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Date: 9/18/2008 3:06:38 PM
Subject: September 24th meeting of CNA Training Enhancement Project at 1:30to 3:30 p.m. at Tri-County Office on Aging in Lansing

Hello, CNA Training Enhancement Project members,

The September 24 meeting of this group-the CNA Training Enhancement Project-is at the Tri-County Office on Aging in Lansing from 1:30 p.m. until 3:30 p.m.

Directions to TCOA and conference calling numbers are listed on the attached agenda for this meeting. Please let me know by COB Tuesday if you will be participating by conference call.

I want to welcome the instructors and administrators of the approved CNA training programs that have responded to our recent letter of invitation to join this effort. Through their emails to me I see great insights and dedication to learning and service.

For everyone that has been a member of the Workforce Development Workgroup, please let me know if you want to be dropped from this email list on the CNA training program. This list is getting pretty long and I am sure that some of you are no longer interested in following this issue so closely.

For this September 24th CNA training meeting, we will be reviewing the attached working documents. There's a lot here but it is all good stuff. Please review these before the meeting to insure that we are on the right track to meet your organization's needs.

At this meeting, I hope that we can fully discuss and make decisions about two specific directions for our work-how do we want to proceed in examination of the issues AND is a competency-based framing of the revised curriculum the right approach. Clearly, these are not final substantive decisions on our project but these decisions are necessary for productive meetings in October, November, and December.

Also, I would like to set dates for the October, November, and December meetings of the CNA Training Enhancement Project. So, bring your calendars.

Have a good weekend and I look forward to working with you next Wednesday afternoon.

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Executive Summary¹

CNA Curriculum and Administrative Recommendations

Completed June 2007

Michigan Model CNA Curriculum

After length consideration of a host of issues and information, the MDCWI work group concluded that students cannot be adequately prepared for caregiving work within the 2006 Michigan Model CNA curriculum. Important topics such as dementia care, person-directed planning, culture change, teamwork, and problem solving are not adequately addressed or required. And, the curriculum does not adequately foster adult-learner centered principles and activities. Therefore, the MDCWI work group recommends the adoption of state legislation to:

- Implement the recommended administrative changes described below and
- Develop a new CNA model curriculum through a collaborative process lead by the Michigan Department of Community Health.

We believe that the 20-year old federal minimum standards that currently define Michigan's program CNA training and CNA registry administration no longer meet Michigan's needs for highly competent, compassionate, respected caregivers.

Administrative recommendations

The administrative recommendations speak to the oversight of the CNA training program and the approved training programs, approved trainers, and the CNA registry. Many of the current MDCH policies that interpret federal law should be continued and bolster by state legislation or rules. Other recommendations outlined below exceed or clarify federal minimum standards in the administrative oversight of the training program. These recommendations are not currently operating within the MI CNA training program.

1. Approved Trainers for CNA Approved Training Programs

- A. Primary Trainers – Maintain current federal law and MDCH policies that require Primary trainers be RNs with a minimum of 2 years of nursing experience, of which at least 1 year must have been in a nursing home within the last 5 years.
- B. Delegated, Training Support and Guest Trainers

¹ A full explanation of the recommendations, including much detail, is available by contacting, Hollis Turnham at 517-327-0331 or HTurnham@PHInational.org

- i. Maintain current policy of using LPNs as Delegated trainers and have one year of nursing home or home care experience within the last 5 years.
- ii. Recommend that a new category of trainer, "Training Support Instructor", open to CNAs who have a minimum of two years of nursing home or home care experience within the last 5 years. A Primary and/or Delegated trainer must be on-site and available when Training Support Instructors are teaching.
- iii. Continue use of content experts to serve as Guest trainers under the supervision of the Primary trainer. Approved programs must notify MDCH when Guest trainers are to be used.

C. Train-the-Trainer Program – We recommend that a Team be formed that includes current trainers, content experts and public representatives, along with an instructional designer to support them, to develop a new, expanded Train-the-Trainer (TTT) curriculum for trainers (not Coordinators), along with a timeline for introducing and requiring the new training. The new training program will need to give substantial attention to:

- a. Changes, if any, in the curriculum developed as a result of state legislation,
 - b. Adult Learner Centered Training Methods
 - c. Differences between the traditional medical model of care and person-centered care model recommended by the Michigan Medicaid Long-Term Care Task Force.
- ii. The State needs to train additional TTT trainers, and offer TTT programs at more sites around the State (based on ability to fill the courses).
 - iii. Delegated trainers should attend those portions of training that do not cover the regulatory and administrative content needed only by Program Coordinators and Primary Trainers.
 - iv. Continue current MDCH requirements that Program Coordinators and Primary Trainers participate in 8 hours of training (for CEU credit) every two years, and that Primary trainers repeat the TTT Program every six years. We encourage similar requirements for Delegated trainers.

D. Transition to New TTT Program - We recognize that an expanded TTT program may be burdensome for some training programs and unpopular with some trainers. We recommend that incentives for participating in the expanded program or allowing experienced trainers to 'test out' of additional training be considered.

