Pepin
Health and Rehab
A **MISSION** HEALTH *Managed Community*

September 5, 2017

To: Members of the Assembly Committee on Aging and Long-Term Care

From: Pepin Health & Rehab Nursing Home, Pepin, WI

Regarding: Our support for Assembly Bill 432 related to C.N.A. Training Hourly Requirements

Committee members,

I, and on behalf of Beth Friedrich, Director of Nursing, apologize for our commitments that would not allow us to attend in person. However, please accept our written endorsement of Assembly Bill 432. We would like to extend our sincere gratitude to Representative Petryk and Senator Harsdorf for authoring this legislation and for the many Republican and Democratic legislators who co-sponsored it.

We would recommend that this bill be passed because of the extreme shortage of certified nursing assistants, because Federal and State requirements would be better if they were equivalent, and because the change is long over due.

Beth and I support Assembly Bill 432 for the following reasons:

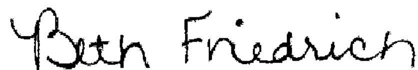
1. We believe that there is no determining factor supporting the idea that quality care provided by C.N.A. Training Requirements in Wisconsin is better than quality of care in Minnesota which adheres to the Federal guidelines for C.N.A. Training Requirements.
2. Pepin Health and Rehab, Nursing Home, is located in Pepin, Wisconsin which is borders Minnesota to the west. Many of the students, from Pepin & nearby towns, that want to enter into a nursing career, take their C.N.A. classes in Red Wing & Winona, Minnesota. Many of these students taking the C.N.A. training sign up for the Minnesota Program because it costs less and takes less time. Most students starting out don't have the monies to take the Wisconsin training class. It has nothing do with the quality of the program, it is about the monies.
3. Beth Friedrich, our Director of Nursing, has worked for over 23 years as a Director of Nursing in Long Term Care Facilities in Western Wisconsin. She believes that the actual on the job experience and continuation of training after a certified nursing assistant starts their career is where their quality of care is improved. Pepin Health & Rehab is constantly training our certified nursing assistants on ways to improve the quality of care

that they provide.

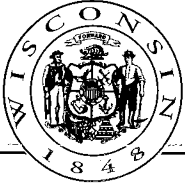
4. After nineteen years of working as an Administrator I have hired many certified nursing assistants who have completed the Wisconsin C.N.A. training programs. Some turn out to be good certified nursing assistants and provide great care, and others, taking the same course, do not. I think a lot has to do with each person's personal desire to want to take care of elderly. It is a personal gift that some people have and others do not. It has nothing to do with the actual number of hours of a particular training program. The certified nursing program is just a starting point in their career. If Assembly Bill 432 were to pass, we would have a greater likelihood of keeping our local students, who go to Minnesota to take the C.N.A. training program, working in Wisconsin instead of staying to work in Minnesota. With the extreme shortage of certified nursing assistants we desperately need the passage of this bill.

Thank you,

Dale Anderson, Administrator of Pepin Health & Rehab



Beth Friedrich, Director of Nursing of Pepin Health & Rehab



State Senator Sheila Harsdorf

Date: September 5, 2017

To: Assembly Committee on Aging and Long-Term Care

Fr: Senator Sheila Harsdorf

Re: Assembly Bill 432 - hours of instructional program for nurse aids.

Dear Chair Weatherston and Committee members:

Thank you for holding a public hearing on Assembly Bill 432. While I am unable to testify today, I appreciate the opportunity to share my testimony and the importance of passing this legislation.

Certified Nursing Assistants (CNAs) or Nurse Aides, provide necessary services to our elderly and disabled members within our communities. However, due to a variety of factors it is difficult to train and recruit these important workers for Wisconsin's long-term care facilities.

In some cases, homes are turning away residents due to a lack of staff to provide proper care. This legislation is intended to help address the shortage of CNAs that nursing homes and other providers are facing by matching Wisconsin training requirements to federal standards of 75 hours of instructional training.

One in seven caregiving positions in long-term care facilities in Wisconsin remains unfilled. Mirroring federal training requirements will help make recruiting and training easier in Wisconsin, particularly when Michigan, Iowa, and Minnesota all align their CNA training requirements with the federal standards.

This bill is a needed reform, supported by many in the field, which will help address the shortage of CNAs in Wisconsin while also making our requirements match those in surrounding states.

Again, thank you for holding a public hearing on AB 432 and I urge your support.

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disability**rights** WISCONSIN
Protection and advocacy for people with disabilities.

September 5, 2017

To: Assemblyman Tom Weatherston, Chair, Assembly Committee on Aging and Long-Term Care
Members, Assembly Committee on Aging and Long-Term Care

From: Disability Rights Wisconsin – Amy Devine, Public Policy Coordinator

Re: 2017 AB 432

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 2017 AB 432 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. DRW opposes the reduction of required training hours and 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

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disabilityrightswi.org
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WHCA / WiCAL

Wisconsin Health Care Association Wisconsin Center for Assisted Living

TESTIMONY IN SUPPORT OF ASSEMBLY BILL 432

PRESENTED TO THE ASSEMBLY COMMITTEE ON AGING AND LONG-TERM CARE

September 5, 2017

Chairman Weatherston 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. Additionally, we thank the bill's authors, Representative Petryk and Senator Harsdorf, along with the bill's many bipartisan co-sponsors, for their support.

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 7 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**. AB-432 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.

AB-432 **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, AB-432 will help **ensure quality advancement** within provider facilities. Without an adequate workforce, it is very difficult for facilities to focus on advancing quality. AB-432 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 Mr. Chairman 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, Executive Director
WHCA/WiCAL
John@whcawical.org
608-257-0125

Jackie Strader, Director of Quality Advancement and Regulatory Affairs
WHCA/WiCAL
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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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Shellie Sonnentag Testimony in Support of Assembly Bill 432

Presented to the Assembly Committee on Aging and Long-Term Care

September 5, 2017

Hello Chairman Weatherston and Committee members. My name is Dr. Shellie Sonnentag. I started working in long-term care 24 years ago and have served as a dietician, a registered nurse, a director of nursing, a nursing home administrator, and a nurse consultant. I have completed my doctorate as an adult and geriatric nurse practitioner. My current role is Vice President of Clinical Services for Real Property Health Facilities Corporation. In this role, I have clinical support and oversight responsibility for 11 skilled nursing facilities in 4 states, including 6 in Wisconsin. I remember 24 years ago, being the youngest most enthusiastic person at the Wisconsin Health Care Conventions and now I have that slight beat-down appearance, which I am totally blaming on the nursing assistant shortage in this state!

In the past 12 months, I have completed the application and approval process for nurse aide training programs in 3 of my 6 Wisconsin facilities. These facilities are Pine View Care Center in Black River Falls, Oakbrook Health and Rehab in Thorp and Plum City Care Center in Plum City.

Each of these three facilities are in rural locations with a limited workforce supply. In my 24 years working in long-term care, I have never seen the nursing assistant shortage as dismal and as long-standing as it has been for the past 18 months.

We have not yet been able to run a class at our Black River Falls facility because we cannot find an RN primary instructor to run it, despite many attempts at advertising the position.

Oakbrook Health & Rehab in Thorp, a 5-star facility and AHCA silver-award winning nursing home, ran their first nurse aide training program in February and March of this year. We started with 10 students, but two dropped out right away due to life circumstances (i.e. finances, no childcare, unable to get time off from their current job, etc.). We ran the class with eight students, six of which we had already hired with the title of "resident assistant", an uncertified position that supports a nursing assistant, but is not allowed any hands-on care responsibilities for the residents. The remaining two students were from other health care settings, so were the only two that paid the $500 program fee. Our primary instructor was one of our administrative staff nurses, who was relieved of very few of her other duties – because let's face it, there's a nursing shortage too.

Just in primary instructor wages for the 120 hours and the student books and workbooks, the facility took on a lowball investment of $3520. As of now, for a variety of reasons, just two of those certified nursing assistants remain on our payroll. You see – we, like many other nursing homes that have a training program – are in desperate need of CNAs. We packed the student schedule full with 8 hour days/5 days a week. There is homework and reading to do in the evenings, exams, jobs, kids, housework, etc. when they got home. By the time some of them made it to the end of the 120-hour program they were already burned out. However, they also chose to have the program delivered this way so they could "get it over with" and "move on with life."

Oakbrook's student population was unique since most of the people were already employed by the facility. They didn't have to figure out how to clear their schedule for a month and live without a paycheck. Many, many people that called to inquire about the class just determined they couldn't get the time off from their current job, couldn't afford the $500 fee for the class, and couldn't live without a paycheck – so they never even made it into the candidate pool.

This bill will help providers get more CNAs in the door, which will help provide care for a growing elderly population. We want people who WANT to serve to have the ability to serve by removing a current barrier to employment – the fact that 120 hours requires weeks more without a paycheck. Plum City Care Center is faced with a unique workforce situation. My facility is located about 9 miles (as the crow flies) from the Minnesota state line, putting them in direct workforce competition with Minnesota, which has the 75-hour nurse aide training requirement. My administrator, Carla Hutter, fields phone calls and email inquiries frequently from Minnesota-certified nursing assistants who would like to come work in Plum City.

One of these job candidates, a lovely 48-year old single mother, who has been a career nursing assistant for the past 29 years in Minnesota, recently moved to Wisconsin and was searching online for nursing assistant opportunities near her. She saw an ad on Indeed for a CNA opening at Plum City Care Center. She went on the CMS website – Nursing Home Compare – and did her research finding that Plum City is also a 5-star facility. She called the facility to inquire about the position and was incredibly disappointed to find out that she wouldn't "qualify" for the exact same position she had been doing for 29 years in Minnesota! She now drives to Red Wing, MN every day for work. She cannot afford to take the time off to RETAKE nursing assistant training in Wisconsin because of the 120-hour requirement. Does anyone in this room know how utterly painful it is for a nursing home administrator to turn away an expert-level career nursing assistant right now? We are talking straight-up chest pain... However, if this bill passes, and Wisconsin has the 75-hour requirement just like neighboring Minnesota, you just helped out every Wisconsin nursing home in this border battle. Maybe Minnesota won't be happy about it – but it's okay, they are kind of used to disappointment (cough, cough – like the Vikings)!

On a serious note, Minnesota is enjoying far better reimbursement than us, which I know Wisconsin is working to address in the current budget. I would like to take this opportunity to thank the legislature for their commitment to increasing reimbursement, and also to say that the CNA training requirement change won't solve everything, but I strongly believe it is a positive measure to help address the long-term care workforce shortage.

My topline message: Nursing home providers wake up every day with one goal: to provide excellent care to our residents. Providers would NOT support legislation that didn't advance care excellence. This bill will help address the workforce shortage and make sure residents continue to receive the high quality care they require.

Thank you!

SHELLIE SONNENTAG, DNP-AGNP, APRN, CD, NHA, WCC, RAC-CT
Vice President of Clinical Services
Real Property Health Facilities

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TO: Members of the Assembly Committee on Aging and Long-Term Care

FROM: Debora B. Klatkiewicz, NHA Administrator of Personnel and Regulations
Park Manor Ltd.

RE: Assembly Bill 402 Relating to: hours of instructional program for nurse aids.

September 5, 2017

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-seven (37) years experience in long term care at Park Manor Nursing Home, the last twenty-four (24) as Administrator of Personnel and Regulations.
- Twenty-one (21) 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.
- 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 Requirments:

- In 1987 CMS enacted the first major revision of federal nursing home requirements of participation. Eventually that document provided requirements for instruction of C.N.A.'s of 75 hours. That requirement has not been changed since inception. 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 one-on-one training the C.N.A.'s received in the employing facilities provided the "icing on the cake" of instruction with real life experience. The one-on-one training occurs regardless of the length of the 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 implementing an across the board increase in the instruction hours would provide even more barriers to individuals who had an interest and an aptitude for providing care as a C.N.A. Attached to the increase in hours was a corresponding increase in costs as well and hence another barrier. As of this writing the workforce issues are exponentially more difficult than nine (9) years ago.
3. The outcome for existing nurse aide programs 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:

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- Facilities strive and struggle to attract, train and maintain qualified nursing staff, including C.N.A.'s to provide the quality of care our residents both expect and deserve. The 120 hour instructional requirement does nothing to improve employment opportunities for either facilities or individuals with potential to be incredible and dedicated caregivers. In fact a serious argument could be to the contrary.
- Currently at Park Manor we employ twenty-one (21) Professional Nurses. These nurses are amazing and competent caregivers. Of those 21, ten (10) or 48% began their employment as C.N.A.'s and then chose to pursue a professional nursing career based on their experience and aptitude. They were stellar C.N.A.'s and have become stellar Professional Nurses. None of them participated in a C.N.A. class requiring 120 hours of instruction. In fact some of them were nurse aides preceding the changes in regulations and were actually grandfathered into C.N.A. status. I do not believe the outcome for these dedicated caregivers would have been improved in any way with an extended C.N.A. class.
- The training component of new employee C.N.A.'s continues in skilled rehab and nursing facilities across the state 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. The training remains a critical and equally important part of employment as a C.N.A.

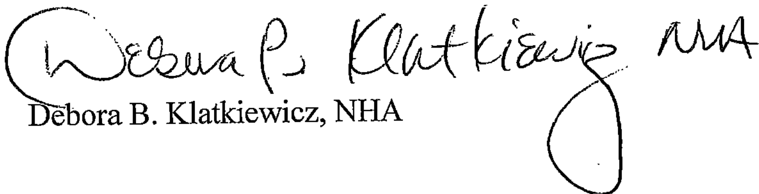
Conclusion:

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 both onerous and costly, but more importantly unnecessary.

Again I emphasize the importance of training and on-the-job experience as pivotal in achieving and maintaining skills and aptitudes of the C.N.A.'s employed in all care settings. It is not difficult to argue for fewer instructional hours when the in-facility training and subsequent experience more than makes up for this.

The dedication of the State of Wisconsin – caregivers, regulators, and legislators –is well known and respected. This legislation in its entirety promotes that dedication and reputation while bringing fairness back to the table. Thank you in advance for your support.

Respectfully,



Debora B. Klatkiewicz, NHA

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September 5, 2017

TO: Committee on Aging and Long Term Care

FROM: Heidi R. Prellwitz, RN, NHA, Director of Nursing, Park Manor, Ltd, Park Falls, Wisconsin

RE: Support of Assembly Bill 432

Personal Background:

- Nurses Aide in long-term care March of 1988 – June of 1994, initially certification was not required, passed the challenge exam when the certification requirement was mandated.
- CNA April 2002 – May 2005, then as GN until nursing board exam.
- RN June 2005 to present
- CNA Instructor – August 2008, Involved in expansion of CareAide class from 75 -120 hours
- NHA December 2015
- Director of Nursing January 2016

Testimony:

The elderly have been a part of my life and close to my heart since a young age. During my formative years I spent a lot of time in the company of my grandparents and their friends. Part of this time was with my grandmother as she volunteered at Park Manor, and as a girl scout with my "adopted grandmother"

My first years as a nurses aide were in my mid teens, with seasoned nurses aides doing the training and the mentoring. From them I learned to be caring and compassionate, how to avoid the advances of the frisky elderly gentleman, how to sit at the bedside of the dying resident and hold their hand, reassuring them they were not alone, how to cry with the family over the loss of their loved one, how to laugh with the silly residents performing antics for us, and most importantly how to love the elderly. These nurses aides had no "formal" training, but a character conducive to this type of work, a true love and appreciation of the elderly population, which allowed them to be molded into exemplary nursing assistants.

As a DON and NHA, I can certainly attest to the fact that we are experiencing a severe shortage of CNA's in our facilities. The current workforce is fortunate to be interspersed with dedicated

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CNA's who work until they can't. The level of burnout in these employees is tremendous and continues to soar. We can only work these people so many hours a day. On average, I would estimate we have 2 – 3 shifts open per day. They have the most physically, mentally and emotionally taxing job in the facility. We are continuously asking them to pick up extra hours, stay for the next shift, or work their days off, which they do, because of their dedication to our residents. In addition, they also work holidays and weekends away from their families, all for meager wages. We have attempted to supplement our CNA workforce with CNA extenders and paid feeding assistants, allowing the CNA to continue with direct care tasks. Although the advantage is the ability to have the CNA doing more hands on tasks, the disadvantage is the CNA loses 1:1 time normally spent bonding and getting to know their residents. At times it appears this has created an assembly line effect. We are taking care of real people, who need our undivided attention.

As one of the primary instructors for the CareAide CNA class in Park Falls, WI, I was intricately involved in changing the curriculum to accommodate the escalation of required hours. There were no new areas of study implemented or increase in subject material, just augmentation of the information previously taught, an increase in lab time, and increased clinical time.

When I look at my CNA's and the quality of their work, I can say with absolute confidence, that there is no appreciable difference in the quality of a CNA who took the 120 hour class versus the CNA who took the 75 hour class. In fact – when I try to make a comparison of the two, I also notice that the CNA who took the 75 hour class has a higher level of understanding, love and compassion, than the CNA who took the 120 hour class and spent more time in a classroom and lab. On average the on the job training of the CNA is approximately 80 – 120 hours. This is time spent with the resident population they will be taking care of, with the equipment and resources of the facility they will be working in, learning the intricacies and demands of that facility. There is no comparison to be made of the value of training on real, live residents, in real-life situations, as compared to training in a lab with a dummy. I am aware that the increase of the class to 120 hours included an increase in clinical time, this still pales in comparison to the value of hands-on experiences.

Additionally, I would like to point out some barriers to obtaining CNA certification. At 120 hours, this population of prospective employees most likely cannot spare to be without a paycheck for 3 weeks. That, coupled with the cost of the class, books and testing, only further deters potential candidates. When considering our CareAide class in particular, this poses a hardship for the facility trying to replace a full-time RN (or 2) for 3 weeks to be the instructor for this class. A reduction of class time to 75 hours would alleviate all these stressors for the CNA candidate as well as facilities that have a CNA class.

Heidi L. Lulley RN NHA

My name is Mindy Meehean, RN BSN, Director of Nursing for Pine Crest Nursing Home located in Merrill, Wisconsin. I have been a Director of Nursing in a 180 bed county owned nursing home for going on 4 years and employed in long term care for over 8 years. When I took on my role as Director my first day on the job I had state surveyors walk in at 4:30 am for a complaint survey regarding staffing. We did receive a citation on our staffing level which came down to one day, one shift where we had call in's and staff out ill. Following that we had to implement mandation, were we mandated our staff to stay over or come in early to cover for call in's and vacancies. This meant certified nursing assistants, which includes single moms and dads, working families, had to find child care and work up to 16 hours a day causing hardships for their personal and family life, staff burn out and even injuries related to fatigue and staff burn out.

It is clearly evident that Wisconsin is aging and there is no doubt about it as our baby boomers continue to age. The Department of Health Services statistics show that by 2040 Wisconsin population of residents 65 and older will be 23.7% from our current percent of 13.7%, almost double.

Currently 87,000 Wisconsin residents live in long term and residential care facilities. And this number is projected to grow. In the next 25 years, the number of Wisconsin residents aging 65+ to the state's population will grow from 1 in 7 to 1 in 4.

Nursing Home vacancies continue to be a huge problem for Wisconsin. The average nursing home vacancy rate is 14.5% from a recent survey which had interviewed 689 facilities in Wisconsin. 1 in 4 providers are experiencing a vacancy rate > 20%. Imagine trying to run a business with 20% of your work hours unfilled. According to the Workforce Development Personal Care Aides/Home Health Aides will have a 28% increase need for employment by 2024, making it the 2nd high-growth occupation in Wisconsin.

We are already in crisis mode in the state of Wisconsin and it will only continue to get worse. Elderly residents in Wisconsin deserve care. This bill will provide more caregivers for Wisconsin.

The average cost to become a certified nursing assistant is $547 including books and tuition. The average salary for this job is $27,000. These programs are not eligible for financial aid meaning this is out of pocket cost for the individual. By decreasing the hours of the program to the federal mandated hours will decrease the cost by $200-300. Thus allowing more people to become certified nursing assistants in the state of Wisconsin and helping the current crisis. In this bill we are not asking for increase funding but the ability for people of Wisconsin to enter into a career without a large out of pocket cost. This will make the career feasible and affordable to many people in Wisconsin and help decrease the current crisis and future crisis, but most importantly allow well deserved care for our elderly residents of Wisconsin.

Thank You

References:

https://www.dhs.wisconsin.gov/aging/demographics.htm

http://www.whcawical.org/files/2015/06/NA_Training_Stats_CY_2015.pdf

http://www.wha.org/pdf/2016workforcereport.pdf

http://www.leadingagewi.org/media/34782/Workforce-Report-2016.pdf

http://worknet.wisconsin.gov/worknet/joblist_highgrow.aspx?menuselection=js

https://www.ntc.edu/programs-courses/all/technical-diplomas/nursing-assistant-CNA

DO ONE THING CAMPAIGN

ADDRESSING THE SEVERE CNA STAFFING SHORTAGE

A Proposed Legislative Action requiring no funding to help eliminate the red-tape associated with becoming a Certified Nursing Assistant

WI Director *of* Nursing Council

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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.

The Long-Term Care Workforce Crisis:

Caregiver vacancy rates, long a concern for Wisconsin long-term and residential care providers, have reached crisis levels. In the largest survey of long-term and residential care providers to date, responses from 689 providers revealed:

- High levels of caregiver vacancy rates in assisted living and nursing homes
- Major problems finding applicants and qualified caregivers
- Significant wage disparity between people working as trained personal caregivers and unskilled entry level workers taking jobs at gas stations, big-box stores, and fast food restaurants
- Lost admissions due to lack of caregivers
- An exodus of caregivers to jobs outside of healthcare
- Widespread use of overtime, double shifts and other strategies to fill scheduling gaps

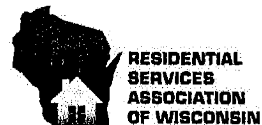
The results of the survey, together with data from the Wisconsin Office of Caregiver Quality showing a decline in persons seeking or renewing certification as nursing assistants (CNA), expose a significant workforce crisis facing providers caring for people in need of long-term and residential care.

