
Committee Meeting

of

ASSEMBLY REGULATORY OVERSIGHT COMMITTEE

“Discussion of nursing home operations, quality of care, facility conditions, the role of the State government in ensuring the well-being of the elderly in nursing homes, and the shortage of health-care professionals”

LOCATION: Committee Room 8
State House Annex
Trenton, New Jersey

DATE: June 17, 2002
9:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman William D. Payne, Chairman
Assemblyman Joseph Cryan, Vice-Chairman
Assemblywoman Nilsa Cruz-Perez
Assemblywoman Connie Myers



ALSO PRESENT:

Assemblyman Craig A. Stanley

James F. Vari
Office of Legislative Services
Committee Aide

Gabby Mosquera
Assembly Majority
Committee Aide

Thea M. Sheridan
Assembly Republican
Committee Aide

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ASSEMBLYMAN WILLIAM D. PAYNE (Chairman): Good morning, everyone. We are here for a Regulatory Oversight hearing on nursing home operation in the State of New Jersey and those related issues.

One of the concerns that we have as legislators and as citizens of the State of New Jersey is that we should be able to and must provide adequate care for those in our society who are least able to take care of themselves. We should be able to care for those who cannot on their own provide for themselves or, perhaps, if their families don't. I think that one of the important things that this state has, and any society has-- A society is judged in the manner in which they treat their elderly and their young. I think that we want to make sure that here in the State of New Jersey that we are providing for people the very best way that we can, providing for their health and welfare and assume the responsibilities that we have to our citizens.

One of the concerns that I have had, and I think others also, is that from time to time we have heard about instances where persons who are clients or residents or patients in the long-term care facilities and others are not receiving the kind of adequate care that they need. One of the concerns I have is whether or not these facilities are being monitored, whether or not we have in place a structure that will see to it that these facilities that are licensed to care for our citizens are, in fact, carrying out their responsibilities in a way that they should. So we would like to be in a mode of prevention rather than correction. In other words, currently, I don't know of any major kinds of problems with any of our long-term care facilities. However, I don't want this Committee or this Legislature to wait until we have some major kinds of

scandals. I think it is very, very important for us to be proactive in order to prevent those kinds of instances from happening.

I have had a personal history in the distant past, maybe a decade or so ago, where one or two of the nursing homes that I had some familiarity with in the northern part of the state was engaged in what I thought was a rather negative behavior or providing insufficient services and care for their patients. And in fact, it was so egregious in an instance where in one of the nursing homes where the air conditioning wasn't working in the heat of the summer, and the patients were moved to another facility that was owned by the same group of people, and they were placed in this facility which was not able to accommodate them. There was no bed space for them. So, therefore, the patients were relegated to sleeping on the floor.

I happened to find out about it, and I visited the place and that was just the most egregious act that was going on there, perhaps. This was during a couple of administrations ago, at least. And also, this same group of people that owned this particular nursing home chain or establishment were also performing questionable kinds of fiscal practices. In other words -- I'm trying to be kind about it -- they were issuing payroll checks and telling their employees not to cash their checks for several days because there was no money to cover them. Well, I don't know whether or not those kinds of situations continue. I did report it at that time. I was not a member of the Legislature. I did report it, and I do believe that there was a follow-up.

Mr. Conroy is here, and he's going to testify about the State's responsibilities in this area. Mr. Conroy is from the Department of Health and Senior Services. All of us here and in the audience, I'm sure all of us have had

either relatives or a friend or someone who is or has been a resident in a nursing home or a long-term facility. So it impacts on all of us, and it's incumbent upon all of us to see to it that those of us who have positions of responsibility see to it that our relatives, our friends, our citizens are given humane kind of treatment.

I think the vast majority of these operators of nursing home facilities are doing a good job. All right. But I don't think that -- we simply cannot rest as long as there may be one that's not doing what it should be doing. So the reason for this hearing is not that we have heard of any kind of outlandish treatment of patients. One of the reasons for this hearing, too, however, is that we know that people who do the work, people who are the home-care workers, and people who work in nursing homes and those who visit the homes for health care are not paid adequately. We are trying to do something about that. I mean, these are people in our society who do work that none of us would want to do, and I think that they should be treated in a much better way than they are.