2. **Approved CNA Training Programs**

A. Online database of Approved CNA Programs and Approved trainers – Job seekers, career counselors, and employers need ready access to all 200+ approved CNA training programs. DCH should establish and maintain a website listing of all

approved CNA training programs with contact information for posting on its web site. We recommend that the listing have the following elements for each training program:

- Be searchable by county and zip code
- Provide eligibility criteria, if any (age, GED, drug testing, physical, etc.)
- Identify costs (including a line item breakdown of various cost components)
- Length and frequency of the programs, and class starting dates if possible
- Job placement assistance, if any
- Detailed contact information

We also recommend that the state explore the legal and technological ability of approved programs and trainers to “update” their own listing rather than using state employee time.

- B. Data Collected from Approved CNA Programs – MDCH has very little data about the activities of approved CNA programs. Basic data will help develop strong a CNA training program and to monitor the program outcomes.
- i. We recommend that a work group, including approved training programs, clinical sites, consumer advocates, and DCH be formed to develop a process to collect the basic data required to understand the current training system.
 - ii. We recommend the following data collection elements be collected from each approved CNA training program:
 - a. Enrollment numbers
 - b. Completion numbers
 - c. Drop-out number
 - d. Number of students passing certification test
 - e. Number of students completing CNA training employed as CNAs in nursing homes
 - f. Number completing CNA training employed in other health care occupations
 - g. Tuition charged by each training program
 - h. Hours/duration of program
 - i. Amount of public funds spent on CNA training including Michigan Works, community colleges, Medicaid and other sources.
 - iii. We recommend the resulting data be made widely available to nursing homes, Michigan Works! Agencies, community colleges, ISDs, nursing programs, aging and disability advocacy organizations and organized labor.

- iv. Data should be collected based on a 12 month period and include all approved CNA training programs. The data is not intended to be used to evaluate each program but the overall training effort in Michigan.
- C. Criminal Background Checks - In the last year, the scope and depth of criminal background checks done on people working in a broad range of long-term care related settings has grown. In order to reduce time and costs of training people who are ineligible due to criminal convictions and to maximize clinical placements:
- i. We recommend that all CNA approved programs be required to conduct both the state and federal criminal background checks before enrolling a student, and that all applicants for training must be eligible to work under PA 26, 27, 28 and 29 before enrollment.
 - ii. We recommend that the State Legislature amend relevant sections of PA 26, 27, 28, and PA 29 to include a process that allows an individual who is ineligible to work because of criminal conviction(s) to show rehabilitation and worthiness for employment in long-term care. The process should put the burden of demonstrating rehabilitation on the applicant.
- D. Trainer to trainee ratios - The current Michigan Train-The-Trainer Manual, Chapter requires training (class) ratios. They are Class/Lecture – not to exceed 22 *trainees:1 instructor*, Lab Practice – not to exceed 12 *trainees:1 instructor* and Clinical Practicum – not to exceed 8 *trainees:1 instructor*. These ratios do not equal out during the three step process (classroom, lab, and clinical) of the class. The classroom ratio should be 24:1. Then a class of 24 could have one lecture instructor, 2 lab instructors and 3 clinical instructors working at the maximum ratio allowed.
- E. Suspension of Authority to Train by Nursing Homes - Federal law prohibits or “locks-out” a nursing home from providing their own CNA training programs when a home is not in compliance with specific federal nursing facility requirements.
- i. We recommend that the Federal lock-out requirement be reconsidered to allow for varying lengths of penalty related to the type and seriousness of the violation.
 - iii. We recommend that the waiver process and alternatives to training be more clearly communicated to locked-out facilities and that more information is provided to approved CNA programs regarding the waiver process for locked-out facilities.

3.Preparation and Prerequisites for Taking the CNA Course

With collaboration and coordination between MDCH and the Michigan Works! Agencies funded by the MDLEG, we believe students coming to the CNA course can be better prepared for success. No legislative actions seems to be required.

4. CNA Registry and Renewal Process

- A. Disciplinary Process for CNA Registrants – Recommend that certified nurse aides be added to Article 15 of the Michigan Public Health Code so that the same disciplinary process used for other regulated health professionals can be applied to certified nurse aides.
- i. Registry applicants be required to respond to a series of questions at the time of application including information regarding misdemeanors and felony convictions as well as any substance abuse problems the individual has had prior to application for the registry.
 - ii. Positive responses to the questions would result in further review of the applicant's credentials by the Bureau of Health Professions. Individuals who are not eligible for work would be denied the ability to test and become registered.
 - iii. After the applicant is registered, felony and misdemeanor convictions as well as actions or complaints filed with the Department be reviewed. The Department would review the allegation and determine if a complaint should be filed and investigated against the registrant.
 - iv. Registrant should be formally notified of the investigation and given an opportunity to participate in an informal compliance conference or an administrative hearing.
 - v. Disciplinary actions that could be assessed against the registrant would include reprimand, probation, fine, limitations on employment, suspension and revocation (flag). The disciplinary actions, other than the "flag" would be for a limited time period. It would also be possible for registrants to ask for reconsideration of actions taken against them if evidence justified review.
- B. CNA Registry Renewal - Continue the State's current practice of allowing verification of 8 hours of RN-supervised work to be accepted from a wide variety of long-term care health settings.
- C. On-line Registration - MDCH should explore new ways to maintain information on the registry, such as allowing individual CNAs to maintain their addresses on-line to ensure that current contact information is accurate for CNAs listed on the registry. This ability is likely to help with renewals of certification.