WHCA / WiCAL

Wisconsin Health Care Association — Wisconsin Center for Assisted Living

LeadingAge Wisconsin

Better Services for Better Aging



The Need for Caregivers!

- More than 87,000 Wisconsin residents live in 4,102 long-term and residential care facilities[1]
- Residents living in long-term and residential care facilities rely on an estimated 73,700 caregivers[2]
- The number of Wisconsin residents living in long-term and residential care facilities has grown 18% since 2003[1]
- In the next 30 years, the ratio of Wisconsin residents age 65 and older to the entire state population will grow from 1 in 7 to 1 in 4[3]
- By the year 2022 the need for personal care workers is projected to **increase 26.4%**[4]

Scope of the Crisis

- Average caregiver vacancy rates of 14.5%, with 1 in 4 providers experiencing rates **20% and higher**
- An estimated **11,500 vacant caregiver positions** in Wisconsin long-term and residential care facilities

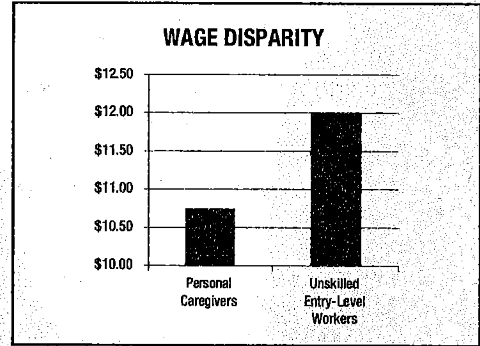
1 in 7 Caregiving staff positions are unfilled ...why?

More than **30%** of providers felt they were unable to compete with other employers

Nearly **50%** had no applicants for vacant caregiver positions

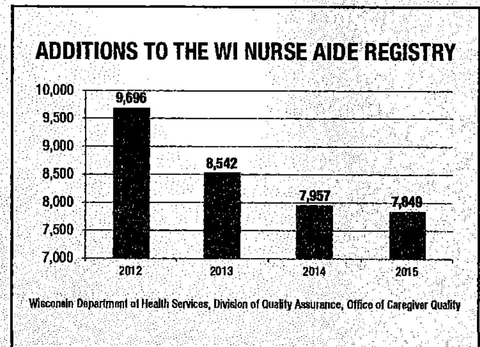
70% said there were no qualified applicants for caregiver openings

Why Is There A Crisis?



Wage and benefit disparity

- Providers reported a median hourly starting wage for personal caregivers of $10.75 compared to $12.00 for local, non-health care employers seeking unskilled, entry level workers
- **4 of 5 personal caregivers** who took jobs outside of health care left for better pay, better benefits and/or better hours



Caregivers are leaving

- 56% of providers had personal caregivers leave for jobs outside health care
- An estimated **10,600 personal caregivers** may have left for jobs outside of health care in the past year

People are not seeking certification as caregivers

- Between 2012 and 2015, **24% fewer people** applied for CNA certification[5]
- The number of people renewing their CNA certification declined by 5,431 between 2012 and 2015[5], a drop of 24%

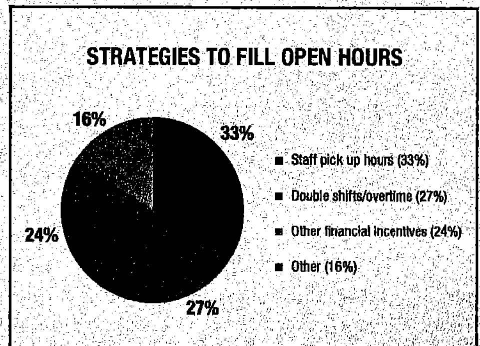
How Providers Are Trying to Cope

Limiting admissions

- **18% limited admissions** in the past year, limiting access to long-term and residential care services to an estimated 5,335 individuals because of caregiver shortages

Limiting benefits

- More than 50% of providers do not offer health insurance to part-time staff
- **1 in 4 providers** had at least 10 employees on BadgerCare Plus, the state's Medicaid health insurance program for low-income persons



Relying on current caregivers to fill open hours

- 84% of the time providers use overtime, double shifts, and/or other strategies to fill open hours which are expensive and can lead to caregiver burnout

We all can agree...

- Wisconsin residents living in long-term and residential care facilities deserve to be treated with dignity and respect
- Residents depend on the caregivers who work in these facilities
- Caregivers are responsible for the care, service, support, and safety of residents
- The work of caregiving is often difficult and demanding
- Caregivers are special people – it's not a job everyone can do

The research validated what we've been hearing from providers:

- Caregiver vacancy rates are reaching crisis proportions, with as many as 11,500 openings across Wisconsin
- The median starting wage for personal caregivers is $1.25 per hour less than the wage non-health care employers are paying for unskilled, entry level workers
- Caregivers are leaving because they can get better pay, better benefits, and/or better hours from non-health care employers
- People simply aren't applying for caregiver jobs
- Providers rely on overtime, double shifts and other strategies to fill open schedules. These stop-gap approaches are unsustainable and ultimately counterproductive if they lead to caregiver burnout.

What must be done to assure there are enough caregivers?

- Increase the number of people entering caregiving careers
- Value the work of caregiving
- Recognize and celebrate career caregivers
- Reward the work of caregivers with competitive wages and benefits

For more information about *The Long-Term Care Workforce Crisis: A 2016 Report,* contact:

- LeadingAge Wisconsin: John Sauer, 608.255.7060, (jsauer@leadingagewi.org)
- Wisconsin Health Care Association/Wisconsin Center for Assisted Living: John Vander Meer, 608. 257.0125, (john@whcawical.org)
- Wisconsin Assisted Living Association: Jim Murphy, 608.288.0246, (jmurphy@ewala.org)
- Residential Services Association of Wisconsin: Dan Drury, 414.322.8979 (ddrury@o4cg.com)

Glossary

Caregivers include registered nurses, licensed practical nurses, certified nursing assistants, persons with CBRF certification, resident assistants, and other direct and personal care workers

Long-term and residential care providers include adult family homes, community based residential facilities, residential care apartment complexes, and skilled nursing facilities

Assisted living includes adult family homes, community based residential facilities, and residential care apartment complexes

Personal caregivers include certified nursing assistants, persons with CBRF certification, resident assistants, and other direct and personal care workers

Footnotes

[1] Wisconsin Department of Health Services, Division of Quality Assurance, *State of Assisted Living – CY 2014*, March, 2015

[2] LeadingAge Wisconsin, Wisconsin Health Care Association / Wisconsin Center for Assisted Living, Wisconsin Assisted Living Association, Residential Services Association of Wisconsin, *2016 Workforce Survey*, March, 2016

[3] Wisconsin Department of Administration, Demographic Services Center, *Wisconsin's Future Population, Projections for the State, Its Counties and Municipalities, 2010 – 2040*, December, 2013

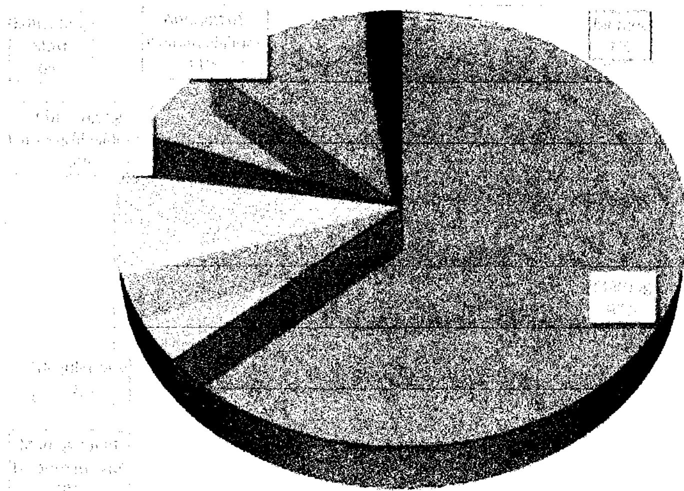
[4] Wisconsin Department of Workforce Development, Office of Economic Advisors, *Wisconsin Long Term Occupational Employment Projections, 2012-2022*, August 2014

[5] Wisconsin Department of Health Services, Division of Quality Assurance, Office of Caregiver Quality

Wisconsin DON Council Survey

- 3 questions were asked:
  - What keeps you in your position?
  - What is your biggest challenge?
  - What would make your job more satisfying?
- 79 respondents

Biggest Challenge



LeadingAge™ Wisconsin

Better Services for Better Aging

September 5, 2017

To: Members of the Assembly Committee on Aging & Long-Term Care

From: John Sauer, President/CEO, LeadingAge Wisconsin

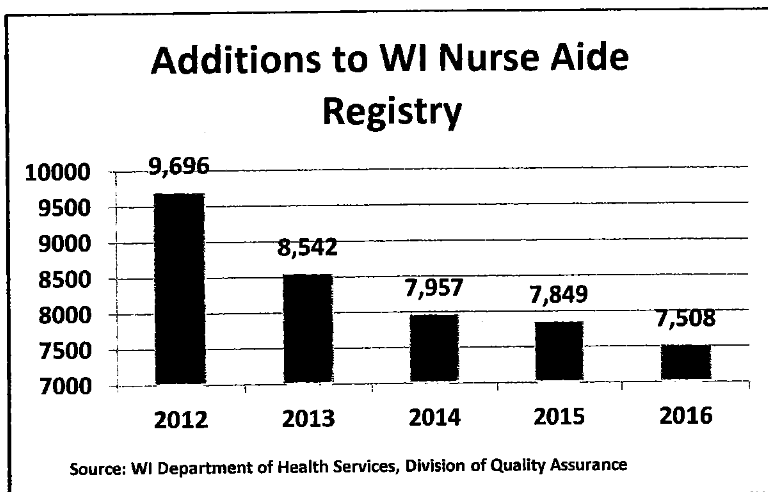
Subject: AB 432, relating to hours of instructional program for nurse aides.

Chairman Weatherston and Committee members - thank you for this opportunity to speak with you today about AB 432.

My name is John Sauer and I am the President/CEO of LeadingAge Wisconsin. LeadingAge Wisconsin is a statewide Association representing not-for-profit skilled nursing homes, assisted living facilities, and other community-based providers in Wisconsin, as well as a number of for-profit long-term care providers who have joined our organization as subscriber members. Specifically, the Association represents 212 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. A recent publication by the Department of Workforce Development (DWD) reveals that the demand of long-term care workers will be 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:



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As noted above, the number of annual additions to the CNA registry has declined by nearly twenty-five percent since 2012. This is an alarming situation knowing that Wisconsin is already experiencing a crisis-level shortage of direct care workers (see: www.leadingagewi.org/media/34782/Workforce-Report-2016.pdf). That is why I am here today to discuss the need for AB 432. 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, AB 432 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. Kwick Trip).

Secondly, all of the members I spoke with agree 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 the 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 skills).

Thank you for allowing me the opportunity to speak today in favor of AB 432. I am happy to answer any questions at this time.

* * * * *

LeadingAge Wisconsin is a statewide membership organization of not-for-profit organizations principally serving older adults and persons with a disability. In addition, several for-profit organizations subscribe to the services the association provides. The State's largest full continuum association, LeadingAge Wisconsin serves 562 long-term care, assisted living and senior housing facilities and over 300 other community-based providers that provide programs such as Alzheimer's support, adult day care, home health, hospice, home care, and meals on wheels. LeadingAge Wisconsin members employ over 38,000 people who provide compassionate care and service to over 48,000 individuals each day. For more information, please contact: John Sauer, President/CEO, jsauer@leadingagewi.org; Annette Cruz, Vice President of Public Policy and Advocacy, acruz@leadingagewi.org; or Brian Schoeneck, Vice President of Financial and Regulatory Services, bschoeneck@leadingagewi.org; at 608.255.7060. www.LeadingAgeWI.org

I am Craig Ubbelohde, and I am a licensed nursing home administrator. I have worked in Wisconsin nursing homes for 40 years; 35 years as an 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 40 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 and included 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 program. 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 of 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.

AB 432 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 AB 432 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 open up 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 up 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 from 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 $13 an hour with no experience and have a comprehensive benefit program (and as an aside, we were notified that our health insurance premiums are going up 40% in January). 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 a facility 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 AB 432 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. Our existing staff work more hours than they desire, in order to pick up shifts. This becomes more costly as facilities have to 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.

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

Before the Assembly Committee on Aging and Long-Term Care
September 5, 2017

Dear Chairperson Weatherston, Vice-Chairperson Petryk, and members of the Aging and Long-Term Care 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 and the Wisconsin Institute for Healthy Aging (WIHA).

Thank you for the opportunity to testify this afternoon on AB 432; 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).

It is my understanding this legislation is intended to help alleviate the shortage of direct care workers by getting certified nurse aides through training and into the workplace more quickly. While I too share in the goal to find solutions to address the workforce shortage, my personal and professional experience and review of research in this area lead me to believe this proposal will not achieve the desired results and may produce unintended outcomes that could put the care of older adults and individuals with disabilities at risk. As a former nursing home social worker, a family caregiver, and an advocate for older adults, I feel it is important this information be shared with you.

As anyone who has ever received care in a hospital, nursing home or other care setting (including home health care) can attest, certified nurse aides or nursing assistants (CNAs) perform extremely important functions. Whether they are helping patients/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 help older adults and people with both short and long-term

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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. In addition to help with daily activities, CNAs are often the ones who notice and report when an individual has a change in condition and who provide daily social and emotional support.

After talking with several CNA training instructors, a number of CNAs actively involved in providing care, as well as some individuals receiving care (and their family caregivers), and after reviewing study data and articles from industry experts; it is clear, quality care and a stable workforce depend on providing CNAs with the training needed to be well-prepared for their challenging and rewarding jobs.

Reports from some of the recent relevant studies (provided on the attached document) indicate:

- Nursing homes in states requiring clinical training hours above the federal minimums had significantly lower odds of adverse outcomes, particularly pain, falls with injury, and depression.
- Customers served by aides with advanced training had 10% fewer emergency visits and training initiatives led to increased retention and job satisfaction.
- An increase in the number of mandatory training hours improves job satisfaction and decreases turnover.
- Training of direct care workers has been show to improve quality of care and worker satisfaction and reduce turnover.
- The 120 hours of required training should be the floor, not the ceiling.

While lowering the required training hours could get students through the training quicker, studies indicate reduced training is correlated to decreased job satisfaction and job retention. Increased turnover rates impact not only the quality of care provided, but also further exacerbate the workforce shortage.

Throughout my discussions with some of those affected by the shortage of workers, I have learned that in many areas there are a wide variety of options for taking the course over a 2 – 6 week period; however, several areas have noted delays in scheduling for the competency exam which is provided by an agency under contract with the Department of Health Services. I have also learned there are other training programs such as nursing that require CNA training as a prerequisite. Many of these individuals do not plan to work as CNAs, but are completing the training as a required step for further training in their chosen career path. Could other options be explored for providing basic CNA training for those not planning to work in the field? Perhaps we could explore altering the ratio of clinical to classrooms hours without reducing the overall training hours. As of December 2016, over half the states in the country require more than the federal minimum (75 hours) total nurse aide training hours. Of additional note, are the over 30 states that require more than the minimum (16 hours) of clinical training. A number of states that require more than the federal total training hours have also increased the percentage of total hours dedicated to clinical training. 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. Last, but certainly not least. Wisconsin will begin implementing the new CNA bridge training program in October of this year. The bridge program will speed up the process for an individual who has successfully completed an instructional program for nurse aides in another state to receive instruction that, when combined with the instructional program in the other state, will result in the individual having received substantially the same instruction as an instructional program approved by DHS under current law. This program will help those trained in other states to more quickly be certified to provide service in Wisconsin which will be especially helpful to communities in border areas of the state. Development of a reciprocity plan could further aid this goal.

Older adults and people with disabilities need and deserve the best, safest, quality of care that can be provided. Rather than reducing the required total training hours for nursing assistants in Wisconsin 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 (including further exploration of the ideas noted above) that will help alleviate the workforce shortage without endangering the care of vulnerable citizens.

Representative Weatherston, Representative Petryk, and members of the committee, thank you for the opportunity to comment on this important issue impacting the job satisfaction and retention of a valuable and much needed directed care workforce and the health and safety of vulnerable Wisconsin residents. 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
Greater Wisconsin Agency on Aging Resources
janet.zander@gwaar.org
(715) 677-6723 or (608) 228-7253 (cell)

Hours of Instructional Program for Nurse Aides AB 432/SB 341 – Updated 9/04/17

- **Assembly Aging and Long and Long-Term Care Committee – Public Hearing on AB 432**

Committee Members: https://docs.legis.wisconsin.gov/2017/committees/assembly/1650

Hearing Notice – Tues. 9/05/17 - https://docs.legis.wisconsin.gov/raw/cid/1398642 NEW INFO: 8/29/17. See also new information on the nurse aide bridge training program below.

- **Bill introduced June 30, 2017 - AB 432/SB 341 relating to: hours of instructional program for nurse aids –** https://docs.legis.wisconsin.gov/2017/proposals/ab432

This bill conforms state law for instructional programs for nurse aides to the federal law requirements for Medicare and Medicaid. *Specifically, the bill prohibits the Department of Health Services from requiring an instructional program to exceed the federal required minimum total training hours or minimum hours of supervised practical training, which is clinical experience, specified in the federal regulation.* The current federal regulation requires no less than 75 hours of training with at least 16 of those hours being supervised practical training. Wisconsin currently requires 120 hours of training which includes at least 32 clinical hours.

Full text of the bill: https://docs.legis.wisconsin.gov/2017/related/proposals/ab432

- **Current Certified Nurse Aide Requirements in Wisconsin**

Wisconsin Nurse Aide Training Program and Registry Manual - Wisconsin-approved programs are currently 120 hours long and include 32 clinical hours.
https://www.dhs.wisconsin.gov/publications/p0/p00118.pdf - (see pgs. 15- 25)
http://www.nursinglicensure.org/cna/wisconsin-nursing-assistant.html#training

- **Current Federal Training Requirements**

Federal regulations require that nurse aides have no less than 75 hours of training prior to receiving their certification. At least 16 hours of a training program must be supervised practical (clinical) training.
https://oig.hhs.gov/oei/reports/oei-05-01-00031.pdf (pg. 5)

- **Nurse Aide Training Requirements – Comparison of States**

Over half of states have chosen to require more than the minimum federal standard of 75 hours for Nurse Aide training, as summarized in the accompanying table: • 30 states and the District of Columbia have extended the minimum number of training hours beyond 75 hours to as many as 180 hours. • 13 states and the District of Columbia require a minimum of 120 or more training hours, the standard recommended by the Institute of Medicine report. • 32 states and the District of Columbia require more than the minimum 16 hours of clinical training, with required clinical hours ranging up to 100 hours (see pg. 1 & table on pg. 2).
https://phinational.org/sites/default/files/research-report/na-training-reqs.pdf (December 2016)

- **Wis. Dept. of Health Services – DQA Memo - 2013 Wisconsin Act 357 – Nurse Aide Training "Bridge" Program** - https://www.dhs.wisconsin.gov/dqa/memos/14-004.pdf and link to **2013 Wisconsin Act 357** - https://docs.legis.wisconsin.gov/2013/related/acts/357.pdf NEW INFO: ADDED 8/18/17
- **Status of the Nurse Aide Bridge Training Program – Chapter DHS 129/Clearinghouse Rule (CR)16-088** https://docs.legis.wisconsin.gov/code/chr/all/cr_16_088 NEW INFO: ADDED 8/21/17

- **Administrative Register/Effective Date CR16-088:** http://docs.legis.wisconsin.gov/code/register/2017/740B/register/cr/cr16_088_rule_text/cr16_088_rule_text NEW INFO: ADDED 8/28/17

Related Articles & Studies

CNA Training Requirements & Resident Care Outcomes in NHs

This study examines the relationship between certified nursing assistant training requirements and resident outcomes in U.S. nursing homes (NHS). Results found a higher ratio of clinical to didactic hours was related to better resident outcomes. Nursing homes in states requiring clinical training hours above federal minimums (i.e., > 16 hr) had significantly lower odds of adverse outcomes, particularly pain, falls with injury and depression. (*The Gerontologist*, 2017, Vol. 57, No. 3, 501-508)

https://oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/57/3/10.1093_geront_gnw049/3/gnw049.pdf?Expires=1502925238&Signature=R9Wi7h-OYJnHATpzq6WL-ch7O7cU3oib-FcFYp~YGWKyyYl~75mGiTk2X0~~A9S8lckc7Dxq951Rmkn-2g3AGIqM6Hl2pq-F0DprM9CxhUfhyZ1gHrGW9V4GG-DvZcd88F5Pv3Etaz8uOdBQZL6Kw97yo70klx7HzZllCoPyovZV2RR433vLdYKG9i6ChDaNpOQ3R~p2ZjmVaYO6o9-GuUMEc~1FlfbHagSRKPi6HtigDjEkP4hxeLl0ro1lurNxlx6SQ1ZjjwMPJALJGH6tsFK5b9TxgB7WVQj7zxjHqBIRguoOAcS6f7VxdNKKZ~nyCKaekcjWM1RNtEdSjFvtSA__&Key-Pair-Id=APKAIUCZBIA4LVPAVW3Q

Strengthening the Direct Care Workforce

TRAINING AND ADVANCED ROLES Quality training ensures that direct care workers have the skills to deliver excellent person-centered care. Unfortunately, training standards for this workforce are inadequate. Federal lawmakers should adopt training standards for personal care aides; encourage states to meet the 120 hours of training for all direct care workers recommended by the National Academies of Sciences, Engineering, and Medicine; and fund training programs related to advancement and working with chronic conditions. (Executive Summary 2017 pg. 3)

https://www.phinational.org/sites/phinational.org/files/phi-federal-priorities-execsum.pdf

"Quality training ensures that direct care workers have the skills and knowledge to deliver excellent person-centered care... In New York City, an 18-month pilot program for advanced training among 1,100 home health aides found that clients served by aides with advanced training had 10 percent fewer visits to the emergency room than clients with aides who did not receive advanced training. Similarly, a multiyear training initiative in New York City led to increased retention and job satisfaction among home health aides who took part in the training program." (Full Report - see pgs. 6-7)

https://phinational.org/sites/phinational.org/files/research-report/phi_federal_report_web_0.pdf

Raise the Floor: Quality Nursing Home Care Depends on Quality Jobs

Training - It is essential to address the training of nursing assistants to better prepare people to do their jobs and to stop the cycle of turnover. Federal training standards for nursing assistants in Medicare and Medicaid-certified nursing homes must be modernized to reflect advances in the delivery of person-centered care, as

well as the realities of the populations served in nursing homes today—those with behavioral health needs, cognitive decline, and those near the end of life. Studies have shown that an increase in the number of mandatory training hours improves job satisfaction and decreases turnover. Additionally, experts have identified additional competencies that new nursing assistants should be required to demonstrate and approaches to training that increase successful learning. Both federal and state policymakers can take action to improve training programs for nursing assistants through: • EXPANDING FEDERAL TRAINING REQUIREMENTS WITH REQUIRED COMPETENCIES: As recommended by the Institute of Medicine, federal requirements should be expanded to 120 hours of pre-employment training. Expanded training should include building skills in communication, relationship building, and problem solving, and also address competencies related to caring for individuals with dementia and other challenging behaviors. The 120 hours should be considered a floor, not a ceiling, and employers should determine the content of on-the-job education for nursing assistants to meet the needs of varied populations (pg. 25). http://phinational.org/sites/phinational.org/files/research-report/phi-raisethefloor-201604012.pdf (April 2016)

CNAs Need More Training

Certified nursing assistants caring for seniors should be required to undergo 120 hours of training, and their compensation should reflect the skills and knowledge required to perform high-quality work, assert the authors of an opinion article published online Monday by *JAMA*, the journal of the American Medical Association. (Sept. 26, 2016)- http://qa2.mcknightsseniorliving.com/news/cnas-need-more-training-better-compensation-authors-say/article/524977/

National Academy of Medicine: Importance of Supporting Direct Care Workers

The National Academy of Medicine's new discussion paper addresses what changes are needed to provide quality care for an aging population.

