**

   Persons residing in nursing homes, boarding care homes, housing with services establishments, and assisted living ought to, where applicable, have the same protections. The Health Care Bill of Rights does not apply to persons residing in HWS/AL. It should.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

2. **Ensure Consistency of Health Care Bill of Rights and the Home Care Bill of Rights**
   The relevant rights granted under the Health Care Bill of Rights and the Home Care Bill of Rights should be the same. They are not. For example, the rights to trained and competent staff and to advance notice of changes in charges or services are not available for residents in nursing homes and boarding care homes. They should be.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

3. **Establish the Right to Appeal Termination of Housing or Services in HWS/AL**
   For an older or vulnerable adult, a discharge from a nursing home or boarding care home, or a termination of a lease or services in HWS/AL, is traumatic and health-threatening. But, while a process exists to appeal a nursing home or boarding care home discharge, there is no similar opportunity under statute to challenge a termination of housing or services in an HWS/AL setting. Older and vulnerable adults residing in those settings deserve the same rights as those living in nursing homes and boarding care homes as to such appeals.

   Amend Chapter 144D (Housing with Services Establishments)

4. **Enhance Protections to Ensure a Safe Transfer in HWS/AL Settings**
   Because of the traumatic and health-threatening impacts of being forced to move when in need of care, ensuring the least traumatic transfer possible should be everyone's goal and responsibility. Currently, while older and vulnerable adults moving from a nursing home or boarding care home are entitled to a statutorily required safe discharge plan, there is no comparable right for an older or vulnerable adult forced to move from his or her HWS/AL residence. A safe discharge plan is necessary in the HWS/AL setting.

   Amend Chapter 144D (Housing with Services Establishments)

5. **Prohibit Waiver of Rights**
   No older or vulnerable adult should be asked or required to waive any rights they are given under law as condition of stay or services or for any other reason.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

E. *Identifying and Prohibiting Deceptive Marketing and Business Practices*

1. **Enumerate and Prohibit Specific Deceptive Practices**

Recommendations with Statutory Changes Needed

STRENGTHEN AND EXPAND RIGHTS OF OLDER AND VULNERABLE ADULTS AND THEIR FAMILIES

A. Establishing the Right to Know About Reports of Abuse

1. **Allow Disclosure of Reports and Records.**
   Disclosure of information in maltreatment/abuse reports must be allowable to the victim and those acting on their behalf. The state law should also be amended to mirror federal law and allow release of medical records to authorized agents after the death of an older or vulnerable adult.
   Amend the Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)
   Amend the Medical Records Act (Minn. Stat. § 144.291)

B. Clarifying the Right to Place a Camera and Electronic Monitoring Device in Rooms

1. **For Abuse Detection.** Abuse detection tools should be enhanced by making clear the right to place cameras and electronic monitoring devices in rooms.
   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

2. **For communication.** The Health Care Bill of Rights should be updated to include the right to obtain and pay privately for Internet service (if not included), not only to use a web camera or electronic monitoring device, but also to enable remote contact with family and friends, and to facilitate other healthy social and commercial interaction.
   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

C. Addressing Retaliation

1. **Protect Older and Vulnerable Adults and Their Families from Retaliation for Reporting Abuse, Filing Grievances, or Asserting Rights**
   - Certain acts that are currently not defined as "retaliatory" under the Vulnerable Adult Act should be added, including, among others, restriction of use of or access to amenities or services; termination of services or lease agreement; sudden increase in costs for services not already contemplated at the time of the maltreatment report; and deprivation of technology, communication, or electronic monitoring devices.
   - Minnesota law needs to be clear that older and vulnerable adults and their families may report abuse without fear of retaliation.
     Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
     Amend Vulnerable Adult Act (Minn. Stat. § 626.557)

D. Ensuring Equal Rights for All and Expanding Resident Rights

G. *Improve Central Reporting of Maltreatment to MAARC*

The recent approval by the Centers for Medicare and Medicaid (CMS) allowing providers to report to MAARC should be implemented as quickly as possible by MDH to strengthen MAARC as the single common entry point for all reports. Families should be directed to report directly to MAARC as well as all mandated reporters including staff. Also, the MAARC intake process much be changed to allow for document and file uploads.

C. ***Ensure Provider Compliance with Abuse Prevention Plans in Nursing Facilities & HWS/AL.***

MDH must evaluate compliance with the Vulnerable Adult Act, in all licensing surveys and maltreatment complaint investigations of entities that serve older and vulnerable adults. Further, MDH must order corrective action for noncompliance, using the authority to fine facilities and services for failing to correct.[23]

An additional problem is that the term "facility" does not include Housing with Services/Assisted Living, despite their residential nature. Therefore, the establishments are not required to have a facility-wide abuse prevention plan. Homelike settings are no less likely to have hazards (e.g. location beside a body of water) than institutional settings.

D. ***Accelerate Reports to Law Enforcement***

We recommend amending Minnesota laws (reporting mandates, timeframes) to clarify which is the lead agency when cases in an MDH licensed facility involve an alleged crime (law enforcement) or adult protective services (APS) are needed by the victim. Clarifying mutual reporting responsibilities is essential to the effective resolution of cases and establishing best practices. In addition, training and notifications should be done for lead agencies and law enforcement on these clarified expectations.

E. ***Improve OHFC investigative Timelines and Require Higher Investigation Rates***

Measurable outcomes should be developed to ensure a higher investigation rate and interventions when such rates fall below established guidelines. In addition, it is crucial that all required investigation timelines established by MDH under the Vulnerable Adult Act are met. Additional resources are needed to continue to meet required timelines.

F. ***Improve OHFC Communications to Families***

Response times and guidelines for relaying information to families and advocates should be added to Minnesota law. The investigator should contact the vulnerable adult's family for an introduction within five days after initiation of an investigation and communicate with the family at a minimum every three weeks throughout the investigation. Communication should not be extended from OHFC to a family who is a suspected perpetrator of the abuse.

Also, it is necessary to enforce stricter guidelines surrounding final notification of the investigation to assure the family member does not receive the results of the investigation later than the facility or perpetrator under the Vulnerable Adult Act.[24] Finally, consumers and families need tools to help them as they search for a home care facility. They deserve a dedicated website, easy to search, which displays the current and historical investigative reports of abuse specific to each facility.

The opportunity to add additional reports of abuse and neglect for the same victim in the same facility to a case already in the process of investigation should be allowed. In addition, multiple reports for the same vulnerable adult and/or the same facility for better tracking of maltreatment data should be cross-referenced.

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[23] *See* Minn. R. 4658.0193 (reporting maltreatment of vulnerable adults; fines)

[24] *See* Minn. Stat. §626.557, subd. 9c(f).

approval to have MAARC serve as the single reporting line for MDH-licensed providers. This approval should eliminate the dual-reporting structure that was creating unnecessary burden on providers and OHFC.

We also encourage clarification in the law requiring providers to inform their staff of the ability to report directly to MAARC on their own, without fear of retaliation. Families must be encouraged to report only to MAARC and not separately to OHFC, with OHFC assisting the family in transferring initial reports to MAARC.

MAARC also does not have the capability to allow individuals to provide or upload critical evidence, including photos and recordings, when filing a complaint. We strongly believe the MAARC reporting system must be upgraded to allow for the submission of documentation from complainants and providers. Currently, vital records, photographs and videos remain undocumented in many cases. This evidence is critical to spur and support prosecution of perpetrators. In addition, reporters of maltreatment currently must request follow-up information about the disposition of the report; instead, we believe an automatic follow-up communication to the reporter should be the standard procedure.