DEFINITION OF CORE SKILL COMPETENCIES

DESIGNED initially FOR
Personal Care Attendants and Certified Nursing Assistants and Home Health Aides

September 2008

By competency we mean:

“the capability to apply or use a set of related knowledge, skills, and abilities required to successfully perform ‘critical work functions’ or tasks in a defined work setting.”¹

The value of using the term competency is that it brings the focus on what someone needs to objectively *know and do* in order to do a job proficiently. It takes the emphasis away from classroom hours and passing tests and puts the focus on on-the-job performance in designing training and curricula.

Definition of competencies can be used for a number of purposes including assessment of job readiness, curriculum development, designing performance evaluation systems, and credentialing incumbent and experienced workers for what they have already learned on the job.

This list of competencies is based on work done in several states by PHI to determine the tasks that are common to direct-care workers in a variety of settings, as well as on competencies developed for the Department of Labor’s Home Health Aide and Certified Nursing Assistant Apprenticeships and federal CNA and HHA training requirements.

Since the competences were developed to include home care settings, you will see competences related to in-home services. Some of these in-home competencies *may* be relevant for Hospice aides since much of their work is done in consumer homes.

While this document (and other variations of it) have been reviewed with a number of stakeholders in other states who represent a variety of interests, it was not developed with an eye to MI, the new federal Hospice training requirements, or reviewed by MI stakeholders. For example, it does not include the Michigan created Dementia competencies or the Adult Abuse and Neglect Prevention training goals.

Needless to say, a set of competencies that are the basis of any MI training program or curriculum would need to be developed here by MI stakeholders. This document is distributed

¹ US DOL Definition

for discussion purposes—to decide if a competency based approach is best for Michigan. If yes, this document could be a starting pointing for defining a set of competencies for this state.

Definition of Core Skill Competencies

1	Role of the Aide
1.1	Explain the importance of the relationship between the consumer and the direct-care worker for quality of care
1.2	Define the role of the direct-care worker in relation to other members of the service team in various long-term care settings
1.3	Explain the role of the direct-care worker in relation to the consumer receiving services in various long-term care settings
1.4	Demonstrate professionalism and responsibility, including in timeliness and appearance
1.5	Explain the purpose of the service or care plan
1.6	Explain the role of the direct-care worker in supporting the consumer's engagement in community activities

2	Consumer Rights, Ethics and Confidentiality
2.1	Listen to and observe the preferences of the consumer
2.2	Respect the consumer's right to privacy, respect and dignity
2.3	Demonstrate ways of promoting the consumer's independence
2.4	Explain the philosophies of consumer-direction and independent living.
2.5	Facilitate the consumer's desire to express their personal faith and observe religious practice as requested
2.6	Respect the confidentiality of consumer information and adhere to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and employer confidentiality guidelines
2.7	Explain the direct-care worker's responsibility to identify, prevent, and report abuse, exploitation and neglect
2.8	Identify types, examples and indicators of abuse, according to PA law, including physical abuse, psychological abuse, exploitation, neglect, and improper use of physical and chemical restraints and methods to prevent them
2.9	Explain the consumer's rights to make health care decisions, including advanced directives and living wills.

For Discussion of the Concept of Competency Based Training and Curriculum
CNA Training Enhancement Project

Prepared by: PHI

2.10	Describe the rights of consumers as addressed in the Americans with Disabilities Act (ADA)
3	Communication, Problem Solving and Relationship Skills
3.1	Explain the term “communication” including the difference between verbal and non-verbal communication
3.2	Demonstrate effective communication, including listening, paraphrasing, and asking open-ended questions
3.3	Demonstrate ability to resolve conflict
3.4	Demonstrate respect and cultural sensitivity in communicating with others
3.5	Demonstrate the use of effective problem-solving skills
3.6	Serve as an advocate for the consumer as directed by the consumer
3.7	Demonstrate respectful and professional interaction with the consumer, significant other(s), and family members
3.8	Demonstrate basic language, reading, and written communication skills
4	Individualized Personal Care Skills According to Consumer Preference and Service Plan
4.1	Assist with tub bath and shower
4.2	Provide bed baths
4.3	Shampoo hair in bed
4.4	Assist with oral hygiene
4.5	Assist with fingernail and toenail care
4.6	Shave consumer
4.7a	Turn and/or position consumer in bed and wheelchair
4.7b	Transfer consumer from bed to wheelchair
4.7c	Position consumer in lift
4.8	Provide consumer with back rubs, foot rubs, leg rubs, arm/hand rubs
4.9	Assist with routine skin care
4.10	Assist with eating and drinking

For Discussion of the Concept of Competency Based Training and Curriculum
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4.11	Assist with dressing, including using elastic support stockings
4.12	Assist with walking
4.13	Make an occupied and unoccupied bed
4.14	Assist with basic toileting needs, including assistance with disposable briefs, using a bathroom or commode.
4.15	Demonstrate proper use of bedpan, urinal, and commode
4.16	Provide perineal care (cleaning of genital and anal areas)
4.17	Clean and ensure appropriate function and care of appliances such as glasses, hearing aids, orthotics, prostheses, and assist with application/removal