I've heard situations where some of the health-care workers are in a contract or have won health-care benefits, etc., etc., and then when it comes down for those premiums to be paid, they're not being paid by the owners, etc. So some of these people who do heavy work, hard work, lifting patients, bathing them, etc., doing things and caring for our relatives are, I think, in many instances not being adequately paid. I think there are ongoing efforts to improve that now, but we want to make sure that we do treat these people who are treating our relatives and friends -- we treat them fairly, so they will, in fact, be able to care for themselves. I mean, these people who work in these

nursing homes and have families themselves very often they are earning minimum wage and simply cannot care for their own. So we're going to discuss some of those things and see whether or not we can avoid some of the pitfalls that may come down the line.

Before I go any further, I'd like to introduce Vice-Chairman of this Committee, Assemblyman Joe Cryan, for any comments he may want to make.

ASSEMBLYMAN CRYAN: Good morning, Chairman. Good morning, everybody.

I want to do two things. First is, one, I want to apologize because I will be leaving here this morning. I serve on the Budget and Appropriation Committees, both of which have active agendas today as well. The primary concern of mine will be in the area of the ombudsman where we've seen complaints -- at least from the data that I've reviewed so far, triple in the past four or five years, and complaints verified, in fact, almost triple as well. So I'll be concerned in that area, as well as the areas of funding, especially given the other two Committees that we serve on. Chairman Payne also serves on the Budget Committee. I know that's an active area for him. He's been an advocate in the funding area for elderly care.

And lastly in this area of nursing home shortages, that we can better understand it, not only as individual legislators, but hopefully something that we can bring to a caucus and help resolve in those issues. So I thank each and everyone of you for coming. I apologize in advance for leaving and thank you all. I look forward to a good Committee meeting.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much, Assemblyman Cryan.

We will now hear from Mr. Bill Conroy from the New Jersey Department of Health and Senior Services.

WILLIAM CONROY: Good morning, Assemblyman. Thank you very much for inviting me. I don't know if you need a microphone in this room, but I'm trying to work the equipment here, and it seems to be on. (referring to PA microphone)

I want to thank you for inviting me. I want to also tell you that Commissioner Lacy sends his regrets. He had a conflict in his schedule and has an interest in this area. He's asked me to represent him today. I want you to know that I serve as Deputy Commissioner in the Department, and I'm responsible for the senior services that are administered in the Department of Health and Senior Services. I have about -- almost half of the employees are actually under the Health and Senior Services section of the Department, and it's a big chunk of it. It's almost 70 percent of the Department's operating budget goes toward senior programs. In fact, it's close to \$2 billion. About 40 percent of that comes out of State funds, and the rest is federal dollars coming into the programs. This includes not only nursing homes, but it includes PAAD, assisted living, medical day care, lifeline, and so forth -- the Older Americans Act funding.

The nursing home program is probably the biggest. I think it's, with the federal dollars coming in, it winds up being close to \$1.2 billion in reimbursement for the program. We also have roughly about \$15 million

coming in to do the inspections, and that's what you wanted to hear about today. That's what I'm prepared to talk about.

I'll speak briefly really just to give you an overview of what our Division of Long-Term Care System does. That's the division that responsible for overseeing quality in nursing homes. I'll describe to you a little bit about the process and the composition and the inspection teams, our findings in nursing home complaints, the enforcement actions that we take, and some of the connected or related issues around nursing home quality.

The Division of Long-Term Care System licences and surveys not only nursing homes but also residential health-care facilities, assisted living, comprehensive personal care homes, alternate family care, and adult medical day care. There are 839 providers in the State of New Jersey with the capacity to serve roughly 75,000 individuals. Of that 839, approximately 365 are nursing homes, 365, with roughly 52,000 beds.

We also license the administrators who literally run these facilities, and we also certify nurse aides. We make sure that they're qualified to perform services. And roughly, we have about 33,000 nurse aides certified in the State of New Jersey. Each and every year we have new people coming in. Moreover every other year, we have to recertify them. So at any given year, we're doing a lot of review and processing with nurse aides.