Among the recommendations pertaining to the direct care workforce are:

- Requiring a minimum of 120 hours of training, including specific training on caring for older adults, to be certified as a nursing assistant or home health aide; (PHI, Sept. 30, 2016)

https://phinational.org/blogs/national-academy-medicine-recognizes-importance-supporting-direct-care-workers

How Can States Support an Aging Population? Actions Policymakers Can Take

Activities Policymakers Can Consider to Improve Recruitment and Retention of Long-term Care Workforce
Training of direct-care workers has been shown to improve quality of care and worker satisfaction and reduce turnover. (pg. 20, June 2016)

https://www.milbank.org/wp-content/uploads/2016/06/MMF-NYAM-Aging-Report.pdf

Caregiver Shortage Looms: 10 Recommendation

#4. Training and capacity of healthcare and social service providers should be improved to help engage caregivers and provide the proper supports.

http://www.beckershospitalreview.com/hospital-physician-relationships/caregiver-shortage-looms-10-recommendations.html

Training Programs for CNAs

Informants demonstrated a clear consensus that 75 hours is insufficient for adequately training CNAs. Although a few of the interviewees suggested higher thresholds, the majority suggested an increase to between 100 and 120 hours. Informants were hesitant to give specific figures, but they generally believed that clinical training should account for a higher proportion of total training time than it does currently. Several informants emphasized that 50 to 60 hours of clinical training was the minimum needed for CNAs to safely work with residents, and some informants said that more even more clinical time was needed. (pg. 2)

Summary and Recommendations

The results of this study suggest a number of recommendations for improving CNA training programs. These recommendations are targeted to federal and state policymakers and training program officials.

- For federal policymakers, the study points to a need to increase the 75-hour minimum requirement to at least 100 to 120 hours, to ensure that CNAs have the training they need to provide good quality care to residents. In addition, improving training may reduce CNA turnover, thereby improving the quality of care and reducing the costs associated with high turnover rates.
- For federal and state policymakers, the study indicates a need to increase clinical training to at least 50 to 60 hours. (pg. 3)

https://assets.aarp.org/rgcenter/il/2006_08_cna.pdf (March 2006)

AARP Real Possibilities in
Wisconsin

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Good Afternoon. My name is Helen Marks Dicks and I am the State Issues Advocacy Director for AARP Wisconsin. Today I am submitting written testimony in opposition to AB 432.

AARP Wisconsin has over 840,000 members over the age of 50 in Wisconsin. AARP looks at the impact of legislation on the 50+ population. Today we are submitting testimony in opposition to AB 432. This bill reduces the number of training hours required to be a CNA in Wisconsin.

This piece of legislation reduces training requirements to the CMS minimal requirement of 75 hours. AARP believes this is too low of a standard and has been advocating on the national level to raise the minimum to no less than 100 hours. Wisconsin is often the leader in health care issues and our exceeding the minimal standards reflects a long held pattern of supporting quality care and in leading the way in setting national standards. Wisconsin was recently recognized for our quality of health care. That quality is a result of our high standards and the quality of our work force.

This is not the time to move backwards in those standards. There are national studies which show that the number of hours of training affects both the quality of care for the patient and the health and safety of the work force. We share the concern that there is a need for more qualified well trained workers, but believe this is the wrong approach to solving that problem. We would support efforts to increase tuition reimbursements for additional and ongoing training, an adequate pay system to allow better pay and benefits to incentivize people to choose this career and other programs to increase recruitment and retention in this area.

We urge a no vote on AB432. It undermines the care of our members and creates greater risk to the workers who would receive less training and therefore be at greater risk to injury. Please do not put Wisconsin's reputation for quality care and quality workers at risk.

If you have questions about this or any other legislative position taken by AARP Wisconsin, please feel free to contact me at 608-286-6337 or by email at hmdicks@aarp.org.

WILLOWDALE
NURSING & REHABILITATION

ASHLAND
Health and Rehabilitation

WAUSAU MANOR

Birch Haven
Senior Living

September 5, 2017

Dear Members of the Assembly Committee on Aging and Long-Term Care,

Thank you for taking the time today to hear public testimony on Assembly Bill 432, 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 skilled nursing 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 432 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,

-NEXT PAGE PLEASE-

Assembly District 19:

SANDRA REYNOLDS, NHA
Administrator
BRIA on the Lake

Assembly District 44:

KATHY KUS, NHA
Director
Mercy Manor Transitional Center

Assembly District 59:

ZACH ZIESEMER, NHA
Executive Director
Willowdale Nursing & Rehab Center

Assembly District 68:

SHERRY GOODMAN, NHA
Administrator
Oakbrook Health & Rehabilitation

Assembly District 74:

BRIDGET STABERG, NHA
Administrator
Ashland Health & Rehab

DALE KELM
President & CEO
Birch Haven Senior Living

DEB KLATKIEWICZ, NHA
Administrator
Park Manor, Ltd.

Assembly District 74 (continued):

JASON HELLEN, LPN, NHA
Administrator
Sky View Nursing Center

JOE SIMONICH, NHA
Administrator
Villa Maria Health & Rehab

Assembly District 85:

ERICA POOLE, NHA
Executive Director
Wausau Manor

Assembly District 88:

CATHY WHITMER, NHA
Administrator
Parkview Manor Health Care

Assembly District 93:

KEVIN LARSON, NHA
Administrator
Spring Valley Senior Living and Health Care Campus

CARLA HUTTER, NHA
Administrator
Plum City Care Center

8-31-17

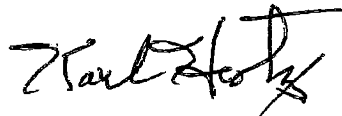
Dear Rep. Weatherston,

Kindly let me explain that I am an Ozaukee County Supervisor representing Thiensville and Chair of the Health and Human Services Committee.

In the above capacity, I am hearing great concern over the bills proposing to reduce the training time for CNA candidates. After reviewing the situation, my committee and I have come to the conclusion that the intent of the bills would be to pump more people into the CNA positions more quickly to help solve a shortage. This is, of course, a well intentioned idea.

However, we do not feel the risk to patients is worth the change. Please do not change the training in WI.

Thank you for considering our thoughts; we hope you take them very seriously.



Karl Hertz
Thiensville

RE: 2017 Assembly Bill 432

As a nurse aid instructor, nursing instructor, and consumer of the health care system in Wisconsin and having worked as a nurse aid, I am opposed to the 2017 Assembly Bill 432 which decreases the current training of Nursing Assistants in the State of Wisconsin from 120 hours to 75 hours.

A. While I acknowledge the current nurse aid shortage and the impact on health care services in Wisconsin, I do not believe that this is largely due to the current length of the nurse aid training program. Turnover rate for nurse aids nationally is among the highest compared to others service avocations. In a June 15, 2017 report submitted by the Wisconsin Department of Veterans Affairs, the State of Wisconsin percentage of full-time nurse aide retention for at least one year is 69% (71% nationally) and part-time is 59%. Addressing factors that affect workforce stabilization such as wages, working conditions, organizational culture, continued training and advancement, and flexible scheduling would seem a more likely solution. Improving the one year retention by even a modest 10% would go a long way to address the current nurse aid shortage.

B. In a paper submitted in 2007 for the American Association of Homes and Services for the Aging, increased entry-level and continued training is important in helping workers improve competency, skills, and confidence and improves recruitment and retention of nurse aids. These researchers found that higher levels of training helped employers find and keep nurse aides. Similarly, studies that tested the effects of enhanced educational programs have observed reductions in nurse aide turnover. Decreasing training programs pre-employment has not been supported in the literature as a recruitment or retention strategy. So why would Wisconsin consider this strategy?

C. Compensation and benefits has long been central to the recruitment and retention of workers, there is no single solution to the pay and benefits issue as nursing homes and not for profit organizations remain strongly dependent on public reimbursement. A growing body of evidence suggest the relationship between staffing to quality outcomes (Castle & Engberg, 2006). There is merit to linking workforce measures and payment to quality and for improving staff retention. But in the end, the basic challenge remains

wages. Until we actively address and look for creative solutions to the inequity of pay of the nurse aid to other jobs, we will not have a viable and long term solution to the workforce shortage.

D. Decreasing the required training hours would require tough decisions to be made on what is not important for a nurse aid to know when caring for our ill and vulnerable citizens. I believe that the current 120 hours of required training is the very minimum to begin to provide safe and quality care. Decreasing the training hours means that onboarding costs and staff time by the hiring organization will likely increase. If hiring organizations do not increase onboarding efforts, retention and safe care will surely suffer.

E. Wisconsin has just recently received the coveted distinction of being first in the nation for health care with the highest overall health care quality by the federal Agency for Healthcare Research and Quality (AHRQ). This is in a large part through the commitment to high quality of training all health care providers recieve. Are we, as a State and responsible to our citizens, willing to jeopardize this commitment?

F. Many nurse aid training programs throughout the State realize that there are barriers to training potential candidates. These programs have developed innovative programming using online and hybrid education coupled with hands on lab and clinical experiences. One of the monetary barriers that students face is the certification exam. There is a written and psychomotor component. Students have difficulty scheduling the psychomotor component and those that fail this component do so unnecessarily because the exam is not consistent with practice and is used punitively instead of a learning opportunity. I would support keeping the written exam for certification but eliminating the costly psychomotor component.

It is my hope that this bill will not come to fruition and that we will come together as a collective group to develop creative solutions for implementation to address the issue. Decreasing the training hours is not the solution to the nurse aid workforce shortage.

Valerie Palarski, EdD, MSN, RN justvaleriern@yahoo.com 715.573.0805

From: Michelle Pike <mpike@co.ozaukee.wi.us>
Sent: Thursday, August 31, 2017 12:30 PM
To: Rep.Weatherston
Subject: Public Hearing on AB 432

Dear Representative Weatherston,
I currently serve as the Director of the Aging and Disability Resource Center of Ozaukee County. I am not able to attend the public hearing on Sept 5th so I am writing to express my concern about AB 432. I believe the bill was originally intended to act as a means to move direct care workers into the workplace faster to help alleviate the workforce shortage. I believe this was a well-intentioned solution but in reality, reducing the required training hours will only serve to create health and safety concerns for those in need of care.

I would encourage you or your staff to do some research regarding CNA Training requirements as they relate to resident care outcomes in nursing homes. What you will find is nursing homes in states requiring clinical training hours above federal minimums had significantly lower odds of adverse outcomes such as falls with injuries, pain, and depression.
I believe what is needed is to bring all stakeholders together to find solutions to the workforce crisis that will work without endangering the care of our state's most vulnerable citizens.

Please do not change the training requirement of 120 hours in WI.

Thank you for time and consideration.

Respectfully,

Michelle L. Pike
Director, Aging and Disability Resource Center of Ozaukee County
121 W. Main Street
Port Washington,WI 53074
(262) 284-8120

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DISCUSSION PAPER

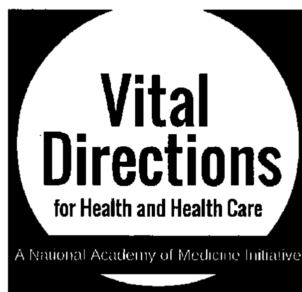
Preparing for Better Health and Health Care for an Aging Population

A Vital Direction for Health and Health Care

John W. Rowe, Columbia University; **Lisa Berkman,** Harvard University; **Linda Fried,** Columbia University; **Terry Fulmer,** John A. Hartford Foundation; **James Jackson,** University of Michigan; **Mary Naylor,** University of Pennsylvania; **William Novelli,** Georgetown University; **Jay Olshansky,** University of Illinois; **Robyn Stone,** LeadingAge

September 19, 2016

About the Vital Directions for Health and Health Care Series



This publication is part of the National Academy of Medicine's **Vital Directions for Health and Health Care Initiative,** which called on nearly 150 leading researchers, scientists, and policy makers from across the United States to assess and provide expert guidance on 19 priority issues for U.S. health and health care. The views presented in this publication and others in the series are those of the authors and do not represent formal consensus positions of the NAM, the National Academies of Sciences, Engineering, and Medicine, or the authors' organizations. Learn more: **nam.edu/VitalDirections.**

Introduction

The proportion of the US population over 65 years old is increasing dramatically, and the group over 85 years old, the "oldest old," is the most rapidly growing segment. People who survive into higher ages in America, which itself is an aging society, face a suite of competing forces that will yield healthy life extension for some and life extension accompanied by notable increases in frailty and disability for many. We spend more, for worse outcomes, than many if not all other developed countries, including care for older persons. Looking forward, our health care system is unprepared to provide the medical and support services needed for previously unimagined numbers of sick older persons, and we are not investing in keeping people healthy into their highest ages. This paper summarizes the opportunities for valuable policy advances in several important spheres that are central to the health and well-being of older persons. In all of them, concerns regarding disparities in health and the severe concentration of risk among the poorest and least educated members of our society present special opportunities for progress and these issues are addressed in detail in other papers in the Vital Directions series.

Key Trends in Demography and Health Equity in the 21st Century

Aging and health intersect both at the level of the individual and at the level of the entire society. For individuals, the extension of life achieved in the last century as a product of advances in public health, socioeconomic development, and medical technology

constitutes a monumental achievement for humanity. Most people born today will live past the age of 65 years, and many will survive past the age of 85 years, but life extension comes with a Faustian trade. Modern medical advances will no doubt endure, but it is possible that continued success in attacking fatal diseases could expose the saved population to a higher risk of extreme frailty and disability as disabling diseases accumulate in aging bodies.

The aging of our society, reflecting the rapidly increasing proportion of older people relative to the rest of the population, is a product of two major demographic events: the substantial increase in life expectancy and the baby boom. At the societal level, this population shift will place great pressure on our fragile systems of health care, public health, and other supports for older persons. Past increases in life expectancy are impressive, but the more recent news is not as good in America. In the middle 1980s, life expectancy of women in the United States was about the average of that in Organisation for Economic Cooperation and Development (OECD) countries. Since 2000, we have ranked last, and the gap between the United States and other OECD countries in health status is also widening. Contributors to the absolute increases in poor health experienced by the most disadvantaged Americans, the poor and less educated, include the concentration in these groups of multiple risk factors, including smoking, obesity, gun violence, and increased teenage pregnancy (NASEM, 2015; NRC, 2012; Schroeder, 2016).

As America ages, it becomes more diverse. By 2030, the non-Hispanic white population will be the numerical minority in the United States. Increased longevity is prevalent among several ethnic and racial groups (such as black, Chinese, Japanese, Cuban, and Mexican American). Younger Hispanics, the most rapidly growing group in our population, are generally US-born and have both higher fertility rates and much higher disability rates than older Hispanics, who are more likely to be foreign-born.

As discussed in detail in other discussion papers in the Vital Directions series, owing largely to socioeconomic factors, many racial and ethnic groups, especially blacks, are at disproportionate risk for adverse health outcomes over the life course compared with whites. Many factors may contribute to the disparity, including biologic disposition to dietary and lifestyle behaviors and failure to receive adequate health care. Given complex sociohistorical contexts, comparisons between racial and ethnic groups may be less useful than comparisons among people within groups—for example, according to socioeconomic status (SES)—in uncovering specific mechanisms.

SES-based racial and ethnic-group disparities exist in both physical and mental well-being, even where access to health care is equal. Although targeted policy considerations regarding disparities are not provided here, it is important to understand that disparities constitute an important target for improvements in each of the key areas we identify for action. Issues of health disparity are addressed more specifically in the Vital Directions Perspective on addressing health disparities and the social determinants of health (Adler et al., 2016).

Key Opportunities for Progress

Enhancing Delivery of Effective Care for Those Who Have Multiple Chronic Conditions

The health care needs of older adults coping with multiple chronic conditions, which account for a vast majority of Medicare expenditures, are poorly managed (MedPAC, 2014). Effective management that engages older adults, family caregivers, and clinicians in collaboratively identifying patients' needs and goals and in implementing individualized care plans is essential to achieve higher-value health care. Evidence-based approaches to care management are available, but the uptake and spread of most models have been sporadic and slow.

Many effective approaches to enhancing delivery of care for older persons have been developed; the problems have generally been in dissemination and implementation, often owing to lack of funding. Examples of such programs are the following:

- *Care options in varied settings: the Transitional Care Model (TCM).* The TCM is an advanced-practice, nurse-coordinated team-based care model that targets at-risk community-based older adults who have multiple chronic conditions and their family caregivers. In several clinical trials funded by the National Institutes of Health, the TCM has consistently demonstrated improvements in patients' care experiences, health, and quality-of-life outcomes while decreasing total health care costs (Naylor et al., 2004).

- *Care options in nursing homes: the Interventions to Reduce Acute Care Transfers (INTERACT) program.* The INTERACT program includes a variety of communication, decision-support, advance care planning and quality-improvement tools, all designed to support nursing-home staff efforts to prevent avoidable rehospitalizations of residents. In a typical 100-bed nursing home, the INTERACT program was estimated to reduce rehospitalizations by an average of 25 per year for a net savings of $117,000 per facility (Ouslander et al., 2011).
- *Care options in the community: home-based primary care.* Programs that deliver team-based primary care in the home for people who have advancing chronic conditions have been shown to be very effective by the Department of Veterans Affairs and in a Medicare demonstration (Independence at Home).

Delivery-of-Care Policy Alternatives

- Widespread adoption of high-value, rigorously evidence-based best practices with demonstrated longer-term value that target older adults, such as those listed above (Naylor et al., 2014), should be encouraged. Resources now targeted to short-term results for older adults who have multiple chronic conditions, such as those focused on reducing 30-day rehospitalizations, should be redirected to longer-term solutions that align closely with the needs and preferences of this population.
- New models of care for older adults in such neglected areas as prevention, long-term care, and palliative care should be developed.
- The Public Health Service should strengthen its efforts, such as the "Healthy People" program, to foster a prevention and health-promotion agenda for longer lives with a deep grounding in socioeconomic determinants of health.
- Robust metrics of effective care management for vulnerable older adults should be developed with emphasis on outcomes that matter to patients and their family caregivers.

Strengthening the Elder Care Workforce

One of the greatest challenges to the capacity of our health care system to deliver needed high-quality services to the growing elderly population resides in the current and likely future inadequacy of our workforce, including both the numbers of workers and the quality of their training.

The Institute of Medicine, now the National Academy of Medicine, drew attention to this issue first in 1978 (IOM, 1978), again in 1987 (Rowe et al., 1987), and more recently in its 2008 report, *Retooling for an Aging America*, which reported an in-depth analysis of the future demand for and the recruitment and retention challenges surrounding all components of the geriatric health care workforce. Despite increased awareness of the impending workforce crisis, the problems persist almost a decade later.

The Professional Health Care Workforce

We have an alarming dearth of adequately prepared geriatricians, nurses, social workers, and public health professionals. The number of board-certified geriatricians, estimated at 7,500, is less than half the estimated need, and the pipeline of geriatricians in training is grossly inadequate. The reasons are many, but a prominent impediment is the substantial financial disadvantage facing geriatricians. Working in fee-for-service systems, which continue to dominate health care payment, internists or family physicians who complete additional training to become geriatricians can expect substantial decreases in their income despite their enhanced expertise. The reason for this is that the care they provide is more time intensive and all their patients will be on Medicare or on Medicare and Medicaid simultaneously ("dual users"), as opposed to the mix of Medicare and commercially insured patients served by most general physicians. The failure of Medicare to acknowledge the value of the enhanced expertise punishes those dedicated to careers in serving the elderly (IOM, 2008). Approaches are needed not only in the fee-for-service system that accounts for most of Medicare but in increasingly important population-based approaches such as accountable care organizations (ACOs).