5	Individualized Health Care Support According to Consumer Preference and Service Plan
5.1	Accurately measure and record temperature, pulse, and respiration
5.2	Accurately measure and record blood pressure, height and weight
5.3	Collect routine urine, stool and sputum specimens according to proper procedures
5.4	Assist consumers with prescribed exercise programs, including walking, standing, transfer and passive range of motion exercises
5.5	Assist consumers who have lung disease with postural drainage
5.6	Assist with the use of prescribed medical equipment, supplies and devices
5.7	Assist with special skin care to prevent decubitus ulcers; observe, record and report skin conditions
5.8	Provide comfort measures to assist in relieving pain
5.9	Apply non-sterile dressing
5.10	Apply non-sterile compress and soak
5.11	Apply cold and/or heat applications
5.12	Assist consumers with ileostomy, colostomy, gastrostomy, and tracheotomy care and catheter care
5.13	Observe, record and report as appropriate
5.14	Assist consumers with self-administered medications

6	In-Home and Nutritional Support According to Consumer Preference and Service Plan
6.1	Assist with meal planning, food preparation and serving, food shopping, storage and handling
6.2	Assist with the preparation of simple modified diets
6.3	Prepare and assist consumers with complex modified diets
6.4	Assist consumer with fluid intake; measure and record
6.5	Assist and encourage consumer to consume nutritional supplements/snacks.
6.6	Assist consumers with care of the home and/or personal belongings
6.7	Support a safe, clean and comfortable living environment

7	Infection Control
7.1	Demonstrate proper hand washing procedures
7.2	Demonstrate application of the principles of infection control in all activities
7.3	Demonstrate the use of standard precautions as indicated
7.4	Demonstrate correct isolation and safety technique in care of consumers with infectious illness
7.5	Prepare soiled linen for laundry

8	Safety and Emergencies
8.1	Use proper body mechanics at all times and demonstrate safe transfer techniques
8.2	Demonstrate proper lifting technique when using lift equipment
8.3	Explain procedures in case of emergencies
8.4	Check prescribed medical equipment before use and notify supervisor of any problems identified
8.5	Demonstrate how to perform CPR and the Heimlich Maneuver

9	Apply Knowledge to the Needs of Specific Consumers
9.1	Describe basic anatomy and physiology of body systems
9.2	Recognize and report abnormal signs and symptoms of common diseases and conditions of body systems
9.3	Describe the normal aging process and its effects
9.4	Identify the specific needs of a person with Alzheimer's disease and related dementia (core) and demonstrate basic principles of intervention strategies (advanced)
9.5a	Identify the needs of people with various physical disabilities
9.5b	Demonstrate the ability to care for people with various physical disabilities
9.6	Identify the specific care needs of and demonstrate the ability to care for a person who is dying
9.7	Identify the specific needs of and demonstrate the ability to care for a sensory deprived consumer
9.8	Describe how age, illness and disability affect sexuality
9.9a	Identify the special needs of a consumer with mental illness
9.9b	Demonstrate the ability to provide services to a consumer with mental illness
9.10a	Identify the special needs of a consumer with intellectual and developmental disabilities
9.10b	Demonstrate the ability to provide services to a consumer with intellectual and developmental disabilities

10	Self Care
10.1	Recognize signs of burnout in self and others, and identify stress reduction techniques
10.2	Demonstrate use of time-management and organizational skills
10.3	Identify resources to maintain personal health and well-being
10.4	Identify options and strategies to respond to abusive behavior directed toward direct-care workers by consumers

CONSENSUS DEFINED

Excerpted from *True Consensus, False Consensus* by Bea Briggs
Published in the Journal of Cooperative Living, Winter, 2001

The consensus process is a decision-making method based on values such as cooperation, trust, honesty, creativity, equality, and respect. Consensus goes beyond majority rule. It replaces traditional styles of top-down leadership with a model of shared power and responsibility.

The consensus process rests on the fundamental belief that each person/organization has a piece of the truth. Each member of the group must be listened to with respect. On the other hand, individuals/organizations cannot be permitted to dominate the group.

This is not to suggest that the consensus process presupposes or automatically confers complete peace and harmony within a group. In fact, in groups that are truly diverse, differences are both a sign of health and an invitation to creativity.

Consensus is not a panacea. It will not work in every situation. In order to invoke the power and magic of consensus, these main elements must be in place:

- Willingness to share power
- Informed commitment to the consensus process
- Common purpose
- Strong agendas
- Effective facilitation.

Procedure for Determining Consensus

In the consensus process, no votes are taken. Ideas or proposals are introduced, discussed, and eventually arrive at the point of decision. In making a decision, a participant in a consensus group has three options.

- To give consent. When everyone in the group (except those standing aside), says “yes” to a proposal, consensus is achieved. To give one’s consent does not necessarily mean that one loves every aspect of the proposal, but it does mean that one is willing to support the decision and stand in solidarity with the group, despite one’s disagreements.
- To stand aside. An individual stands aside when he or she cannot personally support a proposal, but feels it would be all right for the rest of the group to adopt it. Standing aside is a stance of principled non-participation, which absolves the individual from any responsibility for implementing the decision in question. Stand asides are recorded in the minutes of the meeting. If there are more than a few stand-asides on an issue, consensus has not been reached.
- To block. This step prevents the decision from going forward, at least for the time being. Blocking is a serious matter, to be done only when one truly believes that the pending proposal, if adopted, would violate the morals, ethics, or safety of the whole group. One probably has a lifetime limit of three to four blocks, so this right should be exercised with great care. If you frequently find yourself wanting to block, you may be in the wrong group.

Consensus decisions can only be changed by reaching another consensus.

