Wisconsin Association of Homes and Services for the Aging, Inc.

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January 7, 2008

To: Senator Tim Carpenter, Chair
Members, Senate Public Health, Senior Issues, Long-Term Care and Privacy Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: **WAHSA's Continued Opposition to Senate Bill 283 and to the Anticipated Amendment to SB 283**

The Wisconsin Association of Homes and Services for the Aging (WAHSA) and its 187 not-for-profit long-term care provider members **continue to oppose SB 283** for the reasons outlined in our December 5, 2007 public hearing testimony before the Committee. **WAHSA members also oppose the amendment to SB 283** which we anticipate will be introduced and voted upon at Tuesday's executive session: with the exception of the elimination of hospices from the bill, **the amendment was a compromise only of those who support SB 283, not of those who oppose the bill but were willing to work toward a compromise.**

WAHSA members still believe residential care apartment complexes (RCAC) should be removed from the bill because: 1) HFS 89.29(1) effectively prohibits the admission of an individual with Alzheimer's disease or related dementia to a RCAC, unless the person shares an apartment with a competent spouse or other person who has legal responsibility for the individual; 2) we believe there are no RCACs in this state which hold themselves out as providing special services for persons with Alzheimer's disease or related dementia because the RCAC is an inappropriate setting for such specialized care; and 3) if there are RCACs making the claim they offer special dementia-related services, as some have suggested, the DHFS currently has the statutory authority to shut them down.

WAHSA members still believe SB 283 totally ignores the additional costs facilities most likely will be forced to incur to comply with the unknown care and treatment standards the DHFS will develop by rule after SB 283 becomes law. If those standards require the majority of nursing homes and CBRFs to increase staffing and/or training requirements, who will pay for those additional costs? Will Medicaid reimbursement pick up these additional costs or will we be asking the frail, elderly residents of our nursing homes and CBRFs to do so?

WAHSA members also question the germaneness of Sections 9f-9y of the proposed amendment to SB 283; it appears to us these provisions expand the Nursing Home Resident's Right to Know statute under s. 50.095 to include adult family homes, CBRFs and RCACs that both do and do not hold themselves out as providing special services to persons with Alzheimer's disease or related dementia and therefore are beyond the scope of this bill.

Finally, there appears to be an assumption that there are virtually no standards of care applicable to residents of nursing homes and CBRFs (the two areas of care in SB 283 most familiar to WAHSA members) with Alzheimer's disease or related dementia. That simply is not the case. We respectfully suggest committee members review the administrative rules which regulate these care settings: HFS 83 for CBRFs and HFS 132 for nursing homes (the RCAC regulations can be found under HFS 89). Specifically, look at HFS 83.04(13), HFS 83.07(2)(a)5 and 6, HFS 83.11(1)(b), HFS 83.14(1)(a), HFS 83.15(1) and (2), HFS 83.18(1)(d) and (2)(b) and (d), HFS 83.21(4), HFS 83.31, HFS 83.32(2) and (4), HFS 83.42(2), HFS 132.14(4)(b), HFS 132.31(1)(d) and HFS 132.44(2)(a) for an idea of the code requirements which protect the health, safety and welfare of all nursing home and CBRF residents, including those with Alzheimer's disease or related dementia. Since most care in nursing homes and CBRFs is provided by certified nurse assistants (CNA), a review of HFS 129 might also be informative, specifically HFS 129.07(2)(b) and (g) and HFS 129.08(2)(d) and (3).

We surveyed WAHSA members who we believe (although we're still not certain) would be impacted by SB 283 to get a sense of their training and staffing levels and what it is that is "special" about their special care for residents with Alzheimer's disease or related dementia. What we found came as no surprise to us: their dementia unit staffing levels and training requirements were greater than those in their nursing homes and/or CBRFs but they were all over the board. The survey found there is no consistent "way" to provide for the care and treatment of Alzheimer's residents, which isn't surprising since the field, as well as the knowledge of the disease itself, continues to evolve. **The one consistency we found, however, was virtually every one of the 23 survey respondents was deficiency-free in their special care units.**

Any standards, be they in code or developed by the DHFS by rule as part of SB 283, are going to be arbitrary in nature. Some suggest that staff working on an Alzheimer's unit should have a minimum of 8 hours of training before they work on such a unit. Some WAHSA members require more than 8 hours of initial training, some less. But what about the CNA who "gets" the care and treatment of Alzheimer's residents after 6 hours? More importantly, what's to be done with the CNA who doesn't "get" it after 8 hours? The 8-hour standard is purely arbitrary: it's an educated guess that works for some but not for others. Government should not be ultimate arbiter in this decision; that should be left to the facility for they are ultimately responsible for the care they provide. **WAHSA members believe it the responsibility of the facility to determine <u>how</u> special care for Alzheimer's residents is being provided; it is government's role, through the DHFS Division of Quality Assurance (DQA) survey process, to determine <u>how well</u> that special care is being provided.** And if inadequate care is being provided, it also is the role of government to demand and ensure that such inadequacies are immediately rectified.

The care and treatment standards required under SB 283, just as current code, cannot and will not of themselves ensure that quality care is being provided to facility residents with Alzheimer's disease or related dementia. Unlike the SB 283 standards, however, current code establishes outcomes that facilities must meet in order to demonstrate that quality care is being provided. Once again, current code doesn't dictate how facilities care for their residents with Alzheimer's disease; it simply lays out the expectations of quality care buttressed by the power to enforce those expectations. WAHSA members believe this approach, unlike the requirements under SB 283, is in everyone's best interest.

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of *not-for-profit* corporations principally serving the elderly and persons with a disability. Membership is comprised of 187 religious, fraternal, private and governmental organizations which own, operate, and/or sponsor 196 nursing homes. Of that total, 144 nursing facilities are operated by private, not-for-profit organizations; 45 facilities are county-operated; and 7 facilities are municipally-operated. WAHSA members also operate 20 facilities for the developmentally disabled (FDD), 81 community-based residential facilities (CBRF), 59 residential care apartment complexes (RCAC), 14 HUD Section 202 Supportive Housing for the Elderly apartment complexes, 113 apartment complexes for independent seniors, and over 300 community service programs ranging from Alzheimer's support, child and adult day care, hospice, and homecare to Meals on Wheels. In our nursing homes alone, WAHSA members employ over 30,000 individuals who provide compassionate care and service to over 20,000 residents.