In sum, enforcement authority must be strengthened through licensing, in OHFC for better triage and investigation of allegations, and in the corrective measures taken to hold perpetrators accountable. As a corollary, improvements in the abuse and maltreatment reporting processes at OHFC and MAARC will respond to the expressed needs of vulnerable adults, families and providers.

SUMMARY OF RECOMMENDATIONS

A. ***Improve MDH Licensing Inspections/Correction Orders/Fine***
Every three years for a survey for home care providers operating in an HWS/AL setting is too infrequent to allow course corrections for the provider and to allow MDH to monitor the care provided to older and vulnerable adults. Surveys should be conducted every year. The department must have the staff resources and a clear mandate to require compliance when these home care providers are first licensed as well as the duty to survey home care providers more frequently, particularly when violations are found.

B. ***Strengthen and Equalize MDH Enforcement Capacity in Nursing Facilities and HWS/AL***
We call particular attention to the efficacy of plans for correction and time periods for correction prior to the imposition of a fine. These processes should be comparable whether the provider is a home care licensee in HWS or a nursing facility. Furthermore, correction orders, plans, and time periods may be suitable for some violations; however, in cases of sexual assault, serious harm, or maltreatment that results in death, correction orders should be accompanied by an immediate fine. We encourage MDH to, at a minimum, double the penalties for all levels of home care violations from the current structure of $0-$5,000. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult is $5,000.

In light of the potential rollbacks in federal nursing home standards and enforcement, it is imperative that MDH use the tools afforded by state law, except in cases where the federal law is stronger or supersedes. Given the fact that there are no federal requirements for home care services in HWS/AL (with the exception of Medicare certified providers), our state laws are fundamental safeguards but differ substantially from federal laws and are inadequate.

Further, with so much attention on lack of response and deficient enforcement at OHFC, we also encourage MDH to engage in reform from the MDH licensing side. Surveys of MDH licensed facilities are meant to identify deficiencies sooner and prevent abuse from occurring in the first place. MDH has only surveyed approximately 205 licensed-only home care providers each year, although there are currently 1,200 providers.

To be meaningful and effective, these surveys must be completed routinely, and in the case of home care licensees, more frequently than every three years. Many home care providers have not received surveys even on the three-year cycle.

Another problem is that MDH interprets the law to require it to allow facilities time to correct violations before it can issue a fine. MDH believes that it lacks the authority to issue fines unless it first provides an "opportunity to correct," rendering its oversight less effective. Minnesota law should be changed to eliminate the "opportunity to correct" in cases of sexual assault, serious harm, or maltreatment that results in death, where "correction" is not possible, and should be accompanied by an immediate fine.

In addition, more can be done with current law regarding abuse prevention plans under the Vulnerable Adult Act,[22] including expanding the plan requirements to HWS/AL residential settings. MDH should be directed to evaluate compliance with these plans during all surveys and maltreatment complaint investigations.

Law Enforcement Does Not Receive Timely Reports of Suspected Criminal Maltreatment

Currently, law enforcement experiences delays in receiving report referrals from OHFC. Criminal investigations must be conducted as quickly as possible to assure that interviews are timely, crime scenes are preserved, and evidence remains fresh. Solid investigative information is required for a referral for prosecution. Similarly, the likelihood of a case being prosecuted requires solid information to justify criminal charges. In a related matter, law enforcement receives community complaints concerning a vulnerable adult directly and may fail to report that to the MAARC so that emergency protective services can be provided as needed.

Enhancements to MAARC Needed

As to reporting, the Minnesota Adult Abuse Reporting Center (MAARC) was designed to be a single common point of entry (reporting center) for all reports of suspected maltreatment.

We were encouraged to hear Acting MDH Commissioner Pollock report on January 24, 2018 to the Committee on Aging and Long-Term Care Policy that MDH has received federal

[22] Specifically, Minn. Stat. § 626.557, subd. 14.

Testimony in Support of Senate Bill 103 - CNA Training Requirements

Thank you Chairman Testin and the Senate Committee on Health and Human Services for the opportunity to provide comments in support of Senate Bill 103. This bill will bring Wisconsin's training requirements in line with federal standards for Certified Nursing Assistants (CNAs), an important step in breaking down barriers to work.

Under federal standards, CNAs must complete 75 hours of instructional training and 16 hours of clinical training. Wisconsin law currently requires 120 hours of instructional training and 32 hours of clinical training. The additional training hours are a barrier for those in Wisconsin studying to become licensed CNAs. Further, this discrepancy has led to Wisconsin losing quality CNA candidates to neighboring states that do follow the federal standards, which has only exacerbated the healthcare workforce shortages our state is experiencing.

SB 103 will help address the healthcare workforce shortage in Wisconsin, maintain quality training requirements and break down an additional barrier to work in our state. AFP thanks Representative Petryk and Senator Cowles for authoring this important legislation and respectfully encourages the Senate Committee on Health and Human Services to support this bill.

Thank you for the opportunity to provide comments on this important legislation.

Sincerely,

Megan Novak
Legislative Director
Americans for Prosperity – Wisconsin

Written testimony in support of AB 76/SB 103

June 6, 2019

My name is Janese Rix, I am a RN and Director of Nursing at Oak Park Place Grandview in Madison. I serve on the Board of Directors for WHCA and the DON Council. I have worked in health care for 29 years, primarily in Dane County.

I want to thank you for the opportunity to testify before you in support of the Assembly Bill 76 and Senate Bill 103.

I have worked with nursing assistants, side by side and through training during employment at Madison College.

I have witnessed the consequences of staffing shortages and the stress this situation places on residents, families and staff.

I support the Federal law requirement of 75 hours of instructional training to be certified as a CNA. Not only will this allow caring individuals to join health care; this aligns Wisconsin with neighboring States' standards.

Every CNA must go through eight subject areas as a part of training, and that will not change as a result of this legislation. Many facilities care for specific resident populations that require specialized care. Allowing CNAs to get on the floor sooner will help them receive the exact training they need while on the job and through continuing education training requirements. Further, nothing about this legislation will force CNA training programs across the state to change their curricula. Programs that wish to provide additional training hours will still be allowed to do so; the bill simply prevents the Department of Health Services from requiring more than the federal standard.

If federal hourly requirement standards change, Wisconsin's hourly requirements must also change.

In Wisconsin, facilities, residents, families and staff need individuals to join the CNA profession. This Bill will not minimize the value of this role. Rather, this will allow caring individuals to join the work force and meet the needs of those in our community. With additional individuals seeking job opportunities as a CNA the quality of care will be maintained while staff burn out will decrease. This legislation is a positive step through eliminating a barrier in the path to becoming a CNA.

I thank you for this opportunity to testify today.

GWaar
Greater Wisconsin
Agency on Aging Resources, Inc.

Testimony of
Janet L. Zander, Advocacy & Public Policy Coordinator
Greater Wisconsin Agency on Aging Resources, Inc.