The majority of the division's activities are devoted to the inspection of nursing homes and the quality issues that surround it. We are also responsible for the enforcement of the standards and investigation of complaints. We have an aggressive program from monitoring and reporting to nursing homes. All of our surveys are unannounced. All complaints that are

filed with us are investigated. And under our contract with the federal government with the centers for Medicare and Medicaid, which was formerly known as HCFA or Health Care Financing Administration, we must report, and they hold us accountable for the funding that they give us and the responsibility we have in overseeing quality.

It's a rigorous inspection process in which every nursing home is inspected unannounced at least once on an average of every 12 months. In the intervals, surveys can vary from 9 to 12 months so we can maintain that statewide average of 12 months. It can occur at any hour of the day and any day of the week. The frequency is determined in part by the performance history of the home. A minimum of 10 percent of the surveys must be done on off hours, either before 7:00 a.m. or after 6:00 p.m. or on a weekend or a holiday.

Every surveyor is a health-care professional with specialized training in survey procedures. They're trained by protocols established by the federal government. Moreover, they must pass a certification, a federal exam, to prove their competency to conduct surveys. Their professional background is R.N., dietician, social worker, pharmacist. So it's a pretty diversified, multidisciplinary team. We have 12 survey teams in this state, and we have 21 complaint investigators to handle the volume.

We operate a 24-hour complaint hotline, and the number is 1-800-792-9770. We get consumer complaints and facility emergencies that are reported to us by the administration of a facility. In this current fiscal year, the Division received 2431 nursing home complaints. When we get these complaints, we have to triage them. The most serious ones we must get out

and investigate within two days, again, according to protocols established by the federal government.

Approximately one-third of all complaints allege some kind of harm to a resident or residents, and these are investigated as quickly as possible. As I described for you before, we have 21 complaint investigators. All of the investigations are conducted in a manner that's unannounced, and it's seven days a week at all times again.

In this fiscal year, we also, just in total, we've gone out and done 1790 inspection visits overall for standard -- that's combing standard surveys and complaints. When we look at it from a facility to facility basis, it winds up being roughly four and a half times a year we're in any given facility. That sort of matches the general average with the number of complaints filed on any given facility. It's about four for a standard 120-bed facility.

The complaint unit cited 664 deficiencies. And the distribution, when we find deficiencies, we also need to code them based on the scope and severity of the deficiency. Essentially what we found, and here's the distribution -- 13 percent of what we've gone out had no deficiencies. Three percent had deficiencies but were so nominal that they're classified according to the federal government as substantial compliance. The lion's share, 60 percent, had deficiencies, but again they're minimum. There's no actual harm to residents, but there was potential or they were building related. There are problems in their documentation and so forth, but there was no actual harm. And then the balance, we found problems either in an isolated manner or in some kind of pattern or widespread manner.

But essentially, three out of four facilities in the state, when we've gone out and looked, are operating with no problems in any kind of way. So that's an important finding.

ASSEMBLYMAN CRYAN: Bill, I'm sorry, how many deficiencies were there, 664? Was that the number?

DEPUTY COMMISSIONER CONROY: We've cited 664 during these complaint investigations.

We work with providers to improve the quality of care for nursing home residents. But when we have these deficiencies, depending on the scope and severity, we're responsible for doing enforcement. And the most simplest enforcement is to ask the facility to provide a plan of correction. We review that and then we are obligated to revisit the facility and make sure that they are, in fact, carrying out their plan. And then, it is staged upward, depending on the nature of the scope or severity of the deficiency, we can recommend a directed plan of correction. We can initiate civil monetary penalties. I'm prepared to give you information about that. We can recommend temporary management. We can curtail admissions. The most extreme enforcement action is revocation of license. Generally, we don't like to do that because we wouldn't want to uproot residents if the situation could be remedied with better management. If anything, we prefer temporary managers to come in.

ASSEMBLYMAN PAYNE: Let me ask you a question, please? The revocation of license is the most severe punishment or whatever. Let me ask you, on the complaints for physical abuse or sexual abuse, do we have an obligation to report these to the authorities? What happens when there are

complaints such as this, either a physical, mental, verbal, or sexual abuse? What happens then?