Side by Side Comparison of Federal CNA and Hospice Aide Requirements

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
<i>Total Classroom and Supervised Technical Training</i>	75 hours	75 hours	75 hours A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours (no specific areas required). <i>See, 42 CFR §418.76(b)(2)</i>	
<i>16 hours of classroom training must precede any technical training/direct contact</i>		<i>At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:</i> <ul style="list-style-type: none"> • Communication and interpersonal skills; • Infection control; • Safety/emergency procedures, including the Heimlich maneuver; • Promoting residents' independence; and • Respecting residents' rights. <i>See, 42 C.F.R. § 483.152(b)(1)</i>	A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact and an initial orientation for each employee that addresses the employee's specific job duties. <i>See, 42 C.F.R. 483.100(vii)</i>	
<i>Pre-requisites for acceptance into training program</i>	None	None-left to state and individual programs	None-left to state and individual programs	
<i>Training program curriculum:</i>	Secretary shall establish requirements for the approval of nurse aide training and competency evaluation programs,	<ul style="list-style-type: none"> • Communication and interpersonal skills; 	<ul style="list-style-type: none"> • Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff. • Observation, reporting, and documentation of patient status 	

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<p><i>Training program curriculum:</i></p>	<p>including requirements relating to the areas to be covered in such a training program.</p> <ul style="list-style-type: none"> • Must include at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights 	<ul style="list-style-type: none"> • Taking and recording vital signs; • Measuring and recording height and weight; • Infection control; • Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; • Caring for residents when death is imminent; • Caring for the residents' environment; • Safety/emergency procedures, including the Heimlich maneuver; • Promoting residents' independence; • Respecting residents' rights. • Personal care skills, including, but not limited to: • Bathing; 	<p>and the care or service furnished.</p> <ul style="list-style-type: none"> • Reading and recording temperature, pulse, and respiration. • Basic infection control procedures. • Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. • Maintenance of a clean, safe, and healthy environment. • Recognizing emergencies and the knowledge of emergency procedures and their application. • The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property. • Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: <ul style="list-style-type: none"> • Bed bath. • Sponge, tub, and shower bath. • Hair shampoo (sink, tub, and bed). 	

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<p><i>Training program curriculum:</i></p>		<ul style="list-style-type: none"> • Skin care; and • Grooming, including mouth care; • Toileting; • Dressing; • Proper feeding techniques; • Proper feeding techniques; <ul style="list-style-type: none"> • Transfers, positioning, and turning <ul style="list-style-type: none"> • Maintenance of range of motion; <ul style="list-style-type: none"> • Assisting with eating and hydration; <p><i>Mental health and social service needs:</i></p> <ul style="list-style-type: none"> • Modifying aide’s behavior in response to residents’ behavior; • Awareness of developmental tasks associated with the aging process; • How to respond to resident behavior; • Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident’s dignity; and • Using the resident’s family as a source of emotional support. <p><i>Care of cognitively impaired residents:</i></p> <ul style="list-style-type: none"> • Techniques for addressing the unique needs and behaviors of individual with 	<ul style="list-style-type: none"> • Nail and skin care. • Oral hygiene. • Toileting and elimination. <ul style="list-style-type: none"> • Safe transfer techniques and ambulation. • Normal range of motion and positioning. • Adequate nutrition and fluid intake. <ul style="list-style-type: none"> • Any other task that the hospice may choose to have an aide perform. <p><i>See, 42 CFR §418.76(3)</i></p>	

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<p><i>Training program curriculum:</i></p>		<p>dementia (Alzheimer’s and others);</p> <ul style="list-style-type: none"> • Communicating with cognitively impaired residents; • Understanding the behavior of cognitively impaired residents; • Appropriate responses to the behavior of cognitively impaired residents; and • Methods of reducing the effects of cognitive impairments. <p><i>Basic restorative services:</i></p> <ul style="list-style-type: none"> • Training the resident in self care according to the resident’s abilities; • Use of assistive devices in transferring, ambulation, eating, and dressing; • Maintenance of range of motion; • Proper turning and positioning in bed and chair; • Bowel and bladder training; and • Care and use of prosthetic and orthotic devices. <p><i>Residents’ Rights.</i></p> <ul style="list-style-type: none"> • Providing privacy and maintenance of confidentiality; • Promoting the residents’ right to make personal choices to accommodate their needs; • Giving assistance in resolving grievances and disputes; • Providing needed assistance in getting to and participating in resident and family 		

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<i>Training program curriculum:</i>		<p>groups and other activities;</p> <ul style="list-style-type: none"> • Maintaining care and security of residents’ personal possessions; • Promoting the resident’s right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff; • Avoiding the need for restraints in accordance with current professional standards <p><i>See, 42 C.F.R. §483.152(b)(1-7)</i></p>		
<i>Approved Programs</i>		<p>The State—</p> <ul style="list-style-type: none"> • Must specify any nurse aide training and competency evaluation programs that the State approves as meeting the requirements of § 483.152 and/or competency evaluations programs that the State approves as meeting the requirements of § 483.154; and • May choose to offer a nurse aide training and competency evaluation program that meets the requirements of § 483.152 and/or a competency evaluation program that meets the requirements of § 483.154. • If the State does not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, the State must review and approve or disapprove nurse aide training and competency evaluation programs and nurse aide competency evaluation programs upon request. • The State survey agency must in the 	<p>Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse.</p> <p><i>See, 42 CFR 418.76(b)(1)</i></p> <p>A qualified hospice aide is a person who has successfully completed one of the following:</p> <ul style="list-style-type: none"> • A training program and competency evaluation • A competency evaluation program that meets the applicable requirements • A nurse aide training and 	