Before the Senate Committee on Health and Human Services
June 6, 2019

Re: Opposition to SB 103/AB 76 reducing required hours of instructional training for certified nurse aides (CNAs)

Chair Testin, Vice-Chair Kooyenga, and members of the Health and Human Services Committee:

My name is Janet Zander. I am the Advocacy & Public Policy Coordinator for the Greater Wisconsin Agency on Aging Resources, one of three Area Agencies on Aging in Wisconsin. We provide training and technical assistance to support the successful delivery of aging programs and services in 70 counties (all but Dane and Milwaukee) and the 11 tribes in Wisconsin. I am also a member of the Wisconsin Aging Advocacy Network (WAAN), a collaborative group of older adults and professional aging associations and organizations – including the Wisconsin Association of Area Agencies on Aging, the Wisconsin Association of Senior Centers, the Wisconsin Association of Nutrition Directors, the Wisconsin Association of Benefit Specialist, the Aging & Disability Professionals Association of Wisconsin (representing aging unit/ADRC directors and managers), the Wisconsin Adult Day Services Association, the Alzheimer's Association SE Wis. Chapter, the Wisconsin Institute for Healthy Aging (WIHA), the Wisconsin Senior Corps Association (WISCA), and the Wisconsin Tribal Aging Unit Association.

Thank you for the opportunity to testify this afternoon on SB 103; proposed legislation that would **prohibit the Department of Health Services from requiring instructional programs for certified nurse aides to: exceed the federal required minimum total training hours** (currently set at 75) **or minimum hours of supervised practical training (clinical experience)** specified in the federal regulation (currently 16 hours and part of the total 75 hours of training).

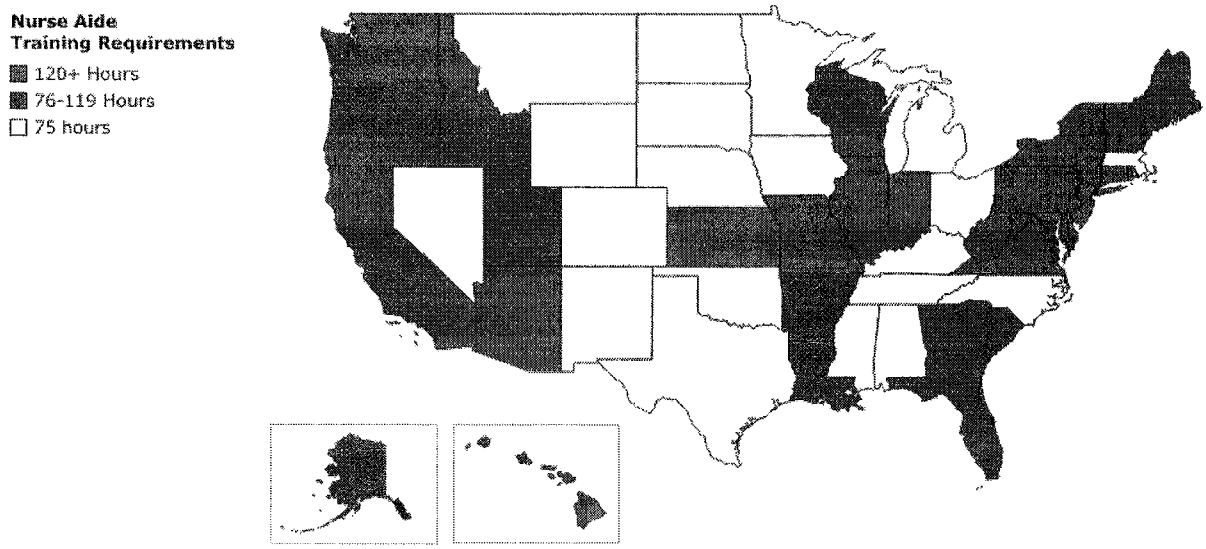
Lowering the training requirements for certified nurse aides (CNAs) has been proposed to:

1. **Address our state's long-term care workforce crisis** by reducing the required total training by 45 hours and the clinical training by 16 hours (from 27% of the total hours to 21%); and
2. **Create regional fairness** by lowering Wisconsin's required training standards to the federal minimums to match the required hours in border states – Iowa, Michigan, and Minnesota.

WAAN like other aging and long-term care advocates is very concerned about the crisis level shortage of CNAs and other direct care workers in our state available to provide essential care for older adults and people with disabilities in skilled nursing facilities, assisted living facilities, and in their own homes and other community-based locations. We know this shortage affects individuals living and working in both urban and rural areas. We also understand geographic areas bordering another state face some unique challenges in recruiting and retaining workers. **We believe these challenges will not be addressed by lowering the required hours of training for CNAs.**

Wisconsin is not alone in facing a severe shortage of CNAs and other direct care workers. The fact is, surrounding states and states across the country are struggling to find workers to provide essential health and long-term care. Workforce shortages are an issue nationwide[1]. This includes the states of Minnesota[2,3] and Iowa[4] whose training programs for CNAs utilize the minimum hours required under federal law. Lower training requirements have not insulated these states from experiencing workforce challenges. There are many proposals and workplans to address the shortage of direct care workers occurring in this state and nation. We have not found one, outside of Wisconsin, that is proposing to *reduce* the required training hours for workers as a solution nor have we found any research to support that lowering the training will entice new workers into the field. In addition to policy reforms that increase wages and benefits, many states and organizations are taking steps to strengthen the workforce by *improving* training and creating career advancement opportunities.[5]

As of December 2016, **over half the states** (30 states and the District of Columbia) **in the country require more than the federal minimum (75 hours) total nurse aide training hours.**[6] The Institute of Medicine recommends that "Federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be **raised to at least 120 hours...**"[7]



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Of additional note, are the over 30 states that require more than the minimum (16 hours) of clinical training (including Illinois [40 hours/33% of the total training hours], Iowa [30 hours/40% of total], and Wisconsin [32 hours/27% of total]). The federal requirement calls for at least 21% of the total training time to be clinical (hands on) training (at least 16 of the total 75 hours). Current Wisconsin regulations require at least 27% of the total training time to be dedicated to clinical training (32 of the 120 hours). In some states, clinical training exceeds 50% of the total training hours. **A higher ratio of clinical to didactic (lectures and textbooks) hours would move students out of the classroom and into the workplace more quickly and has been proven to result in better resident care outcomes. "Nursing homes in states requiring clinical training hours above the federal minimums (i.e. >16 hrs.) had significantly lower odds of adverse outcomes, particularly pain, falls with injury, and depression.**[8] In other words, lowering Wisconsin's required clinical training hours to the federally required level of 16 hours (a 50% reduction from the

current 32 hours of clinical training required) has the potential to cause increased risk of negative consumer/resident impacts.

The complexity of caring for nursing home residents has increased substantially since the federal CNA training requirements were established with the passage of the 1987 Nursing Home Reform Act. Considering the increased complexity of providing care, a 2006 study completed by the AARP Public Policy Institute examined how many hours of initial training and clinical training are needed for CNAs to be prepared to provide good care. The results of the study suggested several recommendations for improving CNA training programs including, but not limited to: increasing the 75-hour federal minimum requirement to at least 100 to 120 hours (which may reduce CNA turnover, thereby improving the quality of care and reducing the costs associated with high turnover rates) and increasing the clinical training to at least 50 to 60 hours.[9]

Changes to the training hour requirements will impact new CNAs working not only in skilled nursing facilities, but also in hospitals, home health agencies, hospices, and intermediate care facilities for individuals with intellectual disabilities. Each of these settings provides some unique opportunities and challenges for both new and seasoned workers. All these work environments count on their CNAs, the frontline workers, to be the eyes and ears for their nurses to alert them to any changes noted in a customer/resident's status. Whether they are helping customers/ residents with a bath, to use the bathroom, to dress for the day, or assisting individuals with meals, their assistance with activities of daily living helps older adults and people with both short and long-term disabilities meet their basic needs. CNAs help caregivers too, as often they work together to support older people and people with disabilities in their homes and communities. The curriculum for these workers includes training in: communication and interpersonal skills, infection control, safety and emergency procedures, basic nursing skills, personal care skills, basic restorative services, client/resident rights, and dementias. Each one of these areas of training (and practice) is critical to helping workers achieve the competence and confidence needed to successfully serve in this role. Quality care and a stable workforce depend on providing CNAs with the training needed to be well-prepared for their challenging and rewarding jobs.