Nursing is also deficient in geriatrics. Fewer than 1% of registered nurses and fewer than 3% of advanced-practice registered nurses are certified in geriatrics. One of the major impediments for nurses is related to the lack of sufficiently trained faculty in geriatric nursing. The same can be said of pharmacists, physical therapists, social workers, occupational therapists,

and the full array of allied health disciplines (IOM, 2008).

Besides the insufficient numbers, there is a growing awareness that the greater problem—which may be amenable to more rapid improvement if appropriate policies are put into place—is the lack of sufficient training and competence of all physicians and nurses who treat older patients in the diagnosis and management of common geriatric problems. This issue of geriatric competence of all health care providers may be the number one problem we face in delivering needed care for older persons.

An additional critically important issue is related to the lack of effective coordination of specialists such as geriatricians with primary care providers. Such lack of coordination seems worst in traditional fee-for-service settings and may be less severe in population-based settings, such as ACOs.

Direct Care Workers

Direct care workers—certified nursing assistants (CNAs), home health aides, and home care and personal care aides (1.4 million in 2012)—provide an estimated 70–80% of the paid hands-on care to older adults in nursing homes, assisted-living homes, and other home- and community-based settings (Eldercare Workforce Alliance, 2014). From 2010 to 2020, available jobs in those occupations are expected to grow by 48% (in contrast with all occupational growth of just 14%) at the same time that the availability of people most likely to fill the occupations is projected to decline (Stone, 2015).

Recruiting and retaining competent, stable direct care workers are serious problems in many communities around the country. Turnover rates are above 50%. Many factors contribute to the turnover, but two major issues are low wages (median hourly wages of CNAs, home health aides, and personal care workers in 2014 were $12.06, $10.28, and $9.83, respectively) (BLS, no date a, b, c) and inadequate training and supervision. Federal regulations require CNAs and home health aides employed by Medicare- or Medicaid-certified organizations to have at least 75 hours of training; that is less than some states require for crossing guards and dog groomers! There are no federal training requirements for home care and personal care workers.

An important issue related to both the professional and the direct elder care components of the workforce is ensuring competence in the recognition, prevention, and management of elder abuse and neglect—a problem that may be especially critical in underprivileged populations.

Workforce Policy Alternatives

Enhancing Geriatric Competence—Priority Considerations

- Physician and nurse training in all settings where older adults receive care, including nursing homes, assisted-living facilities, and patients' homes.
- Demonstration of competence in the care of older adults as a criterion for all licensure, certification, and maintenance of certification for health care professionals.
- Federal requirements for training of at least 120 hours for CNAs and home health aides and demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal care aides.
- Incorporation by the Centers for Medicare & Medicaid Services (CMS) of direct care workers into team-based approaches to caring for chronically disabled older adults.

Increasing Recruitment and Retention—Priority Considerations

- Public and private payers providing financial incentives to increase the number of geriatric specialists in all health professions.
- CMS extending graduate medical education payments to cover costs of residency training to public health physicians and nurses to support their training in geriatric care and health promotion.
- All payers including a specific enhancement of reimbursement for clinical services delivered to older adults by practitioners who have a certification of special expertise in geriatrics.
- The direct care workforce being adequately compensated with a living wage commensurate with the skills and knowledge required to perform high-quality work.
- States and the federal government instituting programs for loan forgiveness, scholarships, and direct

financial incentives for professionals who become geriatric specialists. One such mechanism should include the development of a National Geriatric Service Corps, modeled after the National Health Service Corps.
- The Department of Labor and the Department of Health and Human Services (specifically, CMS and the Health Resources and Services Administration) developing apprenticeship opportunities for direct care workers in the whole array of long-term support and service settings.

Social Engagement and Work-Related Strategies to Enhance Health in Late Life

It is now widely accepted that social factors play an important role in determining health status. As mentioned previously, the issues of social determinants of health status are addressed in detail in other discussion papers in the Vital Directions series. Nonetheless, one aspect of particular importance to older persons deserves attention here. A vast body of research indicates that the degree to which men and women are "connected" to others, including volunteerism and work for pay, is an important determinant of their well-being.

Engagement

The effect of deficient social networks and relationships on mortality is similar to that of other well-identified medical and behavioral risk factors. Conversely, social engagement—through friends, family, volunteering, or continuing to work—has many physical and mental benefits.

Over the last 15–20 years, older people have become more isolated and new cohorts of middle-aged adults, especially those 55–64 years old, have shown a major drop in engagement. In addition, national volunteer efforts—such as Foster Grandparents program, the Retired and Senior Volunteer Program (RSVP), and the Senior Companions program—reach only a small percentage of the eligible target audience and have long waiting lists. Programs with high impact on the volunteers and recipients, such as the Experience Corps, have an inadequate number of high-impact opportunities because of low financing.

Work

An impressive and growing body of evidence suggests that working is health promoting as well as economically beneficial. With overall increasing healthy-life expectancy, many Americans will be able to work longer than they do now. Working longer will be health promoting for many Americans, providing not only additional financial security but continued opportunities for social engagement and participation in society. Leave policies related to employee and family sickness are essential to enable workers to remain in the workforce until retirement and at the same time provide social support for their families.

Work-Related and Engagement-Related Policy Alternatives—Priority Considerations

- Strengthening leave policies related to employee and family sickness.
- Evaluating engagement as a core competence of the care plan for older adults.
- Restoring Medicare as the primary payer for health-insurance claims for older workers of all employers, with a major communication effort to bring this to the attention of employers and beneficiaries.
- Incentives to redesign work to increase schedule control and increase opportunities for work–family balance.
- A choice of retirement options so that people who cannot continue to work full time or in their previous jobs because of functional limitations can remain engaged in flexible, part-time, seasonal, or less demanding roles.
- Strengthened on-the-job and community-college training programs to hone skills and assist middle- and later-life workers in continuing to work or in transitioning to new types of jobs.
- Business tax credits for reinvestment in skill development.
- Strengthened neighborhoods through transportation and housing policies are needed that aim to keep older men and women engaged in their communities.
- Reengineering federal volunteer programs such as Foster Grandparents, RSVP, and Senior Companions to serve a much larger portion of the potential beneficiaries.
- Broadly disseminating intergenerational volunteer programs, such as Experience Corps, which benefit youth and seniors.

Advanced Illness and End-of-Life Care

At some point, the vast majority of older people will face advanced illness, which occurs when one or more conditions become serious enough that general health and functioning decline, curative treatment begins to lose its effect, and quality of life increasingly becomes the proper focus of care. Many such people receive care that is uncoordinated, fragmented, and unable to meet their values and preferences. That often results in unnecessary hospitalizations, unwanted treatment, adverse drug reactions, conflicting medical advice, and higher cost of care.

In September 2015, the Institute of Medicine (now National Academy of Medicine) released *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. The report indicated that there exists a strong body of evidence that can guide valuable improvements in this area, including not only enhancements in the quality and availability of needed care and supports but also strengthening of our overall health system. The report noted a number of important topics to be addressed, including fragmented care, inadequate information, widespread lack of timely referral to palliative care, inadequate advanced-care planning, and insufficient clinician–patient discourse about values and preferences in the selection of appropriate treatment to ensure that care is aligned with what matters most to patients.

Regarding support for clinicians, *Dying in America* found that there is insufficient attention to palliative care in medical school and nursing school curricula, that educational silos impede the development of professional teams, and that there are deficits in equipping physicians with communication skills. Since *Dying in America* was issued, there has been progress in many arenas, including the decision by CMS to pay for advance-planning discussions by clinicians with their patients and continued development of innovative approaches to the delivery of palliative care, such as that adopted by Aspire Health, but critical gaps persist.

Advanced Illness and End-of-Life Care—Policy Alternatives

- Government and private health insurer coverage for the provision of comprehensive care for people who have advanced serious illness as they near the end of life.
- Access to skilled palliative care for all people who have advanced serious illness, including access to an interdisciplinary team, in all settings where they receive care, with an emphasis on programs based in the community.
- Standards for advanced-care planning that are measurable, actionable, and evidence based, with reimbursement tied to such standards.
- Appropriate training, certification, or licensure requirements for those who provide care for patients for advanced serious illness as they near the end of life.
- Integration of the financing of federal, state, and private medical and social services for people who have advanced serious illness as they near the end of life.
- Public education by public health organizations, the government, faith-based groups, and others about advanced-care planning and informed choice, as well as efforts to engender public support for health system and health policy reform.
- Federally required public reporting on quality measures, outcomes, and costs regarding care near the end of life (for example, in the last year of life) in programs that it funds or administers (such as Medicare, Medicaid, and the Department of Veterans Affairs).

Summary

We identify four vital directions for improvement in our capacity to enhance well-being and health care for older Americans:

1. *Develop new models of care delivery.* New models can increase efficiency and value of cost delivery in various care settings and are especially needed for the management of patients who have multiple chronic conditions. Many new evidence-based models are available but have not been widely adopted.
2. *Augment the elder care workforce.* There are and will be substantial deficiencies not only in the number of physicians, nurses, and direct care workers who have special training and expertise in geriatrics but in the competence of health care workers generally in the recognition and management of common geriatric problems. Addressing these quantitative and qualitative workforce gaps will increase access to high-quality and more efficient care for older persons.

3. *Promote the social engagement of older persons.* Engagement in society, whether through work for pay or through volunteering, is known to have substantial beneficial effects on several aspects of well-being in late life. Evidence suggests that older persons are becoming less engaged, and vigorous efforts to promote engagement can yield important benefits for them and for the productivity of society.
4. *Transform advanced illness care and care at the end of life.* Many people who have advanced illness and especially those nearing the end of life receive care that is uncoordinated, fragmented, and unable to meet their values and preferences. Wider dissemination of available, proven effective strategies can enhance well-being and dignity while avoiding unnecessary hospitalizations, unwanted treatment, adverse drug reactions, conflicting medical advice, and higher cost of care.

The suggestions offered in this paper are within reach, and none is expected to be associated with great cost. In many cases, they call for support of strategies that have been proved to be effective but have not been disseminated widely because of structural or funding limitations in our system. Useful change in all sectors will probably require several years, so urgent action is required now if we are to be prepared when the "age wave" hits. The price of failure would be great, not only with respect to inefficiency but with respect to continued misuse of precious resources, increases in functional incapacity and morbidity, and loss of dignity.

Summary Recommendations for Vital Directions

1. Develop new models of care delivery.
2. Augment the elder care workforce.
3. Promote the social engagement of older persons.
4. Transform advanced illness care and care at the end of life.

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PHI Quality Care THROUGH Quality Jobs

RAISE THE FLOOR

QUALITY NURSING HOME CARE DEPENDS ON QUALITY JOBS

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We'd like to thank the W.K. Kellogg Foundation for supporting our work to "raise the floor" for direct-care workers, and SEIU for identifying nursing assistants willing to share their stories.

As this report shows, nursing assistants are the foundation of our system of long-term services and supports. Quality care is rooted in the compassion and skill they bring to their jobs each day. We thank them for doing this essential work, and remain committed to improving compensation, training, and support for all direct-care workers.

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DEMOGRAPHIC CHANGES ARE INCREASING THE DEMAND FOR NURSING HOME CARE

Over 1.3 million older adults and people living with disabilities reside in nursing homes today. As the large generation of post-World War II baby boomers enters their retirement years, there will be significant growth in the demand for long-term services and supports. The largest growth will be among the over-85 population, those most likely to suffer from diseases such as Alzheimer's and most in need of nursing home care. Over three decades, this population will grow from 6.3 million to 18 million.

> The key to delivering quality person-centered services is a skilled, committed direct-care workforce.

At the same time that the number of elders is growing, the number of adults in the "caregiving generations" is not keeping pace. With fewer family caregivers available, there will be increased pressure on our systems of long-term services and supports, but nursing homes are ill-prepared to provide the high-quality care our families and communities expect.

LOW PAY AND POOR QUALITY JOBS ARE PRECIPITATING A CARE CRISIS

The key to delivering quality person-centered services is a skilled, committed direct-care workforce. Yet as a result of low pay, as well as insufficient staffing levels, inadequate training, and limited on-the-job support, nursing home employers can neither recruit nor retain qualified nursing assistants. Not only is turnover extremely high—more than 50 percent of the workforce turns over annually—but it is becoming increasingly difficult to fill vacant positions.

Unstable staffing undermines quality of care in nursing homes. The best care is delivered by a consistent team of experienced caregivers who know their residents well. Nursing homes must begin to invest in their workers today, to end the cycle of turnover and improve care—but also to ensure that they are positioned to meet future demand for safe, 24-hour care.

INVESTING IN AMERICA'S NURSING ASSISTANTS

It is time to "raise the floor" for nursing assistants. Growing and stabilizing the workforce requires paying competitive wages, while also providing health coverage and consistent shifts with full-time hours. Additionally, to stem the cycle of turnover, workers need better training, support, and opportunities for professional growth.

Nursing homes are dependent on public funds—both Medicaid and Medicare—which provide more than half of nursing home revenues. Therefore, better jobs necessitate both public and private investment. To raise the floor for nursing assistants—and ensure quality care for all nursing home residents—this paper calls for new public investment, along with greater accountability, to ensure that funding is directed to the needs of frontline workers rather than administrative overhead and nursing home profits.

"It's hard physically, mentally and emotionally. To be successful, you need to be prepared for what you can control, but more importantly, you need to be prepared for what you cannot control."

— MARIBEL RODRIQUEZ, WATERBURY, CONNECTICUT

INTRODUCTION

Each day nearly 650,000 nursing assistants go to work in nursing homes across the United States, where they attend to the needs of people who—as a result of age, illness, or disability—need assistance with the daily tasks of living. Nursing assistant jobs are some of the toughest jobs imaginable: providing intimate bodily care, lifting and carrying, and giving emotional support to individuals who may not have family or friends nearby, or who may suffer from depression or memory loss. Not only is this direct-care work physically and emotionally draining, extrinsic rewards are minimal: the jobs pay poorly, supervisory support is rare, and training and career paths are limited.

This paper argues that it is time to "raise the floor" for nursing assistants as well as other support staff, the mostly female workers who are employed by our nation's nursing homes.[1] The majority of these underpaid workers don't earn enough to provide the basic necessities for themselves and their families, despite the critical role they play in supporting and caring for people who require 24-hour skilled nursing care.

The low pay and generally poor quality of direct-care jobs—the primary focus of this paper—impacts not only nursing assistants and their families, but every one of us who may now, or in the future, need nursing home care for ourselves or our loved ones. As a result of poor-quality nursing assistant jobs, vacancies are growing and turnover is high, undermining the continuity and quality of care for nursing home residents.

In the face of a rapidly aging population, this situation is untenable. To meet the growing need for long-term services and supports, nursing homes must strengthen and stabilize their caregiving workforces by providing quality jobs. Creating better jobs for nursing assistants will mean better care for the millions of aging Americans today—and in the decades to come.

"My fiancé, Josh, and I work together on the second shift in a nursing home in Erie [PA]. We assist residents with their evening routine and get them ready for bed. While we're at work a babysitter is caring for our two boys.

It's difficult, but I love what I do. I like to go home at the end of the day and know I made a difference and made someone smile.

We don't get paid that much, so Josh and I each pick up 12 hours of overtime a week to help make ends meet. It's like another part-time job on top of our full-time job. Josh is going to school too, to become a registered nurse. That should help with paying the bills.

Working extra hours means we don't get to see our kids as much as we'd like. I did get to see the little one's first steps, but other than that, the babysitter is the one who sees everything."

— KAYLEY WESTFALL, VENANGO, PENNSYLVANIA

NURSING ASSISTANTS EARN NEAR-POVERTY WAGES

Nursing assistants form the backbone of the U.S. nursing home workforce, representing 65 percent of the nursing staff in over 15,000 facilities.[2] These workers wake residents in the morning and put them to bed at night; ensure residents are bathed, groomed, and dressed; lift them from their beds; and take them to meals, activities, and various therapy and medical appointments. Nursing assistants are there when a resident needs to go to the bathroom, needs a glass of water, or would like help getting outside to see the sunshine. Throughout the day, nursing assistants provide the physical, social, and emotional support that is essential to the well-being of the people in their care.

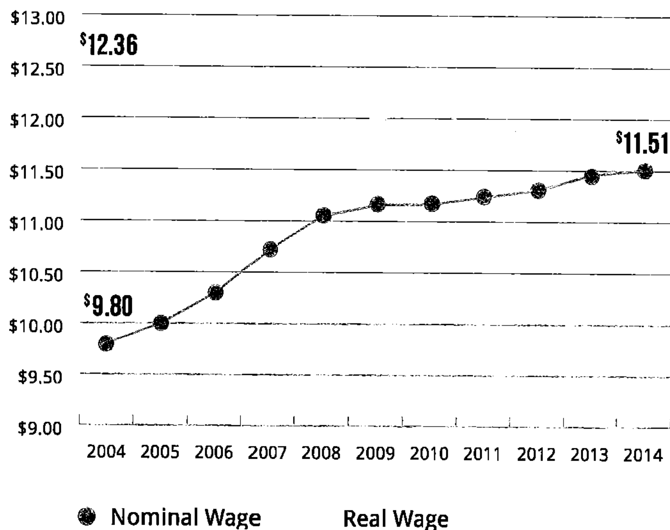
LOW HOURLY WAGE

For this extraordinarily challenging work, these workers earn extremely low wages. Nationally, direct-care workers employed in nursing homes earn a median wage of $11.51 per hour, meaning half of the workforce, literally hundreds of thousands of nursing assistants, earn less than this hourly wage. This compares to a national median wage for all occupations of $17.09 per hour.[3] Notably, over the last decade, real wages for nursing assistants (adjusted for inflation) have decreased by 7 percent (see Figure 1).[4]

ANNUAL EARNINGS REDUCED BY PART-TIME HOURS

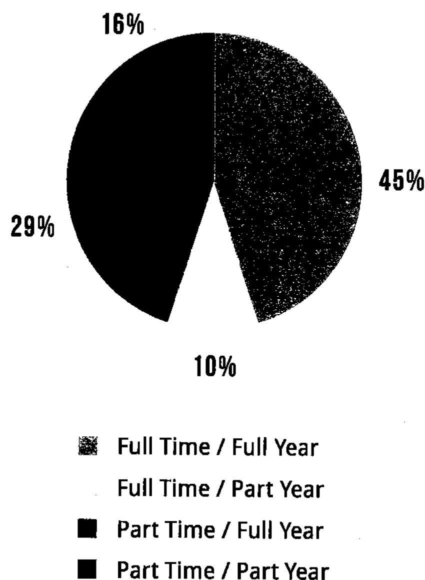
Median annual earnings for nursing assistants — $19,000[5]— reflect not only low hourly wages but also part-time hours. Less than half the workforce (45 percent) has full-time, year-round work (see Figure 2). There is also evidence of erratic scheduling, with more than half of the workforce (55 percent) reporting overtime hours in the past year.[6] This volatility often results from the need to fill shifts at the last minute when inadequate staffing levels are exacerbated by high turnover and absenteeism.[7]

FIGURE 1 | **Nursing Assistants have seen their inflation-adjusted hourly wages decline over the past decade.**



SOURCE: U.S. DOL, Bureau of Labor Statistics, Occupational Employment Statistics (2015, March 25). May National Employment and Wage Estimates United States, 2004 to 2014, adjusted for inflation using the Consumer Price Index for urban wage earners and clerical workers (1982-84=100).

FIGURE 2 | **Less than half of nursing assistants work full-time throughout the year.**



SOURCE: PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2014 ACS 1-year PUMS.

EMPLOYER-SPONSORED HEALTH COVERAGE OUT OF REACH

In addition to earning extremely low annual incomes, nursing assistants are less likely than workers in other occupations to have employer-based health coverage. Just over half of nursing assistants (55 percent) have health coverage through their employer or through a labor-management health fund, as compared to 69 percent of the nation's workforce overall.[8] Even when offered coverage, low wages make it difficult for nursing home workers to pay high monthly premiums, copays, and deductibles.[9]

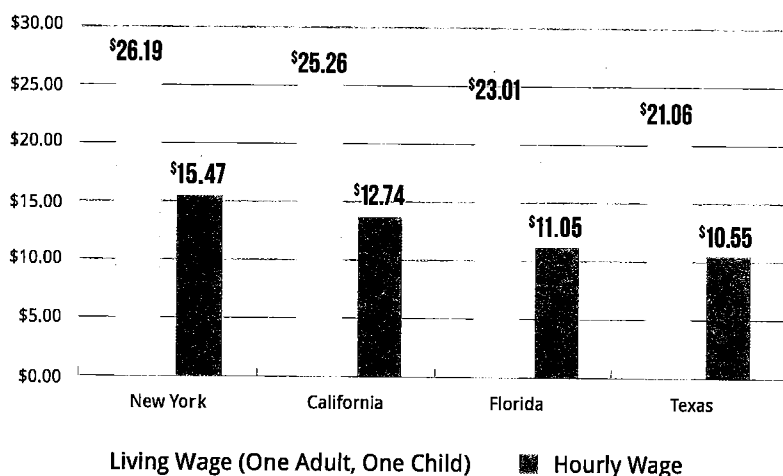
FAMILY INCOME OFTEN SUPPLEMENTED BY PUBLIC ASSISTANCE

Nursing assistants often struggle to support their families. Nearly one in five nursing assistants (17 percent) lives in a household below the federal poverty line.[10] Approximately half (49 percent) live in households in which wage-earners make combined incomes totaling less than 200 percent of the federal poverty level.[11] With wages this low, many nursing assistants struggle to afford housing along with heat and electricity, food, transportation, child care, and medical expenses.