DEPUTY COMMISSIONER CONROY: I'm working the equipment again, but I think the room is small enough, you don't need the microphone. (referring to PA microphone)

When we have an allegation of abuse, we're responsible to go out and investigate that. We work in collaboration with the Office of the Ombudsman. The ombudsman is charged with investigation of abuse and neglect. So we work hand in hand. They refer to us. We refer to them accordingly. We have a nurse aide abuse registry that, again, was created in 1997 and, cumulatively, about 1000 individuals have been placed on that registry as a result of findings of abuse or neglect. The majorities of the findings -- and this is more anecdotal -- Bill Isele, our ombudsman, will be up to tell you in greater detail -- are, in fact, instances of neglect where they just didn't get to the resident on time, answer a call bell, get to them to help them move and then they fall and wind up getting hurt, that kind of thing. Also, many of the incidents are reported by the administration of the facility, so the facility wants to stay in compliance, and it wants it being a reflection of an individual worker within a facility.

In terms of the civil monetary penalties in this fiscal year, we recommended to the-- We recommend to the federal government because we are being contracted to provide federal survey. We recommended civil monetary penalties in the value of \$1.2 million, and the federal government looked at that and actually imposed \$700,000 in fines to 36 facilities, out of the 90 that we referred to the federal government. So the federal government

has an expectation that we're going to be active and make referrals, and I think these demonstrate it accordingly that we take that responsibility very seriously.

There's an overlap to some extent. We have State licensure and the capacity to do State enforcement. Where appropriate, we will cite on State deficiencies that are very specific that are not addressed by the federal government. Things like water temperatures -- in those instances, we've also recommended civil monetary penalties. A provider has an opportunity when we cite deficiencies to challenge them in an informal dispute resolution, and at that time they'll meet with the licensing and enforcement staff -- there's a panel that reviews that -- and they can determine whether or not the citation was appropriate and so forth. After that, the remedy for a provider is to litigate, and they can go to the OAL to have a hearing to see if they have an opportunity to have a full appeal on the deficiency.

We have a very active survey and certification program. The trend is that complaints have been going up. A lot of that, in my opinion, is based on some of the publications that have been made in the major media and some of the news reports on 20/20 and so forth. So there's general consumer -- more consumer awareness. The federal government also has asked each state to be more vigilant and make sure that there's more access to the State enforcement authority.

ASSEMBLYMAN PAYNE: Excuse me. I asked about criminal. For instance, I asked about when there are complaints of physical, mental, sexual abuse. Do we take criminal action? I mean, what happens or is the ombudsman going to answer that?

DEPUTY COMMISSIONER CONROY: Yes. The ombudsman will address that in greater detail. I'm aware, for instance, that in some instances the ombudsman is referred to the local prosecutor for criminal prosecution. In other instances, it has not been to that extent, but we've conducted our own internal investigation. We would again cite the facility, fine the facility, and make the facility address the problem in those instances where that occurs.

One of the paradoxes, though, you should know about taking enforcement on nurse aides-- Well, not just nurse aides, it's just in general enforcement. If a facility has a deficiencies, one of the federal requirements is that they have to suspend their training program to certify nurse aides. Again, this is a mandate. The nurse aides must be, under the federal rules, certified. They must have a 90-hour training course and pass tests. The way facilities recruit nurse aides is: We're going to train you. We're going to do it all in house, and you can get paid while you're getting trained. It's a manner in which a facility can make sure they have the appropriate number of staff and deliver the care.

With an enforcement, their program gets suspended, and they're no longer allowed to bring in new workers, potentially very good workers. It becomes a problem for the facility. So it's one of the paradoxes of the enforcement scheme under which we operate.

ASSEMBLYMAN PAYNE: Assemblyman Cryan.

ASSEMBLYMAN CRYAN: Bill, I have a couple of questions for you.

DEPUTY COMMISSIONER CONROY: Sure.

ASSEMBLYMAN CRYAN: I don't have your testimony. So I need to go back to some numbers.

DEPUTY COMMISSIONER CONROY: I apologize. I didn't have a chance to prepare formal testimony. I'd be happy to give you background information as I have a chance to clean it up.

ASSEMBLYMAN CRYAN: No, I just need some questions because my note taking is a little sluggish. We have 664 deficiencies, 75 percent of which you might categorize as minimum or less than substantial in some way, shape or form. What's the universe for that? Is it 365 nursing homes or is it the 839 that you went to originally?