Older adults and people with disabilities need and deserve the best, safest, quality of care that can be provided. The current shortage of workers puts this care at risk and threatens the future of many local providers. We all have a stake in ensuring a quality workforce exists to meet current and future care needs. Let's work together on solutions to alleviate the workforce shortage that will improve recruitment and retention of these valuable workers, increase quality of care, and will not do any potential harm to these valuable workers or those in their care.

Thank you for this opportunity to testify. I look forward to continuing to work with you to shape public policy that improves the quality of life of older people throughout the state.

Contact: Janet Zander, Advocacy & Public Policy Coordinator
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[1]8 Signs the Shortage in Paid Caregivers Is Getting Worse, Robert Espinoza, PHI, February 2017; https://phinational.org/wp-content/uploads/2017/11/workforce-shortages-phi60issues01.pdf, retrieved 3/22/19.

[2]Severe Shortage Of Direct Care Workers Triggering Crisis, Judith Graham, Kaiser Health News, May 9, 2017; https://www.disabilityscoop.com/2017/05/09/severe-shortage-care-crisis/23679/, retrieved on 3/18/19.

[3] Recommendations to Expand, Diversify, and Improve Minnesota's Direct Care and Support Workforce: Work Plan, Olmstead Subcabinet Cross-Agency Direct Care and Support Workforce Shortage Working Group, July 16, 2018; https://mn.gov/dhs/assets/Workforce-shortage-work-plan_tcm1053-347847.pdf, retrieved on 3/24/19.

[4]Five Ideas From the 2018 Iowa Ideas Conference, Deborah Neyens, The Gazette, Oct 22, 2018; http://www.iowacaregivers.org/uploads/pdf/iowa-ideas-.pdf, retrieved on 3/24/19.

[5]Wisconsin 2018 Health Care Workforce Report, Wisconsin Hospital Association; https://www.wha.org/WisconsinHospitalAssociation/media/WHA-Reports/2018_Workforce_Report.pdf, retrieved on 6/05/19.

[6]Nursing Assistant Training Requirements by State, PHI, 2016; https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/, retrieved on 3/21/19.

[7]Retooling for an Aging America: Building the Health Care Workforce, Institute of Medicine, 2008; http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce/RetoolingforanAgingAmericaBuildingtheHealthCareWorkforce.pdf, retrieved on 3/25/19.

[8]CNA Training Requirements and Resident Care Outcomes in Nursing Homes; Trinkoff, A.M; Storr, CL; Lerner, NB; Yang, BK; and Han, K; Gerontologist, 2017 June ; 57 (3): 501-508; https://www.ncbi.nlm.nih.gov/pubmed/27059825, retrieved on 3/08/19.

[9]In Brief: Training Programs for Certified Nurse Aides, Bernadette Wright, Ph.D., AARP Public Policy Institute Paper #2006-08, April 2006; https://assets.aarp.org/rgcenter/il/inb122_cna.pdf, retrieved on 3/25/19.

June 6, 2019

Good morning, Chairman Testin and Members of the Senate Committee on Health and Human Services

My name is Sherrie Peterson. Thank you for the opportunity to speak with you about an important issue that affects our elderly, one of the most vulnerable segments of our population. I have been a Registered Nurse and educator for the past 47 years. Prior to becoming a nurse, I worked as a Nursing Assistant. Currently I am an independent contractor and consultant for a long-term care facility in Waunakee, Wisconsin.

I began my journey as an educator in the mid 1980's training Nursing Assistants in a long-term care facility, when training was done on the job. In 1987 the Omnibus Budget and Reconciliation Act was passed. The federal act mandated that 75 hours of training were needed to work in federally certified nursing homes. This was an important milestone. It meant that training requirements would be consistent and standardized, so that care in nursing homes would improve. In 2008 the State of Wisconsin changed the number of training hours to 120 hours.

There are many states surrounding Wisconsin who continue to follow the federal mandate of 75 hours of training.

I am sure that many or perhaps all of you have read the Wisconsin Long-Term Care Workforce Crisis 2018 report. The statistics are more than alarming. They are frightening.

The shortage of Nursing Assistants is creating a multitude of problems in the long-term care industry. Every day brings new challenges for Administrators and Directors of Nursing. They struggle to find strategies and ways to have adequate staffing to care and meet the needs of our elderly during their most vulnerable years. Facilities have closed due to shortage of staff or have closed wings which result in less access.

Burnout is common as facilities often ask Nursing Assistants to work double shifts, additional hours, or to care for more residents. Turnover rates are high and qualified applicants are difficult to find. Nursing Assistant work is difficult and demanding. Many CNA's are leaving for jobs which pay more and are less

stressful. Temporary staffing agencies are expensive and are not always able to provide staff. Agencies are also experiencing shortages.

The cost of CNA training, testing and the length of training time can be a barrier for some individuals. Some need to be trained in less time so that they can enter the workforce and start to earn wages to support their families. This also would be beneficial for nursing homes in desperate need for more staff.

I have developed curriculum and taught in 75-hour programs and 120-hour programs. I have found no documented evidence that students from 120 hour or longer programs perform any better than students from 75-hour programs. I recently had a discussion with a CNA instructor from a private entity in Michigan where training programs are 75 hours. She stated that there is a 98% pass rate for students from her training program.

What can be done to help ease the CNA shortage? CNA training could be taught in facilities. Programs could be structured to include classroom time and clinical time with the residents in these facilities. Reducing the number of training hours to 75 hours will allow more individuals to be trained and move into the workforce sooner. Facilities could offer a career ladder program: A CNA could progress to a Lead Aide or a Medication Aide.

Our population is aging rapidly and will continue to do so as the baby boomers enter the age of needing long-term care. More caregivers are already needed to meet the increased demands. The CNA shortage is REAL and continues at an alarming pace. I feel it is important to act quickly so that our elderly can receive the care that they have earned and deserve. On personal note: As I am aging, I am concerned about the quality of care I might receive if the shortage continues.

Again, thank you for your time and consideration of this very important bill.

Respectfully submitted,

Sherrie Peterson RN MS

Madison, Wisconsin

alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.

Testimony of Michael Bruhn, Director of Public Policy,
Alzheimer's Association - Wisconsin Chapter Network on Senate Bill 103 and Assembly Bill 76

Chairman Testin and Committee members, I want to thank you for the opportunity to provide testimony on Senate Bill 103 and Assembly Bill 76. My name is Michael Bruhn, and I am the Director of Public Policy for the Alzheimer's Association – Wisconsin Chapter Network.

The Alzheimer's Association is acutely aware of the challenges associated with recruiting and retaining qualified direct care staff, particularly certified nursing assistants. The need to address this issue will only grow in the coming years as Wisconsin's population continues to age, which is why the Centers for Disease Control and Prevention have deemed Alzheimer's a public health crisis in America. As an example, Wisconsin currently has more than 110,000 individuals with Alzheimer's disease or a related dementia, by 2025 that number is projected to increase by nearly 20% to 130,000. In the year 2040, just 21 years from now, the number will nearly double to 215,000 Wisconsinites with Alzheimer's disease or a related dementia. Ensuring the quality of care for individuals suffering from cognitive impairment is a significant priority for the Alzheimer's Association.