One measure of the cost of these basic necessities is the "living wage."[12] When using this measure, direct-care worker wages also fall short. On average, nursing assistants earn 47 percent less than the living wage for a household of two (one adult and one child) in every region of the country (see Figure 3).[13]

To make ends meet, many nursing assistants rely on public assistance. Medicaid, food stamps, and cash assistance provide additional support for one in three (38 percent) nursing assistant households.[14] These programs provide an important safety net, but they are no substitute for a living wage and the economic stability that comes with the capacity to manage everyday expenses and to save for emergencies, college, and retirement.

FIGURE 3 | **Nursing assistants do not earn a living wage.**



SOURCE: U.S. DOL, Bureau of Labor Statistics, Occupational Employment Statistics (2015, March 25). OES Research Estimates by State and Industry; Glasmeier, A. K. (2014). Living Wage Calculator. Poverty in America, Boston, MA: Massachusetts Institute of Technology.

"The CNAs and nurses at Isabella, they have been there so many years. They all have that attitude that we are there to do an amazing job: to help people get better."

— GLADYS BAUTISTA, NEW YORK, NY

WHY NURSING ASSISTANT WAGES REMAIN LOW DESPITE DEMAND

Despite their vital role in resident care, nursing assistants are undervalued and underpaid. The reasons are multiple: their jobs are tagged as unskilled, entry-level positions; employers often provide less than full-time hours; and in many parts of the country, there is little accountability for how nursing homes spend public reimbursements (Medicaid and Medicare) that pay for the majority of nursing home residents' care. In addition, a long history of racial and gender discrimination has resulted in a further devaluing of nursing home work, which is done primarily by women of color.[15]

UNDERVALUED ENTRY-LEVEL, PART-TIME JOBS

The traditional nursing home organization, developed in the 20th century, is based on the "medical model," which places a high value on licensed medical staff and establishes a strict hierarchy among employees. Nursing assistants, as well as support staff, are at the bottom of that hierarchy. The poorest paid workers staff the laundry, kitchen, and housekeeping departments (see Figure 4 on next page).

The employment model for nursing assistants presumes that they are entry-level workers. As such they are seen as a cost to be managed rather than an asset in which to invest: the best workers are headed for nursing careers and the others are unskilled and easily replaceable.

The reality, however, is different. Nursing assistants have become the primary providers of resident care—an entirely different professional role from that of nurses and one that is a long-term career for hundreds of thousands of women.[16] Many aides prefer their jobs to nurses' medical and administrative roles, but the presumption that direct care is not a career devalues this work and contributes to low hourly wages. Rather than

FIGURE 4 | **Workers in support occupations earn the lowest wages.**

OCCUPATIONAL TITLE	NUMBER EMPLOYED IN NURSING HOMES, 2014	MEDIAN HOURLY WAGE
Food and Beverage Serving Workers (35-3000)	62,540	$9.38
Food Preparation Workers (35-2021)	29,440	$9.58
Laundry and Dry-Cleaning Workers (51-6011)	26,040	$9.87
Building Cleaning Workers (37-2010)	89,760	$9.96
Cooks (35-2010)	50,300	$11.16
TOTAL	**258,080**	

SOURCE: Bureau of Labor Statistics, Occupational Employment Statistics program, Limited to industry 631000, Nursing Care Facilities.

building nursing assistants' skills and loyalty—through quality training, regular schedules that provide full-time work, and living wages—nursing home executives and administrators keep the wage floor low for these positions and accept the consequences of high turnover. Unfortunately, nursing home residents and their families ultimately pay the price when constant staff turnover compromises care.

LIMITED PUBLIC FUNDING

Long-term care in the U.S. is primarily financed by public programs, in particular Medicare and Medicaid.[17] Overall, in 2014, more than $80 billion was spent by public programs on nursing facility care: $52 billion from Medicaid, and $29 billion from Medicare.[18]

Medicaid, one of the largest budget items for states, pays for the care of two out of every three nursing home residents. Thus, the pressure to balance state budgets by reining in Medicaid costs can impact nursing home employers. In 2014 the average cost of a nursing home stay was $220 per day; however, the average Medicaid reimbursement rate was only $186 per day.[19]

Such inadequate reimbursement can negatively impact worker compensation, staffing levels, and care quality.[20] At the same time, it is important to recognize that, as a result of limited transparency, it is difficult to assess how nursing homes spend the public dollars that are their primary source of revenue. Most states do not require public reimbursements to be spent primarily on the provision of direct and indirect care. Without accountability mechanisms, facilities may direct these funds to administrative overhead and profits, rather than appropriately compensating nursing assistants and other low-wage nursing home staff (see sidebar, The Nursing Home Sector).

THE NURSING HOME SECTOR

Nursing facilities remain a major setting for the delivery of post-acute and long-term care for many Americans and will continue to be as the aging population increases, even as other home and community-based services are expanded.

SIZE OF THE SECTOR

Despite growing utilization of home and community-based services, the number of nursing facilities has remained relatively constant over the past ten years: in 2014 more than 15,400 nursing homes across the country provided long-term services and supports, a nominal decrease from 16,100 in 2004.[81] While the number of beds has also remained relatively constant (1.7 million in 2004 compared to 1.6 million in 2014), occupancy rates declined over the past decade (86.3 percent in 2004 compared to 82.3 percent in 2014).[82] On any given day, nursing homes across the country serve over 1.3 million residents.[83]

TYPES OF OWNERSHIP

Nationally, 70 percent of nursing facilities are operated by for-profit companies. In 2014, over half of all facilities were owned by chains, a percentage that has increased slightly in the past five years.[84] Non-profit nursing homes accounted for about a quarter of facilities in 2014—a number that has declined by 10 percent over the last five years.[85]

In recent years many health care organizations have increased in size through mergers and acquisitions, in particular to expand into other lines of health care business to protect against environmental threats.[86] Nursing home chain affiliation has been shown to lower the likelihood of financial failure.[87]

Several of the largest publicly held nursing home companies have been taken over by private equity firms that hope to benefit from the large assets held by chains and their potential for profitability.[88]

FIGURE 5 | **Nursing Home Ownership: For-Profit vs. Non-Profit, 2014**

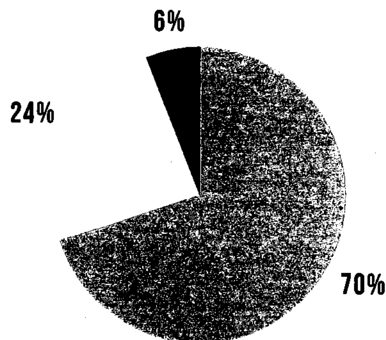
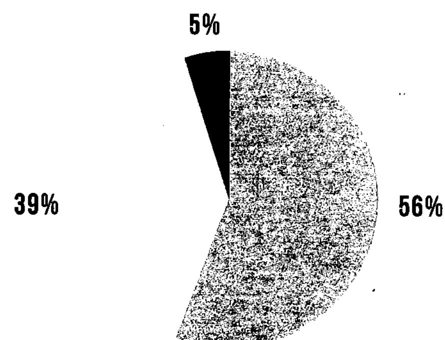


FIGURE 6 | **Nursing Home Ownership: Chain vs. Independent, 2014**



SOURCE: Harrington, et al. (2015). Nursing Facilities, Staffing, Residents and Facility Deficiencies 2009 through 2014. Kaiser Family Foundation. San Francisco: KFF.

FINANCING

Medicaid covers the cost of nursing home care for nearly two out of three nursing home residents (63 percent); however Medicaid—with an average reimbursement rate of $186 per day—contributes only 32 percent to nursing home revenue.[89] Medicare patients account for just 14 percent of nursing home residents, with an average payment per day of $411[90], and the remaining 23 percent pay privately either from personal assets, health insurance plans, or through private long-term care insurance plans. Overall, in 2014, more than $80 billion was spent by public programs on nursing facility care: $52 billion from Medicaid, and $29 billion from Medicare.[91]

PROFITABILITY

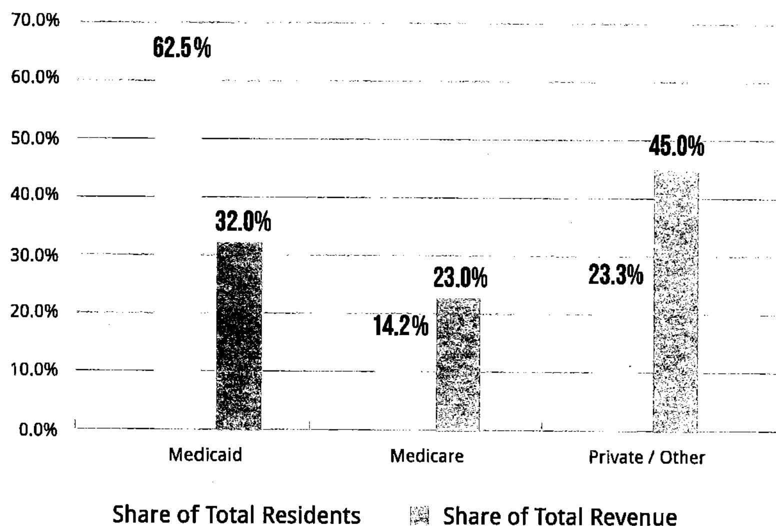
Profit margins in the nursing home industry average less than 2 percent across varied forms of ownership.[92] However, for facilities that are primarily Medicare-funded and focused on post-acute rehabilitative services, the profit margins average around 13 percent.[93] Medicare margins have been over 10 percent for the past 15 years and are expected to remain so in 2016.[94] There is wide variation even among this segment of the industry, however: the top quartile report margins of 20 percent or more and the lowest quartile report margins of only 3 percent. Additionally facilities owned by private equity have higher profit margins, according to the Government Accountability Office.[95]

QUALITY

Whether publicly or privately held, large, investor-focused enterprises have more incentives to cut costs to benefit investors, potentially at the expense of job and care quality.[96] Facilities owned by chains and other large entities, including private equity firms, are associated with higher numbers of deficiencies and poorer quality of care delivered.[97]

Underfunded facilities, particularly those with higher shares of Medicaid funding, are also associated with lower quality measures, poorer staffing levels, and disparities by race and ethnicity in quality of care.[98]

FIGURE 7 | **Nursing Home Residents and Revenue by Payer**



SOURCE: Harrington, et al. (2015). Nursing Facilities, Staffing, Residents and Facility Deficiencies 2009 through 2014. Kaiser Family Foundation. San Francisco: KFF; CMS (2014). National Health Expenditure Accounts, National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-2014. [Dataset].

GENDER AND RACE DYNAMICS

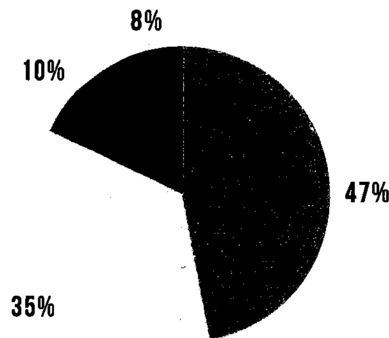
Direct care, similar to other caregiving occupations, is gendered work: 91 percent of nursing assistants are female.[21]

This workforce is also predominantly non-white (53 percent), with African Americans comprising 35 percent; Latino and Hispanic workers, 10 percent; and other people of color, 8 percent. Foreign-born workers comprise 20 percent of the workforce.[22] The overrepresentation of African American women, who represent only 12 percent of the U.S. female workforce, is significant (see Figure 8).

Gender and racial discrimination contribute to both the composition of the nursing assistant workforce and to the continuation of low wages in this field. Care work is presumed to be the same "unskilled" labor that women traditionally provide for free in the home, giving it less value in the marketplace.[23] In addition, nursing homes have provided one of the few avenues of employment for women of color. With a preponderance of marginalized workers—caring for other marginalized groups, elders and younger adults living with disabilities—low wages and poor job quality are perpetuated across the industry.

FIGURE 8 | **Nursing assistants are disproportionately from racial and ethnic minorities as compared to women in the workforce overall.**

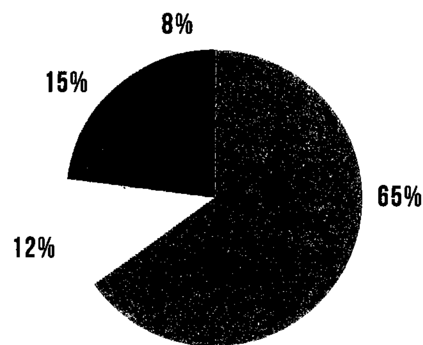
NURSING ASSISTANTS EMPLOYED IN NURSING FACILITIES



- White only, non-Hispanic
- Black only, non-Hispanic
- Spanish, Hispanic, or Latino
- Other or mixed, non-Hispanic

SOURCE: PHI analysis of the American Community Survey, U.S. Census Bureau (2015). 2014 ACS 1-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html

WOMEN IN THE U.S. WORKFORCE



- White only, non-Hispanic
- Black only, non-Hispanic
- Spanish, Hispanic, or Latino
- Other or mixed, non-Hispanic

SOURCE: PHI Analysis of U.S. Census Bureau (2015). CPS 2015 Annual Social and Economic Supplement (ASEC). Retrieved from http://www.census.gov/cps/data/cpstablecreator.html, female civilian labor force, limited to individuals who worked in past 12 months.

"I worked with a young man who had a genuine calling for this field.... The day he left, our facility lost a gifted and dedicated caregiver and he had to walk away from a promising career because he literally could not afford to keep it."

— ALICE, CNAEDGE.COM, "A VOW OF POVERTY"

WHY NURSING HOMES MUST END THE CYCLE OF LOW PAY AND HIGH TURNOVER

The traditional employment model for nursing assistants can be described as a "low investment/high turnover" paradigm. High rates of turnover are part of business as usual, despite the significant cost of recruitment and training—approximately $3,500 per worker.[24] Current demographic trends, however, are making this model unsustainable. Nursing home employers are finding it increasingly difficult to fill vacancies, let alone grow their workforce to meet rising demand.

HIGH DEMAND: A GROWING OLDER POPULATION WITH HIGHER LEVEL OF NEED

The baby boomer generation is turning 65 at a rate of 10,000 individuals every day. As a result, the number of U.S. residents over 65 will grow by 84 percent between 2015 and 2050, from 48 million to 88 million.[25]

More importantly, the population of people over 85 is poised to nearly triple during this time period, growing from 6.3 million today to 19 million by 2050.[26] These are the people most likely to need long-term services and supports in a nursing home setting. AARP reports that half of individuals over the age of 80 live with a severe disability, and one in three needs assistance with activities of daily living.[27] Though many will choose home and community-based services, a significant number will need the 24-hour skilled care provided in a nursing home setting.

Nursing homes increasingly care for people who have severe functional limitations.[28] For the majority, these limitations are age-related. Of residents, 42 percent are 85 or older, and another 27 percent are between the ages of 75 and 84.[29]

Half of residents suffer from Alzheimer's disease or other dementias, a condition that will grow proportionally with the over-85 population. The number of people with Alzheimer's disease is expected to increase from 5 million today to 14 million in 2050, putting increased pressure on family caregivers as well as our system of long-term services and supports.

SHRINKING NUMBER OF FAMILY AND PAID CAREGIVERS

The growing number of older Americans, particularly the very old, needs to be considered alongside another demographic trend—that of a shrinking pool of available caregivers. Research has shown that the current "support ratio" in the U.S. is 7:1. That is, there are 7 adults between the ages of 45 and 64, the traditional age pool for family caregivers, for every adult over the age of 80, the age group most likely to need care. But in just two decades, that ratio will shrink to 4:1, and by 2050, will reach a low of 3:1.[30]

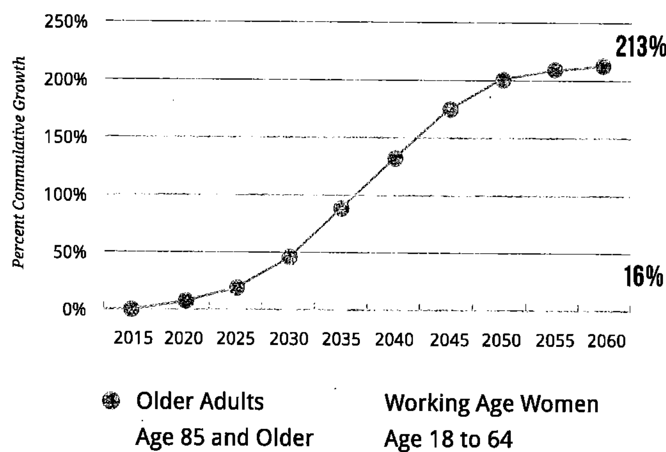
A depleted pool of family caregivers will increase the need for paid caregivers in at-home settings as well as nursing homes. But the rate at which women ages 25 to 54, the traditional demographic of paid caregivers, are entering the labor force is also declining. The number of women in this age group entering the workforce increased by 11 percent between 1994 and 2014, but over the next 10 years, that number will grow by only 2 percent.[31]

The chart below shows the "care gap"—the population over age 85 is projected to grow by 213 percent by 2060, whereas the female working-age population will only grow by 16 percent over that time period.

The model of nursing home employment, which originated in the 20th century, is not sustainable in the 21st century.

This demographic shift is greater than any the U.S. has faced in the past. The model for nursing home employment, which originated in the 20th century when women entered the labor force in record numbers, is not sustainable in the 21st century. With fewer family caregivers and a heightened demand for long-term services and supports, the current labor pool is not vast enough to fill uncompetitive jobs in the nursing home sector.

FIGURE 9 | **The cumulative growth in the 85+ population will exceed that of the working-age population by more than 10 times over the next 45 years, creating a "care gap" crisis.**



SOURCE: U.S. Census Bureau (2015, March). Projections of the Size and Composition of the U.S. Population: 2014 to 2060 (USCB Publication No. P25-1143) Washington, D.C.

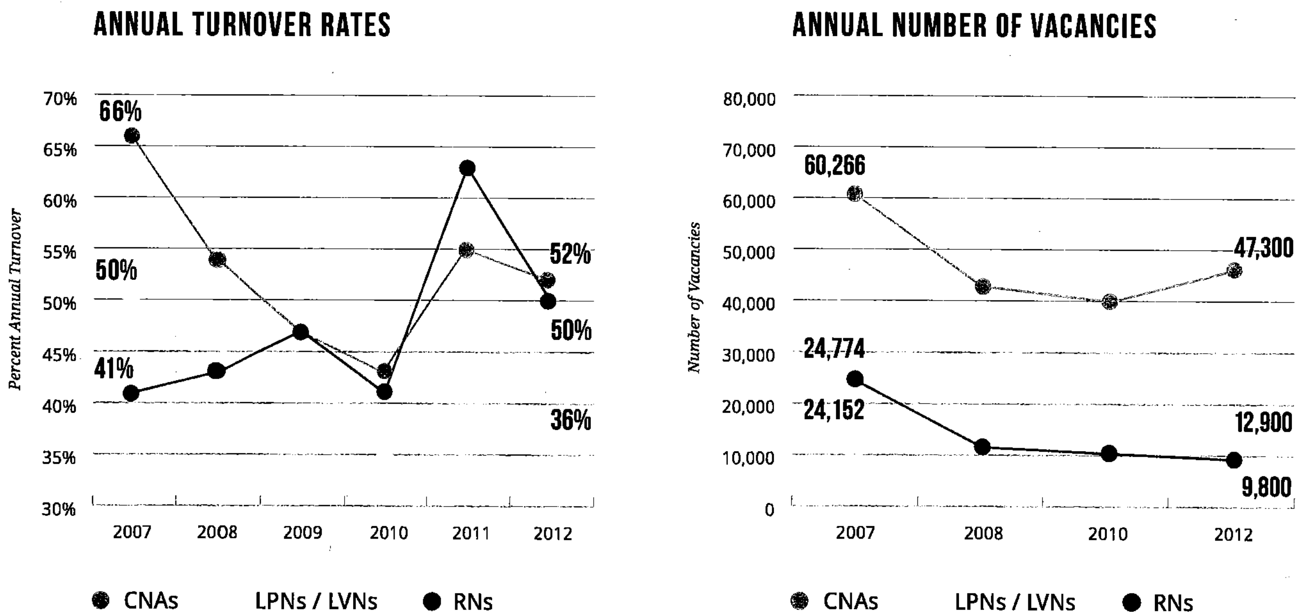
TURNOVER AND VACANCIES ON THE RISE

Historically, employment in nursing homes has tracked closely with the economy. In times of high unemployment, such as the Great Recession from 2007 to 2010, nursing home vacancy and turnover rates plummeted. It is in these times, without the competitive draw of higher wages and better employment conditions elsewhere, that nursing home workers are more likely to stay in their jobs.[32]

But, as the economy has begun to recover in recent years, vacancies in nursing assistant positions have increased and turnover rates are climbing: workers are finding opportunities outside of direct care, in industries with better wages and working conditions.[33] In 2012, when unemployment was 7.7 percent, average turnover rates for nursing assistants exceeded 50 percent.[34]

Today—with unemployment at a low of 5 percent—nursing home employers report that recruitment and retention of nursing assistants is one of their greatest challenges.[35] Without sufficient numbers of experienced and skilled direct-care workers, quality care for people who are the most vulnerable—those in need of 24-hour care—is threatened.

FIGURE 10 | **Turnover and vacancy rates for nursing home staff rise when the economy improves.**



SOURCE: American Health Care Association. (2012). Staffing Reports, 2007 to 2012. Washington, D.C.

"Our training didn't prepare us for working with residents who are sometimes angry or frustrated. If I had a better understanding of what can trigger an otherwise sweet lady to hit others, including those of us who are trying to help, I could help to prevent an incident from happening."

— LAKESIA COLLINS, CHICAGO, ILLINOIS

WHY POORLY STRUCTURED JOBS UNDERMINE SUCCESS AND QUALITY OF CARE

For nursing assistants, inadequate compensation is one of several factors that contribute to the poor quality of their jobs. Other factors that impact workers' success as caregivers, and their decisions to leave the field, are limited training, insufficient staffing, high rates of injury, and a lack of support in the workplace.