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		<p>course of all surveys, determine whether the nurse aide training and competency evaluation requirements of § 483.75(e) are met.</p> <p><i>See, 42 C.F.R. § 483.151(a)</i></p>	<p>competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.</p> <ul style="list-style-type: none"> • A State licensure program that meets the applicable requirements <p><i>See, 42 CFR 418.76(a)(1)</i></p>	
<i>Location of Clinical Sites</i>	None	Left to states	Left to states	Upon application and Department approval, “locked-out” nursing homes can serve as clinical sites for approved CNA training programs.
<i>Class size, student-to-instructor ratios</i>	None	Left to states	Left to states	Maximum class/lecture size 24. Lab 1 to 12. Clinical placement 1 to 8.
<i>Qualifications for instructors</i>		<p>The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;</p> <ul style="list-style-type: none"> • Instructors must have completed a course in teaching adults or have experience in 	Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or a licensed practical nurse under supervision of an RN, or by other individuals under	

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		<p>teaching adults or supervising nurse aides;</p> <ul style="list-style-type: none"> • In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and • Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/ hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields <p><i>See, 42 C.F.R. § 483.152(A)(5)(i-iv)</i></p>	<p>the general supervision of a registered nurse. <i>See, 42 CFR 42 CFR 418.76(b), (e)</i></p>	
<i>In-service training</i>	<p>The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for</p>	<p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—</p> <ul style="list-style-type: none"> • Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; • Address areas of weakness as determined in nurse aides’ performance reviews and may address the special needs of residents 	<p>A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the inservice</p>	

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	individuals providing nursing and nursing-related services to residents with cognitive impairments.	<p>as determined by the facility staff; and</p> <ul style="list-style-type: none"> For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. <p><i>See, 42 C.F.R. § 483.75(e)(8)(i-iii)</i></p>	<p>training provided during the previous 12 months. 42 CFR 417.100 (vii)</p> <p>At least 12 hours of in-service training during each 12-month period</p> <ul style="list-style-type: none"> Training may be offered by any organization, and must be supervised by a registered nurse. The hospice must maintain documentation that demonstrates the requirements of this standard are met. <p><i>See, 42 CFR §418.76(d)</i></p>	
<i>State Nurse Aide Registry</i>		<p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless:</p> <ul style="list-style-type: none"> The individual is a full-time employee in a training and competency evaluation program approved by the State; or The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual becomes registered. <p><i>See, 42 C.F.R. § 483.75(e)(5)</i></p> <p>A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—</p>	<p>A qualified hospice aide is a person who has successfully completed one of the following:</p> <ul style="list-style-type: none"> A training program and competency evaluation A competency evaluation program that meets the applicable requirements A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry. A State licensure program that meets the applicable requirements <p><i>See, 42 CFR §418.76(a)(1)</i></p>	

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		<ul style="list-style-type: none"> • Is a full-time employee in a State approved training and competency evaluation program; • Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or • Has been deemed or determined competent as provided in Sec. 483.150 (a) and (b). <i>See, 42 C.F.R. § 483.75(e)(4)</i> 		
<i>Abuse, Neglect Reporting, and Requirements</i>		<p>The facility must:</p> <ul style="list-style-type: none"> • Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. <i>See, 42 C.F.R. § 483.75(c)(1)(iii)</i> <p>The facility must not:</p> <ul style="list-style-type: none"> • Employ individuals who have been: <ul style="list-style-type: none"> (a) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (b) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. <i>See, 42 C.F.R. § 483.75(c)(1)(i-ii)</i> 	<p>The hospice must:</p> <ul style="list-style-type: none"> (i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator; (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all 	

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			<p>alleged violations must be conducted in accordance with established procedures;</p> <p>(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and</p> <p>(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.</p> <p><i>See, 42 CFR §418.52(4)</i></p>	
<i>Complaint and Discipline Process</i>	None	Left to states	Left to states	Same process as used with other health care occupations; article 15 of the Public Health Code.
<i>Renewal Process</i>		If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency	If there has been a 24-month lapse in furnishing services, the individual must complete another program before providing services.	

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		evaluation program or a new competency evaluation program. <i>See, 42 C.F.R. § 483.75(e)(7)</i>	<i>See, 42 CFR §418.76(a)(2)</i>	
<i>Competency Evaluation: Content</i>		<p>The competency evaluation must—</p> <ul style="list-style-type: none"> (1) Allow an aide to choose between a written and an oral examination; (2) Address each course requirement specified in § 483.152(b); (3) Be developed from a pool of test questions, only a portion of which is used in any one examination; (4) Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations; <p>and</p> <ul style="list-style-type: none"> (5) If oral, must be read from a prepared text in a neutral manner. <p>The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in § 483.152(b)(3) (see above). <i>See, 42 C.F.R. § 483.154(b)(1-2)</i></p>	<p>Must address: (1) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff; (2) Observation, reporting, and documentation of patient status and the care or service furnished; (3) Reading and recording temperature, pulse, and respiration; (4) Basic infection control procedures; (5) Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor; (6) Maintenance of a clean, safe, and healthy environment; (7) Recognizing emergencies and the knowledge of emergency procedures and their application; (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property; (9) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: Bed bath; Sponge, tub, and shower bath;</p>	