While supportive of the stated intent of Senate Bill 103, addressing the shortage of direct healthcare workers, particularly certified nursing assistants (CNAs), the Alzheimer's Association cannot support legislation that would reduce the number of required hours of training particularly for individuals caring for someone with Alzheimer's or dementia. Having a trained and competent staff is imperative because Alzheimer's and other forms of dementia present unique challenges for caregivers. In fact, the Wisconsin State Dementia Plan: 2019–2023, developed by stakeholders in conjunction with the Wisconsin Department of Health Services Division of Public Health, acknowledges the difference in providing care for patients with Alzheimer's and recommends "implementing basic and continuing interdisciplinary training with mandatory minimum standards" for healthcare professionals that have access to patients with Alzheimer's or dementia.

A reduction in the number of hours of required training will, unfortunately, not improve quality of care, worker or resident safety, and there is evidence that it may actually negatively impact employee retention. The Institute of Medicine charged an ad hoc Committee on the Future Healthcare Workforce for Older Americans to determine and assess the healthcare needs of Americans over 65 years of age. The resulting report, *Retooling for an Aging America: Building the Healthcare Workforce*, states that as the population of seniors grows to comprise approximately 20 percent of the U.S. population, they will face a health care workforce that is too small and critically unprepared to meet their health needs. The committee concluded the current training requirements for direct-care workers are insufficient, both in terms of quality of content and quantity of training hours. Their findings included that most nurse aide educators, as well as nurse aides themselves, agree that current levels of education and training for initial certification is inadequate, and CNAs ranked inadequate training among the top three problems that they face.

The report specifically recommended that states and the federal government increase minimum training standards for all direct-care workers, and that the federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be raised to at least 120 hours, which is Wisconsin's current standard. Finally, the report identified inadequate training as a factor that contributes to occurrences of neglect and abuse, especially for patients with behavioral difficulties associated with dementia.

In the debate about this legislation, Wisconsin has been compared a great deal to the State of Minnesota. Unfortunately, elder abuse in Minnesota became such a pervasive issue that former Governor Dayton commissioned a study in 2017 entitled: "Addressing Elder Abuse in Minnesota Long-Term Care Settings." This is an excerpt from just the first page of the executive summary:

> "While years in the making, the scale and gravity of this crisis began to take shape for policymakers during the 2017 legislative session when the Office of Health Facility Complaints at the Minnesota Department of Health reported a 600% increase in maltreatment reports since 2010 and an ability to investigate only 1% of the 20,791 reports from providers and 10% of the 3,491 reports from individuals. The magnitude of the crisis was revealed further in the Minneapolis Star Tribune's shocking and sobering series ("Left to Suffer," November 2017) that described a broken system of care and regulatory oversight that has failed to protect Minnesota's older and vulnerable adults from horrific abuse in nursing homes and housing with services and assisted living settings."

In May, in response to this Elder Abuse Crisis in Minnesota, comprehensive, bi-partisan legislation was overwhelmingly passed and was signed into law. The Minnesota law created a "bill of rights for residents of assisted living facilities" with 26 different "rights," a specific definition of dementia care services (something Wisconsin does not have), and initial and yearly on-going, dementia training requirements for both direct care and non-direct care workers because of the unique nature of Alzheimer's and other forms of dementia. If we are going to emulate Minnesota, shouldn't we consider emulating their new laws?

Senator Cowles and Representative Petryk are both honorable men that I have had the privilege to work with on a number of different issues over the years. They are both sincere in their belief that this will provide some help to ease the healthcare worker shortage. As I stated in my testimony on Assembly Bill 76 earlier this year, the individuals who are here today representing WALA and LeadingAge Wisconsin work for some of the best facilities in the state, and I have no doubt that the directors of these facilities will continue to meet exceptionally high standards. My concern is about the 60 one-star rated nursing home facilities in Wisconsin who are overwhelmingly not members of WALA or LeadingAge. My concern is for the individual with Alzheimer's or a related dementia in a facility where the staff do not have the time or resources necessary to ensure a high level of care because 56% of nursing homes within a 50-mile radius of Milwaukee are rated below average or worse. Just as no one issue will solve the direct care worker shortage, no one factor is responsible for these facilities being rated poorly, but a reduction in training will certainly not improve the quality of care.

The State of Wisconsin made significant progress in 2008 when the number of hours of training were increased to ensure specific instruction on dementia and how to manage the care for those living with the disease. Wisconsin has also been a national leader in our response to the public health crisis that is Alzheimer's disease and other forms of dementia; it would be disappointing to take a step backwards.

Thank you for allowing me to provide testimony on Senate Bill 103 and Assembly Bill 76.

THE WISCONSIN SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

wamd

Wisconsin Medical Directors Support Senate Bill 103

Good morning, Chairman Testin and members of the Senate Committee on Health and Human Services. My name is Rex Flygt, a physician in Baraboo since 1982. I am:

- Board-certified in internal medicine, geriatrics, and long-term care medical direction.
- An attending physician in four Sauk, Columbia, and Dane County nursing homes.
- A medical director there and at one building in my home town, Park Falls.
- Co-chief of the Dean Medical Group geriatrics team in Dane County.
- Past president of the Wisconsin Society for Post-Acute and Long-Term Care Medicine, representing nursing home medical directors across the state, for whom I speak today.

Thank you for the opportunity to testify before you supporting Senate Bill 103, which would align the training standards for Certified Nursing Assistants (CNAs) in Wisconsin with the federal CNA training standards.

We all agree CNAs are a vital component of the post-acute (post-hospital) and long-term care continuum. We also agree we need to encourage growth in this field, because our population is aging at historic rates. Further, Wisconsin is already short on CNAs, and getting shorter: I am told that recent workforce reports show the caregiver crisis is deepening from 1 in 7 positions being vacant in 2016 to 1 in 5 positions vacant in 2018.

The bottom line is that at a time we need more caregivers, we could use a more streamlined pipeline for producing them. What observations support that?

- While it makes sense to some to think that more training beyond the federal standard of 75 hours makes better CNAs, there's little or no support for that in the medical and nursing literature.
- When the Centers for Medicare and Medicaid Services (CMS) revised the Requirements of Participation governing facilities participating in the Medicaid program, the federal CNA training standard of 75 hours was not changed.
- When you look at the Medicare five-star ranking on Medicare.gov, or the data provided to Metastar (the Center for Medicare and Medicaid Services contracted quality assurance and peer review organization) Wisconsin is good, and above the national average on quality—and quite similar to the surrounding states, who observe the federal training standard.

Further, keep in mind what this legislation does NOT do:

- This bill does not alter testing/competency requirements: All certified nursing assistants must still pass the same test regardless of how many hours were in their program. All required core competencies for CNAs would still be covered.
- This legislation doesn't limit the ability of programs to offer CNA training classes with higher hours, it just aligns Wisconsin with the federal standard in place around us.

Thank you for your attention to this matter. I am happy to answer any questions that you may have.

Thomas Rex Flygt, MD, MA, FACP, CMD
Past-president, Wisconsin Society for Post-Acute and Long-term Care Medicine
(f/k/a Wisconsin Association of Medical Directors)
Flygt@centurytel.net

Wisconsin BPDD

WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

June 6, 2019

Senator Testin (Chair)
Senate Committee on Health and Human Services
Wisconsin State Capitol, Room 131 S
Madison, WI 53707

Dear Sen. Testin and Committee members:

The Wisconsin Board for People with Developmental Disabilities (BPDD) thanks the committee for the opportunity to provide testimony on Senate Bill 103/Assembly Bill 76.