LIMITED TRAINING

To become a nursing assistant a worker must attend a pre-employment training program. Entry-level requirements, however, are minimal, and evidence suggests that inadequate preparation contributes to high rates of turnover.[36] Attracting nursing assistants to the field requires better pay—but keeping them requires sufficient preparation for an increasingly complex job.

For nursing assistants employed in Medicare- and Medicaid-certified nursing homes, state certification programs must meet or exceed the federal requirement of 75 hours of pre-employment training—barely two weeks— covering basic paramedical tasks. Only 16 hours of training is required to take place in a clinical setting.

The federal law governing these requirements has remained unchanged since its enactment in 1987. And yet, the U.S. has seen increased acuity among its nursing home resident population, as well as significant advances in knowledge related to dementia care, palliative care, behavioral health treatment, and client rights. In addition, the nursing assistant role has evolved into a distinct and vital position for resident care.

STRATEGIES FOR IMPROVING COMPENSATION AND JOB QUALITY

1. IMPROVE COMPENSATION

- Better wages for nursing assistants are essential to attracting and retaining sufficient numbers of skilled workers to ensure quality person-centered care for nursing home residents.
- Employers depend on public reimbursement, and these rates must adequately reflect the costs of labor. To ensure that employers invest in their workers, increases in reimbursement rates should be tied directly to wages and benefits for nursing assistants and other low-wage staff.
- Nursing assistants provide essential services to clients and their families, and their compensation should include access to health care, retirement, and other benefits that reflect the dignity of their work.

2. PROVIDE FULL-TIME JOBS AND CONSISTENT SCHEDULES

- Full-time hours are key to sustaining the impact of wage increases, reducing call-outs and understaffing, and improving the ability of low-wage workers to achieve economic stability.
- Consistent scheduling allows workers to manage family and other demands, reducing stressors that could negatively impact job performance and commitment.

3. STRENGTHEN TRAINING

- Training regulations must ensure nursing assistants receive the clinical and relational competencies needed to care for clients with increasingly complex and chronic health conditions—and should reflect the nursing assistant's role as the primary caregiver and a member of the care team.
- Methodology that is highly interactive, and specifically designed for adult learners who may have difficulty with traditional lecture formats, is essential to effective nursing assistant training.

4. ENSURE OPPORTUNITIES FOR ADVANCEMENT

- When nursing assistants are given opportunities to grow professionally through training and advanced roles, job satisfaction increases and turnover decreases.
- Experienced nursing assistants can provide valuable support to newer workers through advanced mentoring, coaching, and condition-specific roles, contributing to stronger workforce retention.

5. INVEST IN NEW MODELS OF CARE

- Investments in supportive supervision for workers and opportunities to participate in interdisciplinary teams have been linked to improvements in worker satisfaction and retention.
- The movement toward person-centered nursing homes, where residents have greater control over daily choices, has the potential to create more satisfying roles for nursing assistants and better quality care.

In 2008, the Institute of Medicine (IoM) issued a report recommending a minimum of 120 hours in pre-employment training for nursing assistants.[37] Since that time no change has been made in federal law, but about half of states now require more than 75 hours of training. One in four (13 states) requires between 120 and 180 hours.

While federal training standards have remained unchanged, nursing assistant jobs have become more complex. Not only has resident acuity increased, but behavioral health issues have become common.[38] Among long-term residents, 50 percent are diagnosed with Alzheimer's disease or other dementias, while another 31 percent have psychiatric conditions such as schizophrenia and mood disorders.[39]

Providing intimate daily care to people with cognitive challenges—as well as those with severe physical limitations—takes patience and skill. Nursing assistants need a high level of emotional intelligence as well as sophisticated communication skills. They must understand the complex health conditions of residents and be keen observers to recognize when a resident's condition has changed. They must also know the rules of infection control and body mechanics to protect themselves and residents from illness or injury.

Nursing assistants who remain in the field develop this expertise on the job, usually through informal channels. Aside from a few union- and employer-based education and training programs and career ladders, formal opportunities for workers to learn and grow—to develop more in-depth knowledge of resident conditions such as dementia, or to improve communication and caregiving skills—are rare.[40] Requirements governing the quality of mandatory in-service training are paltry, and most nursing homes do the bare minimum to meet the requirements. Only a small number of nursing homes offer career paths, such as mentoring and advanced specialty positions, that are specifically designed to provide a senior role for nursing assistants.[41]

INSUFFICIENT STAFFING

Among advocates and nursing home workers themselves, the consensus is that nursing home staffing is inadequate to provide long-term residents with quality person-centered care.[42] Research supports this conclusion, finding that insufficient staffing results in higher levels of turnover and undermines quality of care.[43] By our estimate, 75.6 percent of nursing homes fail to meet CMS-recommended nursing assistant staffing levels.[44]

For nursing assistants, heavy workloads leave barely enough time to attend to activities of daily living, ensuring that residents are safe, clean, and fed. Typically, aides have no more than five minutes per resident to engage in conversation or other relationship-building activities that support not just quality care but meaningful and dignified living.[45]

By our estimate, 75.6 percent of nursing homes fail to meet CMS-recommended nursing assistant staffing levels.

For nursing assistants who find meaning in making people's lives better, these time constraints can lead to a sense of frustration or even failure. One former nursing assistant explains that for his colleagues "working short" means "being denied the opportunity to do more for their residents while being responsible for maintaining standards they can never hope to meet."[46]

Scheduling practices also have a significant impact on nursing assistant job satisfaction. According to one researcher, in high-turnover facilities, "schedules were more likely to be seen by everyone as chaotic, a place where you had to get your own as best you could, in a world of dog-eat-dog."[47] When schedules are inconsistent and there is no flexibility to accommodate family needs, absenteeism is

higher, putting additional stress on those who don't call out. The workers who are left to pick up the slack eventually burn out, turnover increases, and the cycle continues.

HIGH RATES OF INJURY

As a result of inadequate training and short staffing, nursing homes have high rates of injury. New workers and those who cite poor job preparation are among those most likely to be injured, though all workers are at risk.[48]

In 2014, nursing assistants were among the top six occupations (along with police officers, correctional officers, firefighters, construction workers, and truck drivers) with more than 300 injuries per 10,000 full-time workers, and had the greatest number of lost work days resulting from on-the-job injury.[49] Overall, injury rates for nursing assistants were three-and-a-half times the national average for all other occupations, and musculoskeletal injuries were nearly six times the national average.[50]

Over half of nursing assistants who are injured (54 percent) report musculoskeletal injuries, usually the result of lifting or carrying a resident, but there are many other risks.[51] Nursing assistants, for example, are injured by residents who engage in aggressive self-protection behaviors. A 2010 study found that in one month 35 percent of nursing assistants reported such injuries.[52]

Elevated injury rates appear to be another factor in high rates of turnover. In a recent study of over 1,300 nursing home workers, three out of ten reported on-the-job injuries during an 18-month period. Injured workers were more likely to leave their jobs—either voluntarily or involuntarily—than non-injured workers.[53]

INADEQUATE SUPPORT AND SUPERVISION

Research over the last 15 years has shown that leadership, supervision, and engaging nursing assistants through interdisciplinary teams can make a significant difference in levels of turnover and quality of care.[54] Leaders who use a consensus style of leadership—in which they solicit and act on input from staff at all levels—build cultures where communication is valued and staff feel respected. To encourage more participation by nursing assistants in care planning and quality improvement, CMS has recently recommended that interdisciplinary teams include participation by nursing assistants.[55]

For nursing assistants, feeling respected is a particularly important variable in job satisfaction and in decisions to leave or stay.[56] Studies indicate that nursing assistants are most likely to leave organizations that are highly centralized and authoritarian, providing nursing assistants with little chance for input into the care of residents.[57] In this type of organization, tensions between nurses and nursing assistants are common, particularly when nurses are dismissive of the knowledge and skills that nursing assistants bring to their jobs.[58]

When the organizational culture devalues and disempowers nursing assistants, a downward spiral is created. Feeling disrespected, the nursing assistant fails to fully invest, which then reinforces the belief of the nurse supervisor that the nursing assistant does not make valuable contributions to the team.[59]

Quality supervision can change these dynamics, but throughout the industry nurses are not necessarily prepared—or empowered—to invest in frontline staff. Overworked themselves, they most often see their supervisory role as enforcing disciplinary policies rather than "teaching, validating, praising, encouraging or being a reciprocal team member."[60] But these practices, along with involving nursing assistants in care planning teams, culture change committees, quality improvement efforts, and mentoring new hires, have consistently been shown to reduce turnover and improve quality of care.[61]

"Everyone deserves a living wage. We can't have people working two or three jobs just to make ends meet. When salaries in nursing homes are so low that people have to depend on public assistance to survive, that's not right. By winning $15, we all have a better shot at taking care of our families and being there for our residents. There's still a long way to go, but it's a step in the right direction."

— MARIBEL RODRIQUEZ, WATERBURY, CONNECTICUT

POLICY SOLUTIONS

To improve the quality of care in our nation's nursing homes, we must begin by investing in the workforce and creating better jobs for the hundreds of thousands of nursing assistants who provide the majority of resident care. For too long, these working women and men have been undervalued. Structures that disempower and disrespect direct caregivers create a negative feedback loop that undermines the quality of care for those who depend on them.

With better pay, better training, and opportunities to grow and learn and to contribute as members of a care team, nursing assistants have demonstrated that they can bring more value to their workplaces (see sidebar, Isabella Geriatric Center).[62] At the same time, improved compensation reduces stress in the lives of nursing assistants and helps them invest in their children and their communities. Better jobs are a win-win for nursing home residents and for hundreds of thousands of underpaid workers and their families across the country.

Private and public investment is necessary to raise the floor for nursing assistants. Payment reform must be combined with a commitment to higher wages, better training and support, and restructured jobs. Below we offer some concrete steps that can be taken to improve the quality of nursing home jobs.

WAGE STRATEGIES

With a median wage of $11.51 per hour and average annual earnings below $20,000, nursing assistants are squarely situated among our nation's underpaid workers, earning in the bottom 30 percent of all wage earners in the U.S.[63] Across other low-pay sectors, advocates are calling for a $15 per hour wage, which, if extended to nursing assistants and

other support staff, could begin to lift hundreds of thousands more workers out of poverty. At the same time, better wages would help nursing homes to recruit a more stable workforce, a necessary step toward providing better quality care to residents.

There are two major strategies for achieving wage increases for nursing home workers:

- **RAISING THE MINIMUM WAGE:** Though the federal minimum wage has not been raised in seven years, states and cities across the country have been making progress toward raising the floor for all workers.[64] At the beginning of 2016, 14 states increased their minimum wage through legislation or through automatic adjustments.[65] Since 2013, 31 municipalities have increased their minimum wage. The largest increases thus far are in the two states and seven cities that have voted to increase their minimum wage to at least $15 per hour over the next several years.[66]

Better jobs are a win-win for nursing home residents and for hundreds of thousands of underpaid workers and their families.

- **SECTORAL WAGE INCREASES:** A sectoral wage strategy focuses on raising wages for a particular group of workers. For example, President Obama raised the wage floor for government contract workers, and the Governor of New York recently approved a wage floor of $15 for fast-food workers.

In Massachusetts and Oregon, independent provider home care aides working in their state's Medicaid-funded consumer-directed programs have established $15 per hour wage floors through collective bargaining. Similarly, some union nursing home workers in Connecticut, Minnesota, and Pennsylvania recently signed contracts that will increase their starting wages to $15 per hour. In New York City, union facilities pay over $17 per hour to nursing assistants and support workers.

The vast majority of nursing home workers, however, are not represented by unions. These workers would benefit from sectoral strategies that help draw attention to the specific wage and job quality issues in this service sector.

The benefits of higher wages are numerous. Not only will better wages benefit nursing home workers, the residents they care for, and their employers, but studies demonstrate that every $1 per hour increase in compensation for low-wage workers generates an additional $1.20 in increased economic activity.[67] That is, better wages provide an economic stimulus for the communities and small businesses in which these workers live.

The cost of higher wages is offset by other gains as well. First, high turnover costs nursing home employers billions of dollars annually. To train and replace one new worker costs as much as $3,500; such costs add up to $6 billion across all long-term care settings.[68] This money would be better invested in the wages necessary to attract and retain workers over the long term.[69]

Higher wages would also reduce nursing assistants' reliance on public assistance. According to one analysis, a dollar more per hour wage increase for workers earning less than $12.16 (which includes more than half of all nursing assistants) reduces reliance on public assistance by 3 percentage points and provides an annual savings to the government of $190 per worker.[70]

PAYMENT POLICIES

Medicaid and Medicare pay for the care of more than two thirds of nursing home residents. This means that nursing homes are more limited than other businesses in their ability to cover higher wage costs through higher pricing. Consequently, better compensation will require reimbursement rates reflective of the true labor costs associated with high-quality jobs, and accountability for how

those dollars are spent. There is already some movement in this direction. While reimbursement rates under Medicaid have been relatively flat over the past several years—28 states had rate freezes in 2012—in 2015, 40 states saw increases in Medicaid reimbursement rates to nursing homes.[71]

Increases in reimbursement must be targeted specifically toward compensation and job quality improvements.

For increases in reimbursement to have the desired impact, however, they must be targeted specifically toward compensation and job quality improvements for nursing assistants and other frontline workers. In addition, accountability mechanisms should ensure that such investments are spent appropriately and not directed to administrative and overhead costs.

Among the mechanisms that can be used to direct reimbursement increases to wages and improve accountability for the use of government funds are:

- **WAGE PASS-THROUGH PROGRAMS:** A wage pass-through directs an increase in public reimbursement to a specific group of employees, in this case nursing assistants and other support workers. National evaluation of the efficacy of this strategy has demonstrated a 12 percent increase in wages for nursing home workers in states that adopted wage pass-through programs over a seven-year period compared to those that did not.[72]

- **VOLUNTARY SUPPLEMENTAL PAYMENTS FOR IMPROVING WAGES:** In this scenario, employers apply for additional funding from state Medicaid systems specifically to cover the cost of providing additional wage increases. Accountability mechanisms include state audits of the use of funds and penalties if funds are not used appropriately. Both Connecticut and Texas have implemented mechanisms to enhance nursing assistant wages through voluntary supplemental payments.[73]

- **DIRECT-SERVICE REQUIREMENT:** Another method for directing wages to frontline workers is to require that a certain percentage of the reimbursement rate be applied toward direct services as opposed to administrative salaries and other overhead expenses. A bill introduced in the Illinois legislature would do just that—requiring nursing homes to direct 50 percent of Medicaid reimbursements to workers providing direct services, including nursing assistants and other low-wage personnel.[74] This legislation would also provide a special "living wage certification" to nursing homes that pay all workers more than $15 per hour.

- **GREATER TRANSPARENCY:** States could require nursing homes to report on minimum hourly wages by job classification, rather than "average" wages. Current cost reports inflate wage information by averaging wages of new hires with long-term workers and by including overtime hours. It is important for residents, family members, and the public to know the real wages paid to nursing assistants and other frontline workers such as those who staff laundry, kitchen, and housekeeping departments. Legislation introduced in Pennsylvania would make minimum wage rates paid to employees publicly available, and create a "living wage certification" program.[75]

HEALTH BENEFITS

Access to affordable health insurance coverage is an essential component of a high-quality job. Under the Affordable Care Act (ACA), nursing home employers are required to provide access to coverage for workers who are employed 30 or more hours per week. Unfortunately, this may incentivize nursing homes to make nursing assistant jobs part-time or, at best, to offer minimal health coverage to meet the ACA's employer mandate requirements.

ISABELLA GERIATRIC CENTER: INVESTING IN QUALITY JOBS

"We have always been workforce-oriented, always about creating opportunities for self-advancement."

—Hope Miller, Vice President of Care Services at Manhattan's Isabella Geriatric Center

In recent years, the engine powering Isabella Geriatric Center's worker-focused culture has been the Labor Management Project (LMP), a unique collaboration between SEIU1199, the labor union that represents many of New York's healthcare workers, and managers and supervisors in the city's unionized nursing homes and hospitals. "We felt that if labor and management could get together and really talk about what it is we need to do together, our constituents—workers and consumers—would end up being served in the best way possible," says Hope Miller, vice president of care services at Isabella.

Since 2003, workgroups comprising certified nursing assistants (CNAs) and other staff represented by SEIU1199, supervisors, and management have met regularly to share ideas related to both better care and better jobs. Miller says that the LMP has "opened up possibilities of awareness of training opportunities through 1199," essentially encouraging CNAs and others to pursue career advancement opportunities available to them both through their union and within Isabella.

Isabella has developed three career-advancement paths for CNAs—rehabilitation aide, clerical support staff, and patient care technician—all of which involve expanded responsibilities and a wage increase.

Gladys Bautista has recently trained to become a patient care technician. Bautista started at Isabella in 2006 as a volunteer, then got certified to be a CNA through Isabella's training program, which is offered free to people in the community. In her role as a patient care technician, she will use her advanced clinical expertise to help improve quality measures and prevent unnecessary hospitalization for Isabella residents.

Isabella has also, since 2011, been involved in the PHI Coaching Approach to Communication, an innovative and immersive training designed to resolve conflicts productively and keep staff focused on providing quality care for residents. Miller says that staff's experiences with the LMP, which continually emphasized the importance of training and communication skills, laid the foundation for PHI Coaching.

Isabella's benefits also help it stand out from other nursing facilities. Certified nursing assistants are offered health insurance, paid time off, a pension plan, and an on-site fitness center. There is even a library on the Isabella campus, staffed by a librarian and stocked with computers and books on a variety of subjects. "When you're working full time and trying to manage a family, having a space to get online and study is difficult," Miller says. The on-site library "has been beneficial for a lot of the staff."

All of these benefits add up to a more supportive work environment for Isabella's CNAs, which is reflected in its turnover statistics. The turnover among Isabella CNAs was 16 percent in 2013, far below the national average of nearly 50 percent. Bautista says that the staff continuity is directly linked to better care for residents. "The CNAs and nurses, they have been there so many years," she notes. "They all have that attitude that we are there to do an amazing job: to help people get better."

In addition to ensuring employers have adequate Medicaid reimbursements and that these payments are targeted to improve wages and benefits for direct-care workers, states should increase access to publicly funded health coverage for nursing home workers who would be eligible through Medicaid expansion under the Affordable Care Act. Medicaid expansion has provided many more low-wage workers with access to quality health coverage, and yet 19 states have still not expanded their programs.[76] If these remaining states expanded coverage to all individuals with incomes below 138 percent of the poverty level, tens of thousands more nursing assistants could be newly eligible.[77]

TRAINING

It is essential to address the training of nursing assistants to better prepare people to do their jobs and to stop the cycle of turnover. Federal training standards for nursing assistants in Medicare- and Medicaid-certified nursing homes must be modernized to reflect advances in the delivery of person-centered care, as well as the realities of the populations served in nursing homes today—those with behavioral health needs, cognitive decline, and those near the end of life.

Studies have shown that an increase in the number of mandatory training hours improves job satisfaction and decreases turnover.[78] Additionally, experts have identified additional competencies that new nursing assistants should be required to demonstrate and approaches to training that increase successful learning. Both federal and state policymakers can take action to improve training programs for nursing assistants through:

- **EXPANDING FEDERAL TRAINING REQUIREMENTS WITH REQUIRED COMPETENCIES:** As recommended by the Institute of Medicine, federal requirements should be expanded to 120 hours of pre-employment training. Expanded training should include building skills in communication, relationship building, and problem solving, and also address competencies related to caring for individuals with dementia and other challenging behaviors. The 120 hours should be considered a floor, not a ceiling, and employers should determine the content of on-the-job education for nursing assistants to meet the needs of varied populations.

Federal training standards for nursing assistants in Medicare-certified nursing homes must be modernized to reflect advances in the delivery of person-centered care.

- **IMPROVING TRAINING DELIVERY:** The current delivery system for entry-level and in-service nursing assistant training is primarily defined by lecture or video formats that fail to engage learners and build skills. Evidence suggests the use of adult learner-centered techniques, including role plays and small group activities that require active participation, are the most successful in transferring skills.

- **STRENGTHENING IN-SERVICE AND ON-THE-JOB TRAINING:** The high level of acuity among today's nursing home residents, the changes in long-term care service delivery, and the focus on preventing hospital readmissions, all make it imperative that required in-service training provide a real path for continual learning and professional growth. One example of quality training for incumbent workers is the SEIU Healthcare Pennsylvania Training and Education Fund's 102-hour curriculum to better prepare nursing assistants to deliver person-centered care. Nursing assistants are given time off to attend the training, which was developed through a labor-management partnership; they receive an hourly wage increase once the training is completed.

• **INVESTING IN EDUCATIONAL PROGRAMMING TARGETED AT NURSING ASSISTANTS:** Many nursing assistants are reimbursed for training costs when they find employment, but many cannot afford the upfront cost to enter a training program. This represents a significant barrier to growing the workforce. A recent proposal in Massachusetts calls for the state to create a scholarship program to cover the full cost of tuition and certification testing for an approved certified nursing assistant training program. It also recommends making funds available to provide adult basic education and English as a second language training to scholarship recipients.[79]

We recommend that states create advanced specialty roles that are transferable between employers.

ADVANCED ROLES

One of the structural problems with the nursing assistant role is the lack of a career path. To attract and keep qualified workers, there must be opportunities to advance professionally to positions with more responsibility and greater earnings.

Though some employers have created career advancement opportunities for nursing assistants, these are internal career ladders that are not recognized as a nursing assistant moves between employers. For example, New York City's Isabella Geriatric Center (see sidebar, p. 24) offers advanced education and three potential career paths: rehabilitation aide, clerical support staff, and patient care technician. While innovative, these advanced positions are unique to Isabella.

Therefore, we recommend that states create advanced specialty roles that are transferable between employers. Currently, a limited number of states offer advancement to the position of "medication aide." Using this as model, states could create positions—with specific credentialing required—for other specialty or senior leadership roles that meet the growing need for aides with higher level skills.