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			Hair shampoo (sink, tub, and bed); Nail and skin care; Oral hygiene; Toileting and elimination; (10) Safe transfer techniques and ambulation; (11) Normal range of motion and positioning; (12) Adequate nutrition and fluid intake; (13) Any other task that the hospice may choose to have an aide perform. <i>See, 42 CFR §418.76(c)(1)</i>	
<i>Competency Evaluation: Administration</i>		The competency examination must be administered and evaluated only by— <ul style="list-style-type: none"> • The State directly; or • A State approved entity which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid. The skills demonstration part of the evaluation must be— <ul style="list-style-type: none"> • Performed in a facility or laboratory setting comparable to the setting in which the individual will function as a nurse aide; and • Administered and evaluated by a registered nurse with at least one year’s experience in providing care for the elderly or the chronically ill of any age. <i>See, 42 C.F.R. § 483.154(c)</i>	<ul style="list-style-type: none"> • Numbers 1, 3, 9, 10, and 11 above must be evaluated by observing the aide’s performance of a task with a patient; the remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient. • Evaluation must be completed by a registered nurse in consultation with other skilled professionals, as appropriate <i>See, 42 CFR §418.76(c)(1-3)</i> A long list of conditions that disqualify a home health agency from doing the competency evaluation program for 2 years. <i>See, 42 CFR 418.76(f)</i>	
<i>Costs/charges to students for training</i>		No nurse aide who is employed by a nursing facility or offered employment may be charged for the training program or textbooks		

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		or other required course materials. <i>See, 42 CFR 483.152(c)(1)</i>		
<i>Provider's allowable costs and Medicaid reimbursement for training costs</i>		The State must provide for reimbursement of an individual's training costs for anyone who, within 12 months, completes training and the evaluation process and then goes to work in a certified nursing home. <i>See, 42 CFR 483.152(c)(2)</i> [In MI, the aide is reimbursed by the home up to \$675 (?) and then home's expense is reported in their annual cost report.]		
<i>Aide provides only Medicaid personal care services</i>	None	None	Before the individual (aide) may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish. <i>See, 42 CFR 418.76 (i)</i>	

CNA Training Enhancement Project

2nd DRAFT Team CHARTER

September 17, 2008

Name of Project: CNA Training Enhancement Project

Project Sponsor: LTCSS Advisory Commission, now. Initially, MI Direct Care Workforce Initiative

Team members: Organizations that formally support the concept of seeking state legislation to define and enhance Michigan's CNA training process beyond the current federal minimum training standards. See attached list. [Roles to be discussed]

Project Leaders: Jules Isenberg-Widel, Hollis Turnham [Roles to be discussed]

Decision (s) requested from the LTCSS Commission regarding:

1. Recommend that the state Legislature authorize the Michigan Department of Community Health to create a CNA training and registration program that is responsive to the state's long-term care needs and stop relying on federal minimum standards.
2. Authorize its Workforce Development Workgroup, with assistance from the Office of LTCSS, to convene a collaborative process of supportive and interested organizations and stakeholders **to fashion the needed legislative concepts, based on the recommendations proposed by MDCWI and other issues as they arise and to recruit and work with legislative champions for passage of the legislation.**
3. Review those legislative concepts as soon as they are developed for adoption and support for their enactment by the state Legislature and implementation by the Department of Community Health

Criteria to Support Decision Making (Known factors that must be taken into account, as well as others agreed upon by people involved in the decision.)

- The federal CNA training standards set "minimum" standards; Michigan cannot go beyond any of those requirements (76, not 75, hours of training, requiring criminal background checks of trainees, investigating complaints about registered CNAs for something other than abuse, neglect or financial

exploitation) require passage of a state law authorizing MDCH to implement those standards.

- The state legislation will not contain all the necessary details to fully implement a CNA training program but will define desired outcomes and framework and will authorize MDCH to complete all details (model curricula, registry operations, etc.) through a collaborative rule or guidance writing process with stakeholders.
 - While not the deciding factors, cost and the length of training must be considered in designing a new MI CNA training program.
 - Lots of different long-term care providers and hospitals recruit and/or hire CNA graduates. "CNA" is a recognized work credential among many employers.
 - Only Medicare and Medicaid certified nursing homes, county medical care facilities, and hospital long-term care units are *required* by federal law to hire CNAs.
 - Job seekers recognize "CNA" as a pre-requisite for many jobs in long-term care and other health care settings.
 - With the new federal requirements for Hospice organizations to receive Medicare and Medicaid funding, there is an opportunity to train people for both settings, to issue credentials to work in both nursing homes and hospices, and to meet federal training requirements for "aides" for both provider groups.
- Others.....

Working agreements/ground rules: Those developed by MDWCI with some adaptations

- Check personal agendas at the door
- One meeting conversation at a time - no sidebars
- Stay focused and committed to the purpose of the meeting
- Listen for understanding before reacting
- Strive for consensus
- Keep within agreed time frames
- Everyone is responsible for keeping the meeting on track
- All ideas are valued
- Be committed to being action and outcomes oriented and expedient
- Be patient, sensitive and respectful to the diversity of the meeting participants and their needs and interests
- Monitor your own "air" time

Objectives:

- Graduates will be well prepared for today's person-centered and person-directed caregiving.
- Employers will decrease their current on-the-job training expenses and turnover-related costs.
- The people served and supported by CNA graduates will experience improvement in the quality of those services.
- The State will have better information and resources to support quality CNA training programs and their instructors.
- CNA training programs and instructors will have better information and resources to provide high quality education.