Our analysis finds that reducing the number of training hours required for certified nurse aides (CNAs) will not improve quality of care for people with disabilities, may result in lower quality care, and is unlikely to improve workforce recruitment and retention.

BPDD does not find that training requirements are a driver in the workforce crisis. Low wages, lack of benefits—including health insurance, paid sick and family leave, retirement, dependent care, commuter benefits etc., and lack of career advancement opportunities are all factors that impact the recruitment and retention of quality caregivers. Our analysis finds that of the factors that contribute to the workforce crisis, changing training requirements does not address any of the drivers of the crisis but does have the potential to negatively impact care quality.

30 states and the District of Columbia have extended the minimum number of training hours beyond 75 hours. The National Academy of Medicine recommends 120 or more training hours become the standard.[1]

Studies have demonstrated that increased training reduces job turnover while increasing job satisfaction.[2] Other studies find increased CNA training requirements are associated with better patient outcomes and quality of care.

Worker and provider organizations have consistently identified improved training as one of the elements needed to improve care quality and retention of competent workers. While there have been a variety of recommendations to increase training, provide training on different specific topics, provide periodic trainings for workers to refresh or acquire new skills, and to offer training at no cost to workers, disability advocates and the vast majority of home and community based providers have not recommended reducing training requirements as a strategy to improve the workforce.

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[1] Paraprofessional Healthcare Institute (PHI) (2016). Raise the Floor: Quality Nursing Home Care Depends on Quality Jobs. https://phinational.org/sites/default/files/research-report/phi-raisethefloor-201604012.pdf

[2] Han, K., Trinkoff, A.M., Storr, C.L., Lerner, N., Johantgen, M., Gartrell, K. (2014). Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis. International Journal of Nursing Studies, 51 (8), 1135-1141.

The WisCaregiver Careers program—developed in collaboration with nursing home advocates and the Board of Aging and Long-Term Care—was launched March 1, 2018 and provides free training and testing for up to 3,000 CNA students to become caregivers in Wisconsin nursing homes. DHS has reported strong interest in the program with more than 5000 people signing up. This program has not been implemented for a sufficient amount of time to be able to assess how free tuition may improve the workforce, however it does indicate significant interest in the training.

With the recent creation of a Caregiver Task Force, BPDD anticipates that advocates and the legislature will be able to develop and advance a comprehensive package to better address the caregiver crisis. One of the charges of the Task Force is to review and address training issues for the overall direct care workforce, including establishment of a career ladder to increase respect for and quality of the workforce.

The broad charge of the Task Force recognizes there are many policies that need to be addressed to improve the workforce. Passage of individual pieces of legislation now without the benefit of the work of the Task Force risks making changes that do not improve the workforce crisis and may have unintended consequences. BPDD recommends that this training hours change be tabled until after the Task Force issues its recommendations.

BPDD is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities (more about BPDD https://wi-bpdd.org/wp-content/uploads/2018/08/Legislative_Overview_BPDD.pdf) .

Our role is to seek continuous improvement across all systems—education, transportation, health care, employment, etc.—that touch the lives of people with disabilities. Our work requires us to have a long-term vision of public policy that not only sees current systems as they are, but how these systems could be made better for current and future generations of people with disabilities.

Thank you for your consideration,

Beth Swedeen

Beth Swedeen, Executive Director
Wisconsin Board for People with Developmental Disabilities

Bethany St. Joseph Corporation

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Inspiring Life, Hope and Healing

June 6, 2019

To: Members of the Senate Committee on Health and Human Services
From: Craig Ubbelohde, Executive Director, Bethany St. Joseph Corporation
Re: Senate Bill 103 (SB 103), related to CNA Training Hours Requirements

Dear Committee Members,

I am Craig Ubbelohde, and I am a family member of a nursing home resident. I am an advocate for seniors in Wisconsin. I am a card-carrying AARP member. I am formerly a nursing assistant. I am a licensed nursing home administrato; and I am the CEO of Bethany St. Joseph Corporation in La Crosse, which operates skilled nursing facilities in La Crosse, Onalaska, Westby, and Galesville.

I have been a family member of nursing home residents in Wisconsin, going back to 1964. Grandma Esther at the St. Croix County Health Care Center and later the Area Nursing Home of Colfax; Grandma Helga Bjerkness at the Area Nursing Home of Colfax; my Great Uncle Herman in Houlton, WI; Grandma Amanda Dahlke, of Houtlon, WI; my mother for short term rehab at Colfax Health and Rehabilitation in 2017; and for the last year and one half, my father, at the Neighbors of Dunn County. I share this background as a family member, because it is how I came to have the professional life and career that I have been so passionate about.

I have worked in Wisconsin nursing homes for 41 years; 36 years as a licensed nursing home administrator or CEO of long-term care organizations in Wisconsin, and 5 years as a nursing assistant. In 1977, one of my friends suggested that we take the nursing assistant training course being offered at our hometown skilled nursing facility. That experience was the beginning of a 41-year career to date. My friend went on to become a physician at the Marshfield Clinic.

At that time, there were no "hours" requirements for nursing assistant training programs, nor formal testing programs. I estimate that the program was 70-75 hours, including clinical hours. When hired, additional orientation time was provided on the floor working as an extra.

When federal requirements for nursing assistant training were established, the "hours" requirement was set at 75 hours. In 2008, Wisconsin increased its training requirement to 120 hours, while our neighboring states maintained the 75-hour requirement. I opposed the increase at that time for the following reasons:

- Students would have another 45 hours of training time that would be uncompensated, creating a barrier to entry into the health care field.

- Training programs would have to dedicate more precious RN hours to provide the additional training hours. This takes them away from other responsibilities such as covering shifts caring for residents or tending to other administrative responsibilities.

- Technical colleges would raise the fees being charged to students, increasing the direct costs of attending, in addition to the other financial costs of quitting a job to attend the training.
- No additional reimbursement would be provided for the increase in the number of hours.

It turns out that all these predictions came true, including one that I did not foresee. And that is the university nursing programs, physical and occupational therapy programs, and other health occupation programs would require the completion of the nursing assistant training program as a requirement for admission to their program. This means that some of the nursing assistant training programs are filled with students who really have no intention of ever actually working as a certified nursing assistant. They are merely in the training program to meet the requirement of their educational program.

The disparity in training hours between Wisconsin and neighboring states creates another problem for us and makes Wisconsin a net worker exporter. In our area, there is a training program in Winona, MN but workers trained in that program are not eligible to work in Wisconsin nursing homes. Yet, Wisconsin trained nursing assistants can work in Minnesota nursing homes, and with better Medicaid reimbursement, Minnesota nursing homes can offer higher pay.

The situation we are facing today is one of extreme shortages of people coming into nursing assistant training programs; a shortage of Registered Nurses which is a barrier to providing the instructors for the training programs; and a shortage of training programs in general. In our area, $6,000 signing bonuses are being offered for registered nurses.

SB 103 will not solve all of the issues regarding our direct care worker shortage, but it would go a long way to help the situation. In summary, I support SB 103 which would prevent the Department from requiring more training hours than required by federal regulations, for the following reasons:

- Bringing Wisconsin's training requirements to par with the neighboring states would allow access to a pool of graduates from training programs across our borders, for employment in our facilities.

- Reducing the "hours" requirement would reduce the economic barriers for those seeking nursing assistant training. Fewer unpaid hours of time would be required on the front end, opening opportunity for those Wisconsinites at lower economic levels in Wisconsin.

- Additional training programs may be offered by facilities as RN trainers would be pulled away from other duties for fewer hours. When they are training, they are not available to cover open shifts for caring for the residents.