Given the emphasis on coordinated care and reducing hospital readmissions and emergency department use across the health care sector, maximizing the value of the nursing assistants' knowledge is essential. Advanced roles that maximize participation in care team planning, family education and support, and communicating information during shift changes could improve care outcomes.[80]

"Our residents depend on us, often for everything.... We have to take away their cares and worries and return to them their dignity. It's an incredibly hard task. Add to that the stresses of our own everyday lives.... Add to that the low pay, the financial necessities that often have us working extra shifts or second jobs. As long as I'm an aide I have to accept that I'm at risk for burnout.... This means I have two hard jobs before me... do my work well today and make sure I can do my work well tomorrow.

— MAY, CNAEDGE.COM, "FRUSTRATION AND FATIGUE"

CONCLUSION

Investments in our nation's nursing assistant workforce are ever more critical as we face a looming care crisis: the number of adults who will need long-term care is ballooning, but the pool of people to provide it remains stagnant. While many older adults express a preference for home and community-based settings, for those who cannot be cared for safely at home, nursing homes remain the best option. We need to ensure that all nursing homes provide their residents a high-quality living environment along with quality care. That requires a well-trained, compassionate, and stable nursing assistant workforce.

To attract and retain nursing assistants, policymakers and employers alike need to envision how these jobs become a family-sustaining career comparable with those in other industries. Efforts to improve job quality across other low-pay sectors, therefore, must include nursing assistants and support staff along with home care aides, retail workers, and food service employees. Hundreds of thousands of nursing home workers and their families will benefit from raising the wage floor. At the same time, better wages stimulate local economies, helping people to afford basic goods and services that may currently be out of reach.

But investments in nursing home jobs should not stop at compensation—modernizing the training standards to reflect the current and future role of these essential workers, offering high-quality adult learner-centered educational opportunities, and creating career ladders within the direct-care profession can further help to stabilize the workforce while providing added value to the system. More than $6 billion is being spent annually on turnover across all long-term care settings, money which could be redirected towards improved wages and job quality. Additionally, public funds that account for 55 percent of nursing home revenues should be carefully accounted for, with any increases tied directly to improved compensation and training for direct-care workers. Such investments will help to stabilize nursing assistant jobs, making them more competitive with other industries, reducing turnover and vacancies, improving retention, and ultimately ensuring that our loved ones can access the quality care they deserve.

APPENDIX A: NURSING ASSISTANT DEMOGRAPHICS*

Employment	649,260
AGE	
16-24	21%
25-34	26%
35-44	19%
45-54	18%
55-64	14%
65+	4%
Mean	38.51
Median	36.00
SEX	
Male	9%
Female	91%
RACE AND ETHNICITY	
White only, non-Hispanic	47%
Black only, non-Hispanic	35%
Spanish, Hispanic, or Latino	10%
Other or mixed, non-Hispanic	8%
Non-White	53%
CITIZENSHIP	
U.S. Citizen	92%
Foreign-Born	20%
MARITAL STATUS	
Married	34%
Widowed, Divorced, or Separated	23%
Never Married	43%
EDUCATION LEVEL	
High School or Less	51%
Some college or degree	49%

EMPLOYMENT STATUS	
Full Time/ Full Year	45%
Part Time or Part Year	55%
40 or more weekly hours	55%
HEALTH INSURANCE	
Health Insurance Through Employer	55%
Health Insurance Purchased Directly	8%
Public Coverage	22%
No Insurance	20%
PERSONAL EARNINGS	
Median Hourly Wage	$11.51
Median Annual Earnings	$19,000.00
FEDERAL POVERTY STATUS**	
<100% FPL	17%
<200% FPL	49%
<300% FPL	72%
PUBLIC ASSISTANCE	
Any Public Assistance	38%
Food Stamps	27%
Medicaid	19%
Cash Assistance	3%

SOURCES/NOTES: Employment and wage estimates are based on three occupations employed in nursing and residential care facilities (NAICS 623100): nursing assistants (SOC 31-1014), home health aides (SOC 31-1011), and personal care aides (SOC 39-9021). Median hourly wage for "nursing assistants" is a weighted average of the median hourly wages for these three occupations. U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (2015, March 25). May 2014 National Employment and Wage Estimates United States. Retrieved from http://www.bls.gov/oes/

Demographic analyses are based on two census occupations employed in nursing care facilities (Census industry code 8270): nursing, psychiatric, and home health aides (Census Occupation Code 3600) and personal and home care aides (Census Occupation Code 4610). American Community Survey, U.S. Census Bureau (2015). 2014 ACS 5-year PUMS. Retrieved from http://www.census.gov/programs-surveys/acs/data/pums.html

*Nursing Assistant refers to all direct-care workers employed in nursing facilities: nursing assistants, home health aides, and personal care aides.

**Federal poverty level is determined at the household level, based on the actual household composition of the survey respondent.

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Research Article

CNA Training Requirements and Resident Care Outcomes in Nursing Homes

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Abstract

Purpose of the Study: To examine the relationship between certified nursing assistant (CNA) training requirements and resident outcomes in U.S. nursing homes (NHs). The number and type of training hours vary by state since many U.S. states have chosen to require additional hours over the federal minimums, presumably to keep pace with the increasing complexity of care. Yet little is known about the impact of the type and amount of training CNAs are required to have on resident outcomes.
Design and Methods: Compiled data on 2010 state regulatory requirements for CNA training (clinical, total initial training, in-service, ratio of clinical to didactic hours) were linked to 2010 resident outcomes data from 15,508 NHs. Outcomes included the following NH Compare Quality Indicators (QIs) (Minimum Data Set 3.0): pain, antipsychotic use, falls with injury, depression, weight loss and pressure ulcers. Facility-level QIs were regressed on training indicators using generalized linear models with the Huber-White correction, to account for clustering of NHs within states. Models were stratified by facility size and adjusted for case-mix, ownership status, percentage of Medicaid-certified beds and urban-rural status.
Results: A higher ratio of clinical to didactic hours was related to better resident outcomes. NHs in states requiring clinical training hours above federal minimums (i.e., >16 hr) had significantly lower odds of adverse outcomes, particularly pain falls with injury, and depression. Total and in-service training hours also were related to outcomes.
Implications: Additional training providing clinical experiences may aid in identifying residents at risk. This study provides empirical evidence supporting the importance of increased requirements for CNA training to improve quality of care.

Keywords: Certified nursing assistant, regulation, clinical training hours, resident outcomes, quality indicator, Minimum Data Set

Purpose of the Study

Certified nurse assistants (CNAs) are direct care workers who provide 65% of the daily assistance and health-related care for residents in long-term care facilities (American Health Care Association [AHCA], 2004; Squillace et al., 2009). Because of their close relationships with patients, CNAs are relied upon in the NH setting for preliminary identification of patients at risk. For example, recognition of pain cues in cognitively impaired residents (Liu 2014) is a task delegated to CNAs by licensed nurses. Therefore, adequate training is an essential component for CNAs working in NHs.

To become certified as a CNA, U.S. federal regulations require at least 75 initial training hours with a minimum of 16 clinical hours, plus 12 annual in-service training hours (Code of Federal Regulations, 2012). Required CNA training hours vary by state, since many U.S. states have chosen to require additional hours over the federal

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minimums, to keep pace with the increasing complexity of care. The Office of the Inspector General (OIG), back in 2002, identified concerns among long-term care stakeholders about federal CNA training requirements, specifically the apportioning of didactic versus clinical training hours. Of greatest concern to CNA supervisors was that 16 clinical hours was insufficient to adequately prepare new CNAs for employment in long-term care facilities (OIG, 2002). In addition, CNAs themselves desired more clinical time and felt that they were inadequately prepared for real-life resident care (Sengupta, Harris-Kojetin, & Ejaz, 2010). The high turnover of CNAs (70% of some training program graduates) has also been identified as a potential consequence of insufficient clinical training experience for CNAs (OIG, 2002).

All staff in NHs require training to maintain care quality, and training needs of CNAs should not be overlooked. Better resident outcomes, such as fewer falls and lower average medication use, have been found in NHs in states requiring CNA training and in-service hours above federal minimums (Trinkoff et al., 2013). Other studies have found that additional CNA didactic training was related to adequate care for residents with cognitive impairment or low functional activity (Fitzpatrick, & Roberts, 2004; Smith, Kerse, & Parsons, 2005). Despite these findings, little is known about the impact of hours of CNA clinical preparation on resident outcomes. This study builds on our prior work relating CNA training and certification to resident outcomes, by examining state-level clinical versus didactic training regulations with an updated analysis of total initial training and in-service hours.

Design and Methods

The conceptual framework guiding this research is an adaption of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon et al., 2006). The SEIPS model draws from Donabedian's structure-process-outcome model (Donabedian, 1972) by emphasizing linkages of work system design to resident outcomes through care processes. We hypothesized that NHs in states with more stringent CNA training regulations (i.e., more training hours; higher ratios of clinical to didactic hours) would be associated with NH QI rates that reflect better care. Therefore, NHs in states where CNA training is more extensive will have lower adverse outcome rates. Studying regulatory changes in relation to outcomes can strengthen our understanding of the importance of regulatory requirements for CNA training and the potential impact of these regulations on outcomes.

Design and Sampling

Initially, we compared state CNA training regulations from 2010 to 2004, the year for which we first analyzed CNA regulatory data. Then we linked 2010 regulatory data from all 50 U.S. states and the District of Columbia to 2010 resident outcomes data from 15,508 NHs. We excluded 165 facilities that did not provide any facility characteristics or that had missing values for all resident outcomes. The University of Maryland Baltimore Institutional Review Board approved the study protocol.

Data Sources

Nursing Home Compare

The Center for Medicare and Medicaid Services (CMS) website provides public access to data files with detailed information about every Medicare and Medicaid-certified NH in the United States. For this study, 2010 NH Compare files were used to obtain facility-level QIs and facility characteristics (CMS, 2014). Data were from the CMS Minimum Data Set (MDS) 3.0 that measured residents' physical and cognitive status, acute medical condition and behavioral and emotional status at the facility level to create a comprehensive view of care for U.S. NHs (RTI, 2014). MDS QIs are generated annually, using quarterly data on resident care outcomes and other parameters reported by NHs. Compared to MDS 2.0, MDS 3.0 has improved resident input, uses more refined measurement tools to capture clinically relevant QIs and requires 48% less time to complete (Saliba & Buchanan, 2012).

State-level CNA Regulatory Data

Several online sources were used to compile state-level 2010 CNA training regulations. Regulations were first abstracted from the Paraprofessional Healthcare Institute (PHI) 2011 and AHCA websites, with additional information obtained from the NH Regulation Plus, University of Minnesota website (AHCA, 2009; PHI, 2011; University of Minnesota, 2012). If clarification was needed, appropriate state officials were contacted by telephone; three states were contacted to verify clinical hours in effect for 2010, and 22 states were contacted about in-service hours. This approach was similar to that used previously to obtain complete state-level regulatory data (Trinkoff et al., 2013).

Measures

Resident Outcomes

Long-stay QIs were calculated as facility-level rates defined as the percentage of residents with a targeted condition or with changes to resident mobility (MDS 3.0) (CMS, 2014). QIs used in this study were as follows: percentage of residents with pain, antipsychotics, falls with injury, weight loss, and pressure ulcers with definitions shown in Table 1.

Reliability and validity of MDS QIs has been reported in previous studies. An inter-rater reliability trial reported a cumulative correlation coefficient for all diagnoses as 0.74 (Hawes et al., 1997); for pain management and pressure ulcers, inter-rater reliability was 0.75 and 0.74, respectively (Mor et al., 2011). Good agreement levels were noted

Table 1. Definition of Included CMS Long-stay Nursing Home Quality Indicators, MDS 3.0

Quality indicator	Definition
High risk pressure ulcer	Percentage of high risk residents with pressure ulcer in last 7 days
Weight loss	Percentage of residents who lose 5% or more of weight in last 30 days, and 10% or more of weight in 6 months
Falls with injury	Percentage of residents experiencing one or more falls with major injury since most recent prior assessment
Depressive symptoms	Percentage of residents who have depressive symptoms in last 14 days
Antipsychotic medication	Percentage of residents who received an antipsychotic medication in last 7 days
Pain	Percentage of residents who self-report moderate to severe pain in last 5 days

Source: CMS, MDS 3.0 Quality Measures Users' Manual (RTI, 2014).

between MDS 2.0 QIs and chart reviews (Mor, Intrator, Unruh, & Cai, 2011). Improved reliability levels were found for MDS 3.0 compared with MDS 2.0, with most MDS 3.0 variables having good to excellent inter-rater reliability (Saliba & Buchanan, 2012). A variety of outcomes have been shown to be related to NH characteristics in previous studies and support the validity of the outcomes data (Bostick, Rantz, Flesner, & Riggs, 2006; Collier & Harrington, 2008; Horn, Buerhaus, Bergstrom, & Smout, 2005).

NH Compare suppresses values for long-stay measures in a NH when the denominator is less than 30. For a NH with suppressed values, this could mean that the QI rate was very low and/or that the home was small and therefore did not have enough residents to reach that denominator. QI rates for NHs with suppressed values were imputed following the imputation rule developed by Brown University (D. Tyler, personal communication, June 5, 2012). The numerator was set at 5 and the denominator was calculated using bed size multiplied by occupancy rate. After imputation, the percentage of NHs with missing QIs was less than 5%. Each QI was then dichotomized such that NHs exceeding the 75th percentile for each QI were considered to be lower quality compared with those with rates at or below the 75th percentile.

State Regulations

State-level CNA training hour requirements were coded for clinical, in-service, and total initial training hours dichotomized as follows: 0 = required hours at federal minimums; 1 = required hours exceeding federal minimums. Thus, clinical hours were coded as 0 = 16 hr, 1 > 16 hr; in-service as 0 = 12 hr, 1 > 12 hr; and total initial training hours as 0 = 75 hr, 1 > 75 hr. The ratio of clinical to didactic hours was created as follows: for each state, the actual clinical hours required were divided by didactic hours (obtained by total initial hours minus required clinical hours) to form a ratio.

Facility Characteristics

Facility Characteristics included facility size categorized by number of beds (<50, 50–99, 100–199, ≥200 beds), case-mix, ownership status (for-profit vs. not-for-profit), percentage of Medicaid-certified beds and urban-rural status. Case-mix was adjusted using expected staffing—a measure of facility case-mix defined as expected number of hours of care provided on average to each resident each day (CMS, 2014). Expected staffing was drawn from the CMS Nursing Home Compare website (CMS, 2014) and was designed to be used as a proxy for case-mix (Cowles, 2014).

Analysis

Descriptive statistics were used to estimate frequencies and percentages for the study variables. Each facility-level QI was regressed using generalized linear models with the Huber-White correction to account for clustering of NHs within states. Additional analyses were stratified by NH size due to a significant interaction effect of NH size and training hours on QI rates. Models examined associations of state-level training hour regulations (i.e., clinical hours, in-service hours, total initial training hours, and ratio of clinical to didactic hours) on resident outcomes (QIs) with and without adjustment for case-mix, ownership status, percentage of Medicaid-certified beds, and urban-rural status.

Results

Changes in CNA Training Hours

The distribution of required CNA training hours by state and NHs in the United States in 2004 and 2010 is presented in Table 2. The proportion of states requiring extra initial training hours beyond federal minimums increased to 61% in 2010 from 53% in 2004. For clinical training hours, in 2010 one-third of states had regulations requiring the 16-hr federal minimum. The other 31 states and District of Columbia required more clinical training hours—ranging from 20 (Rhode Island) to 100 hr (California and Missouri). Mandatory in-service training hours were unchanged from 2004; only three states (California, Florida, and Nevada) required more than the federal minimum. The proportion of states requiring extra initial training or in-service hours also increased slightly in 2010 to 29% from 24% in 2004 (Supplementary Appendix 1).

Because more states in 2010 required additional training hours compared with 2004, we also investigated how this translated down to actual NHs within states. Slightly more than half of all U.S. NHs (59%) were required to employ CNAs with training hours over federal minimums; clinical and in-service training hour requirements did not vary across facility size (Figure 1). There was no statistical

Table 2. Frequency and Proportion of States and Nursing Homes in U.S. 2004 Versus 2010 by Required Training Hours

	2004				2010			
	State (n = 49)[a]		Nursing home (n = 16,125)		State (n = 51)		Nursing home (n = 15,508)	
Total initial training								
Greater than 75 hr	26	(53.1)[b]	8,300	(51.5)	31	(60.7)	9,426	(58.6)
75 hr (minimum requirement)	23	(46.9)	7,825	(48.5)	20	(39.3)	6,664	(41.4)
In-service training (annual)								
Greater than 12 hr	3	(6.1)	2,125	(13.2)	3	(5.9)	2,002	(12.4)
12 hr (minimum requirement)	46	(93.9)	14,000	(86.8)	48	(94.1)	14,088	(87.6)
Requirement for initial and in-service training								
>75 total initial training hours and >12 hr annual in-service	3	(6.1)	2,082	(12.9)	3	(5.8)	1,966	(12.2)
>75 total initial training hours or >12 hr annual in-service	24	(49.0)	6,261	(38.8)	29	(56.8)	7,511	(46.7)
75 total initial training hours and 12 hr annual in-service training (federal minimum)	22	(44.9)	7,782	(48.3)	19	(37.3)	6,613	(41.1)

[a]District of Columbia and Alaska were excluded from the analysis in 2004. [b]Values in parentheses are percentages.

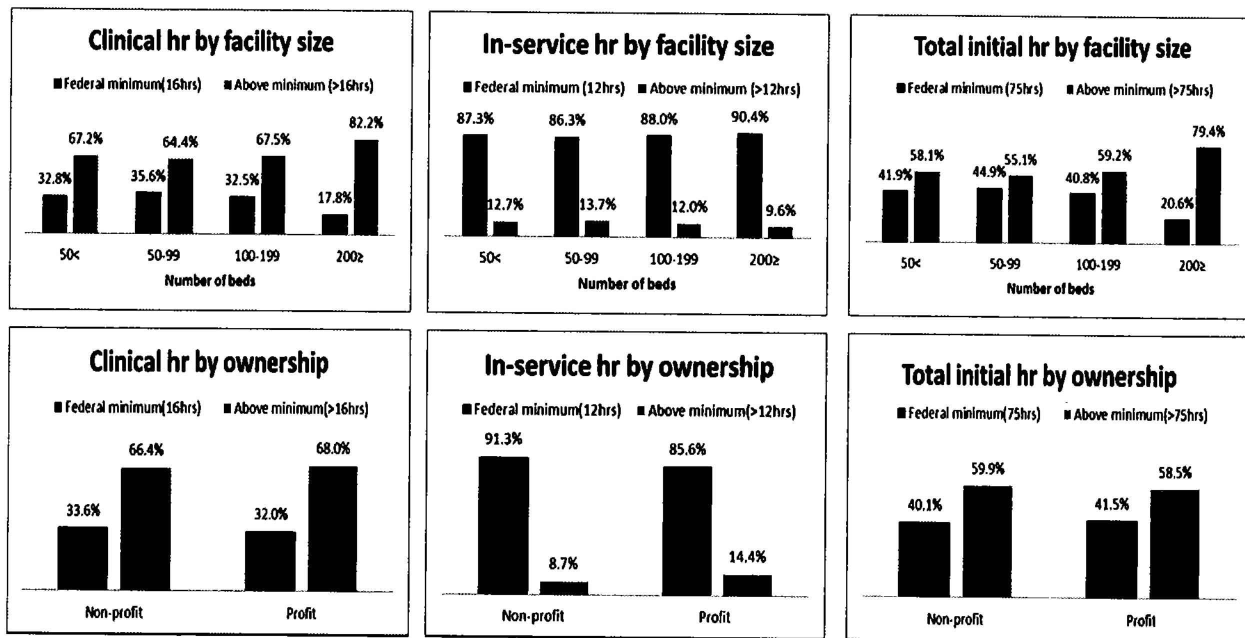

Figure 1. Proportion of U.S. nursing homes operating under their state training hour requirements by facility size and ownership, 2010 (n = 15,508).

variation in total initial training hours across facility size. The only training difference by ownership status was a smaller proportion of not-for-profit NHs offering additional in-service training compared with for-profit NHs (8.7% vs. 14.4%, p = .013).

CNA Training Hours and Resident Care Outcomes

Table 3 presents associations between each QI and required clinical hours, ratio of clinical to didactic hours, in-service hours, and total initial training hours stratified by NH size and adjusted for case mix, ownership, percentage of Medicaid-certified beds, and urban-rural status. We hypothesized that as required training hours increased, QI rates would decrease. Therefore, relationships with an estimated odds ratio (OR) below 1.0 would support this hypothesis. As the significance of the estimates changed little after adjustment, we therefore only presented the adjusted findings.