DEPUTY COMMISSIONER CONROY: That's the 365. There are also, and I want to make sure-- I missed this, and this is an important statistic. That is a reflection of complaint inspections alone. Then there are annual surveys for the 365. And during annual surveys, deficiencies also get cited and coded.

ASSEMBLYMAN CRYAN: That's why the ombudsman numbers are different than yours.

DEPUTY COMMISSIONER CONROY: Right.

ASSEMBLYMAN CRYAN: That answers one of my questions. So, of the 365 nursing homes that fall under our purvey today, we have 664 deficiencies. If we drop the 75 percent, we're in the 120-some-odd range, whatever that number is -- 100 or so -- that are realistic complaints that need to be dealt with and whether they are criminal or whether they are others. Can you give for me some understanding of the 365 nursing homes, do we have

repetitive problems? I'm only talking about the serious ones? The 25 percent remaining, do we have continuing repetitive problems with those homes?

DEPUTY COMMISSIONER CONROY: We have had -- you can count them really on one hand -- the facilities that we've had problems with, and that goes back to the Chairman's opening remarks.

ASSEMBLYMAN CRYAN: Right.

DEPUTY COMMISSIONER CONROY: And what we've been trying to do now is if we see a relationship between the ownership, we start to look more closely at the ownership because what we've learned in our experience is that if one of the facilities starts to have problems, sometimes it's because they have shifted the moneys around to another facility. So we've tried to get a better grip on the overall operation of the chain, so to speak. But there really, it's just been a handful of facilities -- one or two owners who have had financial difficulties, for whatever their motives or reasons, they've had trouble operating. Fortunately, they've been selling their facilities and leaving the operation of nursing homes to the State.

ASSEMBLYMAN CRYAN: When then, through the Chair, can I ask -- I guess that's what we're interested in, right? Would that be a fair way to put it.

ASSEMBLYMAN PAYNE: I think so.

ASSEMBLYMAN CRYAN: Those are the-- I'd like to see a list of those. Through the Chair, I'll make that request.

Secondly, are there -- and again, the Chairman talked about criminal-type things with abuse and so on. Can you just summarize for me a little bit the actual types of complaints here? You touched upon it a little bit,

and skipping the water temperatures and things like that, what are the serious ones that we're really seeing out there? What's going on?

DEPUTY COMMISSIONER CONROY: Usually they stem from accidents or incidents of an unknown origin. So that's the way it gets reported. So, if something is suspicious, we go out there. Somebody has been neglected and has fallen and gotten seriously hurt. We have those incidences. You have elopements. That's another very serious problem, especially for the--

ASSEMBLYMAN CRYAN: What did you say? Could you say it again?

DEPUTY COMMISSIONER CONROY: Elopements.

ASSEMBLYMAN PAYNE: People walking off--

DEPUTY COMMISSIONER CONROY: Alzheimer's patients who've left the property, left the premises, and whether or not anything has happened to them, just in and of itself, the fact that they've eloped, is a serious problem because they're at such high risk for getting hurt. So we've had those instances.

The actual harms have to do with things like weight loss, with decline in functional capacity, where if somebody formerly was able to transfer, get from the bed to the bathroom and so forth. Independently, they've fallen, now they can't do it as well, and it's because, again, there was some accident and an aide neglected to get there on time when they were ringing the call bell. So you have those kinds of things. You have skin breakdown, weight loss, those kinds of measurable declines. But fortunately, they've been fairly few and far between. When you look at all the calls coming in, and we get every kind of call from missing laundry, missing eye glasses -- to serious.

ASSEMBLYMAN CRYAN: Two more, two last questions for you. The 664 complaints, is that 2001? What is that?

DEPUTY COMMISSIONER CONROY: The operating year?

ASSEMBLYMAN CRYAN: Yes.

DEPUTY COMMISSIONER CONROY: I believe it's in our current fiscal year, but let me double-check that from my notes. Yes, it's in this current fiscal year.

ASSEMBLYMAN CRYAN: Okay. So it's not quite completed yet?

DEPUTY COMMISSIONER CONROY: No.

ASSEMBLYMAN CRYAN: Is it through May, just so I understand it?

DEPUTY COMMISSIONER CONROY: I believe so.