- With the reduction in hours, one would hope the fees at the technical colleges for the program could be reduced, which would reduce the economic barrier to this entry level job.

  From the Western Technical College website, including application fees, background checks, accuplacer testing fees, course fees, textbook fees, workbooks, handouts and dvd fees, a uniform patch, the course fees and testing fees, the direct out of pocket cost is $738.23 on the front end. Add in $50 - $75 for a uniform and you are at $800. Do you know many high school juniors or seniors who can come up with $800 on the front end? How about single moms employed in another career, earning $10? Can they afford to quit that job while they attend an unpaid 120-hour training program, while still obtaining child care so they can attend?

  Additional costs include travel to the course site, estimated at $100. Lost wages, at $10 per hour x the extra 45 hours is $450 in lost wages. This puts the economic front end barrier at over $1,300.

Our organization has tried everything including providing tuition scholarships for students in CNA training programs. We have an outside provider providing training programs at a site on our campus, yet we can't get enough graduates through the program. We start CNAs at $14 an hour with no experience and have a comprehensive benefit program. Medicaid reimbursement for skilled nursing facilities does not cover the cost of care, which is roughly 70% of a facility's costs which puts us at a competitive disadvantage with hospitals in our community. The only barrier we can't remove as an organization is the excessive "hours" requirement for the training.

In 1977, the only cost to me to become a nursing assistant was a few hours a night after school. If I had faced the same economic barriers as exists today, I doubt I would have ever entered the training program. Please pass SB 103 so we can increase the pipeline of trainees, so we can fill unfilled positions, and so we can increase the opportunities for Wisconsinites at the lower level of economic circumstances. I have seen staffing challenges cycle up and down throughout the years, but this time it is different. It hasn't been a three- or six-month difficult stretch. It has become ongoing since 2016. Our existing staff work more hours than they desire, in order to pick up shifts. This becomes more costly as facilities must up the ante to cover night shifts, weekends etc., when staff are already stretched to the limit. Completing a nursing assistant training program and working with the elderly can serve as a jumping off point to further training as a licensed practical nurse and registered nurse, as well as other health occupations. In my case, it led a sixteen-year-old high school junior to a lifetime of service to the elderly.

It is my professional opinion, and my personal opinion as a concerned family member, that it is in the best interests of the residents in our skilled nursing facilities, the staff who care for them, the organizations that employ them, and for the long-term care system in Wisconsin, that the training hours required for certification as a nursing assistant be changed to match the federal requirement and neighboring states' requirements of 75 hours of training.

Thank you.

Sincerely,

Craig Ubbelohde,
Executive Director

LeadingAge™ Wisconsin

Better Services for Better Aging

Date: **June 6, 2019**

To: **Members of the Senate Committee on Health & Human Services**

From: **John Sauer, President/CEO, LeadingAge Wisconsin**

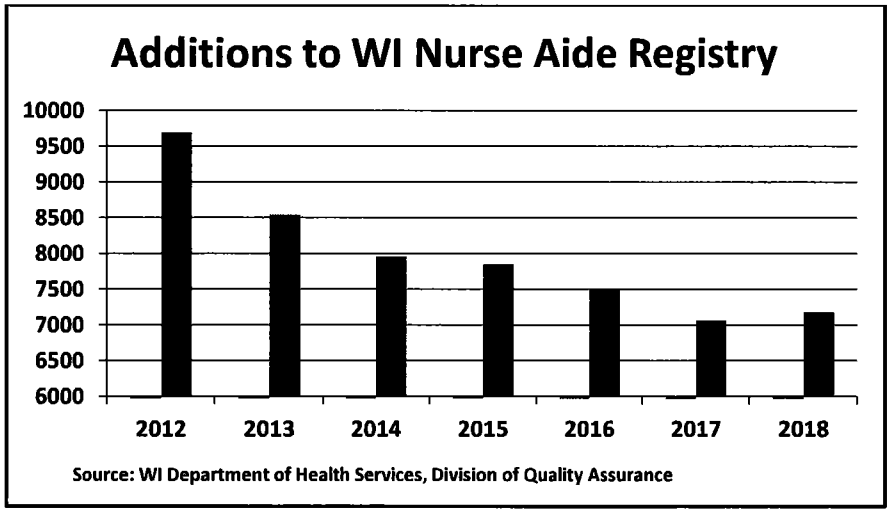
Subject: SB 103, relating to hours of instructional program for nurse aides.

Chairman Testin and Committee members - thank you for this opportunity to speak with you today about SB 103.

My name is John Sauer and I am the President/CEO of LeadingAge Wisconsin. LeadingAge Wisconsin is a statewide Association representing mission-driven skilled nursing homes, assisted living facilities, and other community-based providers in Wisconsin. Specifically, the Association represents 185 skilled nursing facilities in Wisconsin who are facing a workforce crisis.

As you know, Wisconsin's population is aging. As baby boomers begin to retire, our State's overall labor force supply is expected to decline while the demand for health care professionals will continue to rise. According to the Department of Workforce Development (DWD), the demand of long-term care workers is over five times the projected growth rate compared to all other industries.

To offer some perspective on the employment challenges facing the nursing home provider community, please consider the disturbing trend in the number of new certified nursing assistants (CNAs) annually added to the State's nurse aide registry since 2012:



As noted in the chart, the number of annual additions to the CNA registry has declined by over twenty-five percent since 2012. This is an alarming situation knowing that Wisconsin is already

experiencing a crisis-level shortage of direct care workers, as reported in our 2018 Workforce Report. That is why I am here today to discuss the need for SB 103. We must remove barriers for people entering the long-term care field, and we must begin to explore other ways to attract more workers into this field.

To be sure, SB 103 will not single-handedly solve the state's long-term care workforce shortage. What it does do, however, is offer an opportunity for long-term care providers to manage their training programs in a way that allows them to better compete for workers. To this point, I offer the following considerations:

First, the current training requirement of 120 hours is a barrier for persons looking to secure a job that pays $12-$14/hour. Asking potential CNAs to enroll in a training program before they can secure a job, most often means they are doing so at great expense while forgoing wage-earning time. Reducing the number of hours of classroom training time means a person does not have to sacrifice 45 hours during which she or he incurs costs but most often is not compensated. We have heard from members who recognize that additional training time can be a barrier to employment because individuals may elect to pursue another job that is less demanding, does not require them to forego wages, and/or is immediately available (e.g. Kwik Trip).

Secondly, the provider community agrees that the success of a person serving as a CNA is largely determined by what happens AFTER she or he is hired by the nursing home. It is what occurs during the first 90 days of employment, such as the on-the-job training, mentoring, buddy system, in-service education, and resident-staff ratios during the extended orientation program; combined with the overall culture of the mission-driven organization, that determines a CNA's success. These factors are far more important than the pre-employment classroom training. That is why LeadingAge Wisconsin has made available to members extensive resources/tools on CNA leadership, in-service training, retention strategies, mentorship, team building, communications and competency programs.

Third, without an adequate workforce, it is very difficult for facilities to focus on advancing quality. Our Board of Directors noted that a 75-hour training program can help to attract more aides into nursing homes, allowing them to address quality concerns through adequate staffing. This will help address overtime, double shifts, less than desirable staff-resident ratios, and the need to use pool help. Our RNs have said to us, "Find me the caregiver staff, so we can provide the best care possible; let us train and coach the new CNAs. We can't train and coach persons who never enter the field."