Clinical Training Hours

In general, we detected a pattern that NHs in states requiring more clinical training had better QIs than NHs in states

Table 3. Association Between CNA Training Hours and QI Rates (>75th percentile) in U.S. Nursing Homes, Stratified by Bed Size, After Adjustment[a] (N = 15,508)

	Pain (>75th percentile)		Antipsychotic use (>75th percentile)		Falls with injury (>75th percentile)		Depression (>75th percentile)		Weight loss (>75th percentile)		Pressure ulcer (>75th percentile)	
	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)
Clinical training hours (>16 hr vs. 16 hr)												
<50 beds	0.63	(0.32, 1.24)	0.97	(0.66, 1.44)	0.88	(0.62, 1.25)	0.62*	(0.40, 0.97)	0.78	(0.58, 1.03)	1.33	(0.45, 3.93)
50–99 beds	0.61*	(0.50, 0.75)	0.84	(0.57, 1.26)	0.71*	(0.54, 0.95)	0.65	(0.38, 1.14)	0.84	(0.67, 1.04)	1.04	(0.79, 1.38)
100–199 beds	0.73	(0.52, 1.03)	1.10	(0.67, 1.79)	0.93	(0.70, 1.24)	0.78	(0.49, 1.26)	0.86	(0.70, 1.06)	1.15	(0.89, 1.49)
≥200 beds	0.35*	(0.19, 0.63)	1.08	(0.61, 1.91)	0.84	(0.54, 1.31)	0.71	(0.44, 1.14)	0.64	(0.41, 1.01)	1.36	(0.76, 2.41)
Ratio (clinical/didactic)												
<50 beds	0.59*	(0.36, 0.98)	0.81*	(0.66, 0.99)	0.82	(0.59, 1.14)	0.47*	(0.37, 0.61)	0.88	(0.59, 1.30)	1.21	(0.73, 2.02)
50–99 beds	0.82*	(0.68, 0.98)	0.82	(0.64, 1.06)	0.68	(0.43, 1.06)	0.59*	(0.38, 0.92)	0.81*	(0.67, 0.98)	1.07	(0.93, 1.23)
100–199 beds	0.87	(0.70, 1.08)	0.90	(0.60, 1.36)	0.81	(0.56, 1.18)	0.71*	(0.50, 1.00)	0.87	(0.69, 1.09)	1.03	(0.88, 1.20)
≥200 beds	0.87	(0.47, 1.61)	0.94	(0.65, 1.35)	0.78	(0.47, 1.30)	0.50*	(0.30, 0.84)	0.91	(0.55, 1.52)	0.71	(0.47, 1.09)
In-service training hours (>12 hr vs. 12 hr)												
<50 beds	0.11*	(0.05, 0.23)	0.60*	(0.42, 0.84)	0.43*	(0.31, 0.59)	0.34*	(0.20, 0.59)	0.34*	(0.26, 0.45)	1.56	(0.75, 3.24)
50–99 beds	0.68*	(0.51, 0.90)	0.69	(0.46, 1.04)	0.34*	(0.18, 0.63)	0.26*	(0.17, 0.40)	0.58*	(0.48, 0.71)	1.32*	(1.14, 1.53)
100–199 beds	0.84	(0.67, 1.04)	0.79	(0.39, 1.60)	0.54	(0.27, 1.07)	0.40*	(0.29, 0.55)	0.81	(0.50, 1.31)	1.00	(0.80, 1.26)
≥200 beds	0.86	(0.48, 1.56)	1.76	(0.53, 5.82)	0.46*	(0.24, 0.88)	0.26*	(0.18, 0.36)	0.74	(0.38, 1.47)	0.61*	(0.40, 0.96)
Total initial training hours (>75 hr vs. 75 hr)												
<50 beds	0.52	(0.25, 1.09)	0.92	(0.60, 1.42)	0.82	(0.56, 1.20)	0.55*	(0.36, 0.85)	0.81	(0.59, 1.11)	1.43	(0.49, 4.15)
50–99 beds	0.73*	(0.57, 0.94)	0.76	(0.52, 1.12)	0.68*	(0.50, 0.92)	0.65	(0.39, 1.09)	0.96	(0.75, 1.22)	1.15	(0.90, 1.47)
100–199 beds	0.80	(0.59, 1.08)	0.79	(0.48, 1.30)	0.83	(0.64, 1.08)	0.72	(0.48, 1.08)	0.97	(0.77, 1.23)	1.23	(0.97, 1.57)
≥200 beds	0.34*	(0.20, 0.59)	0.80	(0.43, 1.49)	0.77	(0.47, 1.25)	0.79	(0.50, 1.23)	0.69	(0.44, 1.08)	1.81*	(1.11, 2.93)

Note: CI = confidence interval; OR = odds ratio.

[a]Models adjusted for case-mix, ownership status, percentage of Medicaid-certified beds and urban-rural status; reference categories for all of the quality indicators: <75th percentile.

*p < .05.

where only the federal minimums were required (Table 3). NHs in states requiring additional clinical training hours were less likely to have a high percentage (i.e., >75th percentile) of residents with pain (50–99 beds: OR = 0.61, 95% confidence interval [CI] = 0.50, 0.75; ≥200 beds: OR = 0.35, 95% CI = 0.19, 0.63), falls with injury (50–99 beds: OR = 0.71, 95% CI = 0.54, 0.95), and depression (<50 beds: OR = 0.62, 95% CI = 0.40, 0.97) after controlling for case-mix, ownership, percentage of Medicaid-certified beds, and urban-rural status, compared to NHs in states with the federal minimum requirements.

Ratio of Clinical to Didactic Hours

The ratio of clinical hours divided by didactic hours had a significant negative association with the QIs, especially among all NHs for rates of depression. In other words, as clinical hours as a proportion of total training hours increased, there was a significant decrease in odds of NHs having residents with depression, regardless of NH size. Pain, antipsychotic medication use, and weight loss were similarly related, especially in smaller NHs: pain (<50 beds: OR = 0.59, 95% CI = 0.36, 0.98, 50–99 beds: OR = 0.82, 95% CI = 0.68, 0.98), antipsychotic medication use (<50 beds: OR = 0.81, 95% CI = 0.66, 0.99), and weight loss (50–99 beds: OR = 0.81, 95% CI = 0.67, 0.98).

In-service Training

NHs located in states with additional in-service training hours were less likely to have residents with higher QI rates compared with states requiring the federal minimums. Increased in-service hours were associated with lower odds of falls with injury and depression regardless of facility size. Associations between higher in-service training requirements and lower rates of pain, antipsychotic use, and weight loss were significant for smaller NHs. Pressure ulcers showed a mixed association with in-service training hours, depending on facility size (Table 3).

Total Initial Training Hours

After adjustment for case mix, ownership status, percentage of Medicaid-certified beds, and urban-rural status, in general, NHs in states requiring more training had better rates of QIs than NHs in states requiring only federal minimums (Table 3). This association was statistically significant for three QIs: pain (50–99 beds: OR = 0.73, 95% CI = 0.57, 0.94; ≥200 beds: OR = 0.34, 95% CI = 0.20, 0.59), falls with injury (50–99 beds: OR = 0.68, 95% CI = 0.50, 0.92) and depression (<50 beds: OR = 0.55, 95% CI = 0.36, 0.85). Whereas pressure ulcers showed the opposite pattern: NHs in states requiring more total initial training hours than federal minimums had higher odds of pressure ulcers (OR = 1.81, 95% CI = 1.11, 2.93).

Implications

This study presents new empirical findings stressing the importance of clinical training hours by examining their relationship to resident care outcomes. We found that NHs in states requiring additional clinical training hours above the federal minimum (i.e., >16hr) had significantly lower odds of adverse resident outcomes, particularly pain, falls with injury, and depression. Furthermore, a higher ratio of clinical to didactic hours was also related to better resident outcomes. This study also extends and affirms our previous work on CNA requirements for total initial training and in-service training hours (Trinkoff et al., 2013). However for our current study, we used more recent data with adjustment for case-mix, ownership, percentage of Medicaid, and urban-rural status yielding improved though still comparable estimates.

The strong association between in-service training hours and all of the included QIs is also notable in our study though only a few states now require this, suggesting that ongoing training is critical to maintain the quality of care in NHs. Our findings regarding clinical hours also are worthy of additional discussion.

Clinical experiences have been a mainstay of nursing education, both in clinical settings and more recently in simulation, and greater clinical competence in nursing has been associated with greater clinical experience (Takase, 2013). Additional clinical experience has also been associated with observed competence and improved attitudes toward end-of-life care, which includes pain identification by nursing students (Chow, Wong, Chan, & Chung, 2014). Although similar research on CNA clinical education is not available, our findings that NHs with better resident outcomes were more likely to be located in states requiring increased clinical education hours are not surprising. Pain and depression identification in long-term care settings, especially among demented patients, is of continuing concern (Ersek, Polissar, & Neradilek, 2011; Swafford, Miller, Tsai, Herr, & Ersek, 2009). Consideration of increasing the clinical hours in CNA training programs could be an important step in addressing this complex problem.

The finding of increased pressure ulcers associated with increased total initial training hours was opposite to the hypothesized result, whereas for in-service hours, significant findings were conflicted (i.e., they occurred in both directions). Pressure ulcer QIs are based on their identification at any stage, including those that are just developing. Identification of pressure ulcer risk and development are important skills for CNAs to learn (Dellefield & Magnabosco, 2014). More research is needed to examine this finding and to assess whether CNAs with increased training hours might be identifying ulcers at earlier (and more treatable) stages compared with other CNAs.

Several limitations should be acknowledged when interpreting study results. First, this study used a cross-sectional design; therefore, causal relationships among variables cannot be confirmed. Second, imputation of suppressed values in NH Compare could have biased the estimates, though imputation was performed to reduce selection bias from exclusion of NHs with suppressed QIs. NHs with

suppressed QIs had fewer QI cases due to smaller size and/or due to better care quality. However, there is still a possibility of misclassification bias due to the imputation strategy. To minimize this potential bias, we examined the interaction effect of training hours and facility size on QI rates. As a significant interaction was found, we generated all estimates stratified by facility size. In addition, there is the possibility that one or more uncontrolled state-level variables could contribute to the reported findings. We acknowledge that there may be state-level variation that is uncontrolled after inclusion of variables such as case-mix, ownership, proportion of Medicaid and urban-rural status. Nonetheless, the purpose of our study was to examine differences in state-level training regulations as a possible source of between-state variation, allowing us to consider regulation as part of the variation among states.

We have presented evidence supporting that increased CNA clinical, in-service and total initial training hour requirements over federal minimums were related to NH QI rates reflecting better care quality. As the need for additional CNAs develops, due to increased numbers of elderly requiring care, it will also be important to examine what training content is actually desired by CNAs, and how additional training could affect CNA job satisfaction and turnover. A previous study of CNA training and job satisfaction found that CNAs with additional training in dementia care and work life skills (e.g., resolving conflicts and problem solving) were more satisfied with their jobs (Han et al., 2014). Meanwhile, efforts by stakeholders and policy makers to view additional CNA training hours as a potential means to improve care seem warranted.

Supplementary Material

Please visit the article online at http://gerontologist.oxfordjournals.org/ to view supplementary material.

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Kim Marheine, Ombudsman Program Supervisor,
Christopher McElgunn, Counsel to the Board
State of Wisconsin Board on Aging and Long Term Care
Before the Committee on Aging and Long Term Care
on AB 432 – Hours of Instruction Program for Nursing Aids
September 5, 2017

Good morning, Chairman Weatherston, Vice Chair Petryk and members of the Committee. I am Kim Marheine, Long Term Care Ombudsman Program Supervisor for the Wisconsin Board on Aging and Long Term Care. I appear this afternoon to speak on behalf of the approximately 88,000 Wisconsin citizens currently living in our nursing homes and assisted living residences, regarding proposed reductions to the current nursing aid training hours, and speaking in opposition to AB 432. With me is Christopher McElgunn, our Counsel to the Board, and he will speak first to the some of the research and statistical information regarding this issue.

Mr. McElgunn

I would like to start my testimony by first thanking Attorney General Brad Schimel for taking action to address the mistreatment of our senior population by creating a Task Force on Elder Abuse. Over the next two decades, Wisconsin's 65 and older population will increase by 72% and one in nine seniors have reported being abused, neglected or exploited in the past twelve months. The Task Force, of which the BOALTC is pleased to be a part, will bring together the resources and knowledge of a multi-disciplinary team of professionals to study the impact of elder abuse in Wisconsin, assess ways to improve outcomes for this growing population of citizens and develop strategies to address barriers in investigation and prosecutions of elder

abuse. An educated and well-trained contingent of staff is a vital step in recognizing and preventing the abuse of residents in our long term care settings.

The Centers for Medicare and Medicaid Services (CMS), as part of the Omnibus Budget Reconciliation Act of 1987, mandated regulations requiring a minimum of 75 hours of training – barely two weeks - for nurse aids. This mandate has remained unchanged since the Act's adoption in 1987, 30 years ago, despite the fact that medical and psychosocial acuity of residents has increased greatly.

Thirty states and the District of Columbia have since extended the minimum number of training hours beyond the 75 hour federal minimum, topping out with the 180 hours required in Maine. No state that has extended the minimum number of training hours has ever subsequently reduced the minimum number of training hours.

The assertion has been made that there is no evidence longer training impacts quality of care. This claim is false. Experts within the medical and long-term care community have weighed in and I would like to highlight some their findings:

- In a 2016 discussion paper sponsored by the National Academy of Medicine and co-authored by faculty members of Columbia University, Harvard University, the University of Michigan, The University of Pennsylvania, Terry Fulmer of the John A. Hartford Foundation and Robyn Stone Senior Vice President of Research and Executive Director of the LeadingAge Center for Applied Research, the authors concluded in regard to direct care workers:
    - "Recruiting and retaining competent, stable direct care workers are serious problems in many communities around the country. Turnover rates are above 50%. Many factors contribute to the turnover, but two major issues are low wages and inadequate training and supervision."

- A recommendation for "an increase in federal requirements for training of at least 120 hours for certified nursing assistants (CNAs) and home health aides and demonstration of competence in the care of older adults as a criterion for certification."

- A 2016 report issued by the Paraprofessional Healthcare Institute recommended:

    - "It is essential to address the training of nursing assistants to better prepare people to do their jobs and to stop the cycle of turnover. Federal training standards for nursing assistants in Medicare and Medicaid-certified nursing homes must be modernized to reflect advances in the delivery of person-centered care, as well as the realities of the populations served in nursing homes today—those with behavioral health needs, cognitive decline, and those near the end of life. Studies have shown that an increase in the number of mandatory training hours improves job satisfaction and decreases turnover."

    - "As recommended by the Institute of Medicine, federal requirements should be expanded to 120 hours of pre-employment training. Expanded training should include building skills in communication, relationship building, and problem solving, and also address competencies related to caring for individuals with dementia and other challenging behaviors. The 120 hours should be considered a floor, not a ceiling, and employers should determine the content of on-the-job education for nursing assistants to meet the needs of varied populations."

- In a research study published in 2015 the Gerontological Society of America found:

    - "Nursing Homes in states requiring additional clinical training hours above the federal minimum had significantly lower odds of adverse resident outcomes, particularly pain, falls with injury, and depression...This study also extends and affirms our previous work on CNA requirements for total initial training and in-service training hours."

Finally, and most recently, this August, Wisconsin was named the top state in the nation for health care with the highest overall health care quality score among all 50 states, according to the federal Agency for Healthcare Research and Quality (AHRQ). The ranking is based on Wisconsin's performance across more than 130 statistical measures that AHRQ uses to evaluate health care performance, including long term care. Wisconsin ranked third highest last year and has been out of the top three only twice in the past decade. We should continue to endeavor to maintain Wisconsin's status as a leader at providing quality care. It would be irresponsible to burden the current staff of long term care facilities, already stretched thin and working overtime, to take on the additional task of providing initial training for their co-workers. Following the advice of experts within the medical and long-term care community, and continuing to emphasize the importance of the fundamental training provided to nurse aids, is essential to this effort.

Ms. Marheine

As background, the Board operates the Wisconsin Long Term Care Ombudsman Program, a federally mandated advocacy service for residents of long term care facilities. In Wisconsin, our twenty-one Ombudsmen provide advocacy services for residents as well as consultative and educational offerings for care providers and families on topics ranging from residents' rights and person-directed care, to preventing and dealing with resident abuse and neglect. Among the most frequently occurring complaints and requests for consultations are those concerning persons who are medically complex and who are unhappy with the care they receive. Persons with even routine needs related to dementia often struggle to have their needs met by unprepared providers. Persons with chronic mental illness who require specialized medication management and/or behavioral supports, persons who have unique needs associated with their bariatric status, and increasingly, persons who are drug-dependent and attempting to maintain their drug use in their nursing home or assisted living residence, are among those who call for our services.

As previously noted, in the 30 years since the passage of federal minimum training requirements for CNAs, persons who live in nursing homes have changed significantly. They are both younger and older. They are living longer and with far more complex needs. Some,

due to their unique needs, have lived in multiple settings and have failed in those settings. They then find themselves in a nursing home that, even with the state's current mandate of 120 hours of CNA training, is unable to meet their unique needs in ways that are respectful, dignified and skilled. In 2008, recognizing the need for increased skills amongst CNA's, Wisconsin enacted legislation to raise CNA training hours from the federal minimum to its current 120 hour level. The legislature recognized, at the urging of family members affected by dementia and the advocacy community, a need for more CNA education particularly aimed at care for persons with dementia. The need for increasingly skilled direct care workers has only grown today, and is now accompanied by the new and equally complex scenarios and processes noted previously, that CNA's must also now attend to with proficiency and confidence in the course of their work.

CNA's today are the foundation for our health care, and provide the most intimate and often the most challenging care for our state's most vulnerable individuals, many of whom are both medically and psychosocially complex. CNA's are also the first point of contact for angry or grieving family members, and today, as was also the case in the 1980's, staff shortages in almost every realm of long term care service provision are dire. Some note that a remedy for this health care worker shortage might be accomplished by decreasing CNA training hours, getting new CNA's on the floor more quickly, and supervised and mentored largely by the nurses working alongside them. The Board on Aging and Long Term Care would contend that this is not a valid remedy on a number of points, most obviously to note that virtually every sector of labor, both skilled and unskilled, has vacancies for qualified staff. Further, registered nurses are also among those professions where shortages are seen. It would be irresponsible to further burden a nurse, already responsible for the complex medical management of each resident, with also having to train, coach, remediate and supervise lesser prepared CNA staff.

The argument has also been put forth by the Wisconsin Director of Nurses (DON) Council that increasing CNA training hours has not resulted in a lower rate of Immediate Jeopardy cites in nursing homes, correctly noting that Immediate Jeopardy cites have continued to rise over the recent years. Immediate Jeopardy cites are those that are most severe in a nursing home, and designate a situation of such seriousness as to pose an actual or potential threat of harm, safety or death for a resident. Reviewing the Immediate Jeopardy cites for Wisconsin for the

past several years, it is noted that very few of these have been incurred by faulty CNA practice. Further, we have not seen any proposed language of what might be eliminated from the curriculum in decreasing the current training requirement by 45 hours. Our concern is any training eliminated might include vital discussions about working with people in ways that are respectful and dignified, no matter the challenges, assessing and responding to situations of potential abuse, understanding and engaging with residents and their family members about residents' rights to self-determine their care and treatment.

Ombudsmen have access to all residents in all of Wisconsin's licensed and certified long term care settings. Ombudsmen spend a significant amount of time talking with administrators and other leadership staff about how they might continue to provide the highest quality of care and concern for their residents, while also meeting the challenges of a shrinking workforce as the older adult demographic continues to increase. I would like to note some of the creative alternatives already being implemented:

- Working with a community's local HOSA (Health Occupations Students of America – now known as Future Health Professionals) chapter to engage high school aged persons who may be interested in a career in health care.
- Offering flexible hours and shifts to accommodate older workers, single parents, persons working another job, and students who may be studying nursing or another health-related field.
- Looking at the position description of a CNA and making changes to remove some of the non-skilled aspects of CNA work that might be performed by another type of staff.
- Offering a career ladder for CNA's who want to pursue an advanced degree or advanced training, and who agree to continue to work for the nursing home post graduation or certification.
- Seeking ways to elevate the value of a CNA as a career by offering tangible supports such as more pay, uniform allowances, meals and child care in the workplace, affordable health insurance and retirement plans, scholarships or tuition reimbursement for advanced education or training.

Cheryl Hennen, State Ombudsman in Minnesota, shares this comment about the CNA crisis in her state, and I quote, "While it is true that the wage enhancements that resulted from the passage of Minnesota Value-Based Reimbursement Legislation have helped Minnesota facilities with staff recruitment and retention, there are still staff shortages that exist due to sheer demographic shifts and low unemployment."

Removing the benefit of a full and meaningful training requirement, particularly during a time when those in our care need more and not less skill, only furthers the attitude that investing in CNA's to make them qualified, skillful and confident is too time-consuming and expensive. This serves only to further devalue an already undervalued but so very crucial part of the health care workforce.

Wisconsin's aging population deserves the best opportunity we can provide for them to receive quality, patient-centered, care. As an alternative to reducing vital training hours, the Board on Aging and Long Term Care suggests the following:

- Streamline the testing process and reduce wait time to allow nurse aid students that graduate from a training program to test and become certified in a more timely fashion. As articulated in the Director of Nursing Council's position statement, the average individual seeking an entry level nursing aide position waits approximately six weeks to become certified. The proposed legislation does not change the turnaround time for certifying an individual to go from three weeks to two. However, by eliminating unnecessary time gaps, the goal of providing interested individuals a reduced timeline for employment can still be accomplished, without sacrificing fundamental training hours.

- Consider forming a taskforce that would include nursing home residents and family members; CNA's; CNA trainers; facility administrators and other concerned stakeholders to more fully examine the nurse aid workforce shortage and review what alternatives are being implemented successfully in Wisconsin and, as this is an issue being faced nation-wide, what other best-practices can be drawn from across the country.

- Increase scholarship opportunities for individuals interested in entering the field.

- Seek reciprocity for certified nurse aides from other states that meet certain minimum criteria.

- Tour a nursing home with an ombudsman. Speak with residents about their care and those who care for them. Ask residents and their families their thoughts about decreasing training.

Wisconsin has always been a state that proudly proclaims that its greatest assets are its people, their work ethic, their creativity, their care and concern for one another. We have never been a state to be satisfied with meeting a minimum requirement, but have always strived to be the best, to be at the top of any ranking, to lead the nation in the most impactful of ways. To so boldly say that we would be satisfied with meeting a minimum requirement for the training of the people who care for our most vulnerable, the people who built our communities and our families, is not the Wisconsin way. For any of us who have experienced first-hand the need for long term care services, we know that working as a CNA is a difficult and rewarding job and we should be working to make that job more quality filled.

We thank you, Chairpersons Weatherston and Petryk, and the Committee, for giving the Board on Aging and Long Term Care this opportunity to be part of this important and potentially transformative discussion. We will be happy to respond to any questions that you or the Committee may have.

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