ASSEMBLYMAN CRYAN: Okay.

ASSEMBLYMAN PAYNE: I saw reports up through maybe January, or at the latest, I saw January, I think. As you've said, it goes up through May?

DEPUTY COMMISSIONER CONROY: I've asked the staff to provide me with some current information. So I just had a chance to look, and I believe it's not noted, but I believe they are able to run it off with a federal computer system.

ASSEMBLYMAN CRYAN: If it's not May, then, through the Chair, please clarify that?

DEPUTY COMMISSIONER CONROY: I'll clarify it.

ASSEMBLYMAN CRYAN: And I guess I said two, but now I have one more on top of that.

DEPUTY COMMISSIONER CONROY: Sure.

ASSEMBLYMAN CRYAN: The 664, how do I -- I mean, I see the ombudsman reports -- how do I correlate 664 to previous years? Is it too high, too low? Is in the median?

DEPUTY COMMISSIONER CONROY: I'll have to get back to you with that. I don't know the trend. I know the general trend in terms of total referrals--

ASSEMBLYMAN CRYAN: Is up. Right.

DEPUTY COMMISSIONER CONROY: --has been going up like the ombudsman's. It's following more or less the same trend. And I believe, it's proportional. So it has -- just numerically it's gone up, because roughly one out of three are verified.

ASSEMBLYMAN CRYAN: If it's off proportion or somewhere where you couldn't infer from the ombudsman data if it will come up somewhere different, through the chair, I would ask if you could provide that.

And the last thing is that the 33,000 nurses aides. Just like I needed you to get me set on 365 nursing homes, could you get me set -- 33,000 nurses aides work where? Are they in the nursing homes, or is this a universe larger?

DEPUTY COMMISSIONER CONROY: They are in nursing homes. They're working in assisted living residences as well.

ASSEMBLYMAN CRYAN: Okay.

DEPUTY COMMISSIONER CONROY: And some are not working using the certification for this employment. In fact, we've seen a little bit of a downward trend in new enrollment, new applications, over the last year.

ASSEMBLYMAN CRYAN: And is that mirroring this overall problem that we have with the nurse shortages and so on? Is that a reflection of that?

DEPUTY COMMISSIONER CONROY: I would believe so.

ASSEMBLYMAN CRYAN: This recertification process that we have, in your view, is it the way that we do it -- and you did take the time to explain it -- is it acceptable in the way that we do it, or do we need changes there?

DEPUTY COMMISSIONER CONROY: I feel that it's an appropriate program in terms of the recertification. We have a criminal background check that's required, that's part of it. If anything, if we could -- it really doesn't interfere with quality, but if we administratively-- The faster we could turn it around, the better it is.

ASSEMBLYMAN CRYAN: But you're satisfied that the program itself works?

DEPUTY COMMISSIONER CONROY: Yes.

ASSEMBLYMAN CRYAN: Okay.

ASSEMBLYMAN PAYNE: Mr. Conroy, you said there's 33,000 nurses aides. What level of professionalism are they? What training do they have? And then also, you have -- does that include the numbers of certified nurses?

DEPUTY COMMISSIONER CONROY: It just includes -- no, it doesn't include professional nursing or LPN -- it is strictly nurse aide.

ASSEMBLYMAN PAYNE: What do they pay? What are their average salary?

DEPUTY COMMISSIONER CONROY: I'd have to get back to give you the accurate number, but I believe it's roughly-- I don't know. I think it's \$9 an hour. I think if you look at different parts of the state, it's actually sort of variable. I'd like to report back to you the accurate statewide average.

ASSEMBLYMAN PAYNE: Thirty-three thousand. What do we need? Does that represent a--

DEPUTY COMMISSIONER CONROY: Mathematically, if you just look at the number of facilities and bed capacity, there's an adequate number, just in and of itself, even with some who were not practicing. The problem is the match of where they reside and where the facility is located, and it becomes a transportation problem for some aides and some facilities. So that's a difficulty. It's one of the biggest ones. Then obviously, with the economy -- the last several years, the economy being strong, people were opting out of this work and getting other kinds of jobs. They were working in the retail sector rather than in health care. It's entry level, and you don't need to have an academic background. You come out and just get trained after high school.