Decision making authority: Recommendation to full Workforce Development Workgroup and then to LTCSS Commission.

State Legislature must authorize activities that exceed the federal minimum CNA standards.

State Legislature must authorize Hospice training program through the state CNA training program.

Decision making process: Consensus as defined by the LTCSS Commission. Attached.

Frequency and length of meeting: Monthly with conference calling abilities.

Draft Agenda – September 24, 2008
CNA Training Enhancement Project
1:30 – 3:30 p.m.

Community Conference Room B
Tri-County Office on Aging
5303 S. Cedar Street
Lansing, MI 48911
517.887.1440

Directions: You can take Cedar Street exit from I-496 (head south, 3-4 miles) or I-96 (head north, maybe one mile). This multi-function Ingham county building is near the corner of S. Cedar and Jolly Road. Use the north entrance, **Door #1** to the building for the TCOA suite of offices.

Conference call in numbers: Toll: 1-719-234-7853 **passcode** 245156

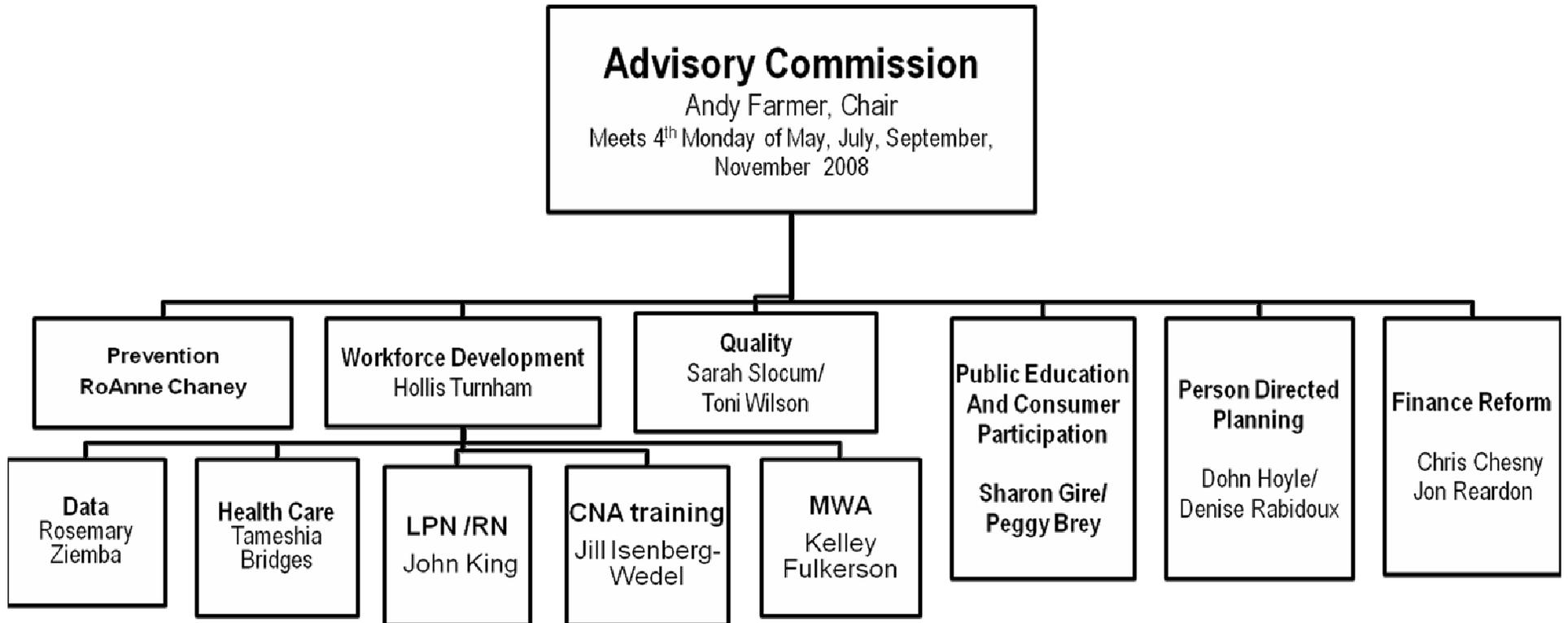
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| 1:30 p.m. | Welcome and introductions, particularly to the CNA approved training programs that are joining the effort |
| 1:40 p.m. | Review of draft Team Charter, take 2 [attached]; the revised Side by side comparison of CNA and Hospice requirements [attached]; and the new law student who will be aiding us – David Woods |
| 2:00 p.m. | Review of draft list of Competencies [attached] – reactions to the concept of framing legislation around this concept, what’s missing from the draft |
| 2:30 p.m. | Review of administrative recommendations [attached] – does your organization agree with this list of topics, what, if any, topics are missing |

3:00 p.m. Discussion of how to Structure work legislative concepts for both curriculum and administrative recommendations -- separate committees??, discussion as a whole??, which issues to tackle first?

3:20 p.m. Agreed action steps

Next meeting

LTC Supports and Services Advisory Commission Workgroups



For information about the Commission and its Workgroups, including agenda, minutes, handouts, go to www.michigan.gov/ltc

May 2008