Lastly, the bill does not force training programs to go to 75 hours. If some or most the training programs want to remain at 120 hours, or choose something in between, they will be able to do so. We expect those training programs located near the neighboring states of Minnesota, Iowa and Michigan who are all at the federal standard, to recognize the competitive nature of CNA employment and offer a 75-hour program. **Regardless of the number of training hours offered, all students will be required to pass the SAME competency test (written and clinical skills).**

Thank you for allowing me the opportunity to speak today in favor of SB 103. I am happy to answer any questions at this time.

WHCA / WiCAL

Wisconsin Health Care Association Wisconsin Center for Assisted Living

TESTIMONY IN SUPPORT OF SENATE BILL 103/ASSEMBLY BILL 76

PRESENTED TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

June 6, 2019

Chairman Testin and Committee members, thank you for taking the time to hold a hearing on this bipartisan bill and to continue a discussion on addressing the critical issue of the long-term care workforce crisis in Wisconsin. On behalf of our member providers across the state, we are grateful for the opportunity to discuss the provider community's support for this bill.

As you all are aware, Certified Nursing Assistants (CNAs), or Nurse Aides, provide necessary services to elderly and disabled citizens within our communities. However, due to a variety of factors, it is difficult to train and recruit these important workers in Wisconsin's long-term care facilities. A recent survey of long-term care facilities in Wisconsin found that 1 in 5 caregiving positions remains unfilled. Wisconsin's long-term care facilities are concerned that Wisconsin's statutory and administrative framework makes it more difficult to train and recruit qualified CNAs.

Federal law has a minimum requirement of 75 hours of instructional training, including 16 hours of clinical training, to be certified as a CNA. However, Wisconsin requires 120 hours of classroom instruction with 32 hours of clinical training. Wisconsin facilities are at a significant disadvantage; Michigan, Minnesota, and Iowa all mirror the federally authorized standard of 75 hours.

Along with the legislature's current efforts to increase reimbursement, changing the CNA training requirement is an important step in the right direction in helping providers **address our state's long-term care workforce crisis**. SB-103 has earned support from many stateline legislators on both sides of the aisle who have heard directly from providers that Wisconsin's current training requirements often serve as a barrier to employment, as employers across the border can offer a less burdensome certification program for employee prospects.

SB-103 **creates a clear standard** for Wisconsin regulators and providers, as the bill's language aligns Wisconsin's standards with federal standards. If federal hourly requirement standards change, Wisconsin's hourly requirements must also change.

By helping address Wisconsin's long-term care workforce crisis, SB-103 will help **ensure quality advancement** within provider facilities. Without an adequate workforce, it is very difficult for facilities to focus on advancing quality. SB-103 will help Wisconsin facilities have the staff to maintain quality care. Establishing a 75-hour training standard will address current personal time and resource barriers for prospective CNAs, resulting in more individuals becoming interested in pursuing a CNA opportunity. There clearly is a correlation between adequate staffing and the quality of care provided.

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Opponents of this bill argue that aligning with the federal 75-hour standard will hurt care quality in Wisconsin. We refute that claim and believe that quality will only improve if we take proactive steps to get more CNAs in the door and on the floor in long-term care facilities.

Consider neighboring Minnesota, which uses the 75-hour requirement: in certain quality measures, Minnesota long-term care providers outperform Wisconsin providers; in other measures, Wisconsin providers outpace their Minnesota counterparts.[1] The fact is, no single prevailing factor serves as a single solution for care quality, and each state has unique needs and demands that require different approaches.

In Wisconsin, facilities need individuals to come into the CNA profession. While this legislation is not a cure-all for Wisconsin's long-term care workforce crisis, it is a positive step through eliminating a barrier in the path to becoming a CNA. Many capable, eager candidates cannot afford to pay for training or go additional weeks without an income to complete Wisconsin's current training requirements.

Every CNA has to go through eight subject areas as a part of training, and that will not change as a result of this legislation. Many facilities care for specific patient populations that require specialized care, and allowing CNAs to get on the floor sooner will help them receive the exact training they need while on the job and through continuing education training requirements.

Further, nothing about this legislation will force CNA training programs across the state to change their curricula. Programs that wish to provide additional training hours will still be allowed to do so; the bill simply prevents the Department of Health Services from *requiring* more than the federal standard.

We ask that you listen to providers themselves – those who wake up every day with the noble goal of delivering the best care possible to Wisconsin's most vulnerable populations. Providers agree that aligning Wisconsin's CNA hourly training requirements with the federal standard will help address the workforce crisis, which will benefit residents by providing more CNAs to provide the care they need and deserve.

Again, thank you Chairman Testin and committee members for your time and consideration of this bipartisan bill. Please do not hesitate to contact WHCA/WiCAL with any questions you may have.

Respectfully,

John Vander Meer, President & CEO
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Tina Belongia, Director of Quality Advancement and Regulatory Affairs
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[1] WI Department of Health Services Division of Quality Assurance – Bureau of Nursing Home Resident Care 2017 Data. View at www.whcawical.org/dqadata.

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Testimony for Senate Bill 103

In November, the Washington County Board passed 2018 Resolution 57 to support this legislation. Last session, an exact bill was introduced, which passed the Assembly. The bill federalizes Wisconsin's 120 classroom hours for CNAs. Federal regulations and neighboring states require 45 fewer hours. The goal of the legislation is to ensure quality CNA candidates quickly enter the pipeline and are on the nursing floor learning the facility culture and residents' needs. Wisconsin faces a shortfall of qualified CNA and other nursing aides. Washington County's Samaritan Campus has approximately twenty openings for CNAs.

The entire change for the bill is this: *The department may not require additional instructional hours to exceed the federal required minimum under 42 CFR 483.152 (a).*

Because most regulations for skilled nursing facilities are written and enforced by the Federal Centers for Medicare and Medicaid, using the federal standard makes sense. Under the bill, should the federal standard change, so would Wisconsin's. Elsewhere in Wisconsin regulations, it is not required for all nursing aides to be certified. For instance, some assisted living facilities may hire nursing aides who are not registered. This is the case in Washington County's Samaritan Campus as we have both assisted living and skilled nursing facilities.

For about thirty years, the federal government has required states to create nursing aid training programs and establish requirements for competency. For most of those years, Wisconsin required the federal standard of 75 hours. The CNA training hour requirement is written in administrative rule and has not been set by the Legislature. It is important for Wisconsin and neighboring states to have similar rules to encourage reciprocity and qualification as CNAs move around the country.

Many aging advocacy groups are opposed to this legislation. These groups will testify that they would like to see more clinical hours for CNAs to ensure the highest quality of care for residents. The groups suggest that clinical hours improve resident lives. We agree. This is why we have a robust on-the-job training program. The reality is CNAs who participate in strong on-the-job training learn the culture of the facility while learning technical aspects of the job. For instance, a "Hoyer lift" may not be the same product in every facility. Hoyer is a brand for a floor or sit-to-stand lift. Prior to my career in public policy, I learned this difference when I was at Direct Supply selling lifts to facilities across the country.

Washington County takes great pride in our mission and our vision statements. Our mission requires our employees to create an environment to "enjoy our authentic quality of life through ... access to basic needs." The time it takes each CNA to comfortably achieve this mission varies and should not be overregulated.

All administrators care about their residents and want the best treatment possible. This bill would do nothing to lower the standard of care that Washington County Samaritan Health Center residents and families have come to know. Samaritan Campus will maintain a robust on-the-job training to ensure our care standards are met. We urge you to pass this legislation to give homes more flexibility hire the right people for the job.

Respectfully submitted by Ethan Hollenberger