ASSEMBLYMAN PAYNE: What is the starting salary? You said, the average is about what?

DEPUTY COMMISSIONER CONROY: It varies from facility to facility. In facilities, what they do is they try to get a handle on the competition so that they can stay afloat with the proper staffing. So, again, in northern New Jersey, it might be different than if you looked at--

ASSEMBLYMAN PAYNE: Give me some idea of what you think the starting salaries are in north Jersey, south Jersey?

DEPUTY COMMISSIONER CONROY: I think in some places they're offering \$11, \$12 an hour. Other places it's lower than that.

ASSEMBLYMAN PAYNE: Like what? How low?

DEPUTY COMMISSIONER CONROY: I have to get back to you. I really don't-- I haven't studied the wage issue for nurse aides.

ASSEMBLYMAN PAYNE: Okay. All right. Thank you.

Assemblywoman Cruz-Perez.

ASSEMBLYWOMAN CRUZ-PEREZ: Good morning, Mr. Chairman. My apologies for being late.

I can answer some of the question because I met with certified nurse assistants in south Jersey. Some of the salaries that, at \$7, if they're not trained, when they become certified, they were paid \$8, \$9 an hour, not \$11. I would love to know where, so I can send people there.

I have a question, and I don't know if you addressed that issue because I wasn't here. My apologies again. Do we know the ratios -- how many patients for-- You're talking about 33,000 nurse assistants in the State of New Jersey. Do we know how many patients per nurse assistant?

DEPUTY COMMISSIONER CONROY: Well, there's a minimum staffing requirement for nurse staffing. It's broken down between professional

staffing and the nurse aides. I believe the split is 80 percent can be nurse aide and the 20 percent is for professional staff, for LPN and RN, and then it gets adjusted based upon the clinical acuity of a resident. So, if they have special needs, whether they have decubiti, they need extra wound care and so forth, a facility will be allowed or be expected to provide additional staffing, and they would get reimbursement accordingly. It is not a straightforward-- It's not a ratio. It's more based on minimum number of hours. It's not a ratio of one staff member to X number of patients.

Facilities, depending on their situation, staff at different length. Some facilities staff to the minimum, some staff-- The majority don't. The majority staff over the minimum because they can't risk getting sued for problems in the facility, or they want to deliver good care, obviously. Many have exceedingly high staffing. And whether they have an endowment that allows them to do that, and-- Unfortunately, there is not as many that do that because of some of the fiscal issues that they have to deal with as operators. But it's not a straightforward ratio, it's based on minimum numbers of hours per patient per day.

ASSEMBLYWOMAN CRUZ-PEREZ: So we don't actually have, through the Chairman, we don't actually have anything that stipulates how many patients can one person handle?

DEPUTY COMMISSIONER CONROY: It winds up being you back into it based upon the hours, the standard for hours. I could give you the details of that if you'd like to look at it and to try to arrive at that number. But, you know, again, it's going to be, depending on the size of the facility and the configuration of the facility.

ASSEMBLYWOMAN CRUZ-PEREZ: Do we have any idea-- Can you give us an idea to say for us to be able to do a job and do it well and take care of a patient, how many patients one person should be handling, a nurse assistant for example? We don't have an idea?

DEPUTY COMMISSIONER CONROY: There's not any definitive science that says what is the absolute--

ASSEMBLYWOMAN CRUZ-PEREZ: Number.

DEPUTY COMMISSIONER CONROY: --guarantee for quality. I believe there have been some studies out that say if you drop at a certain level, then you're running the risk of problems, but it doesn't necessarily equate to good quality. I'm not familiar with all the staffing studies, but clearly that's a big issue and that's what is being publicized over the last year or two as staffing ratios. I might add that a facility that hires per diem staff -- you could have a lot more per diem staff than regular staff and the per diem staff because they don't know the patients. They don't know all their routines, and it's an activities of daily living type of scenario -- might not deliver the best of care compared to somebody who really knows the patient. So it winds up being more complicated. It has to do with retention, training, the quality of the work place, and definitely having assistants or workers.

ASSEMBLYWOMAN CRUZ-PEREZ: Okay. It is a problem. I was a certified nurse assistant in the state of Texas. But then I'm going in detail when the ombudsmen people explain to me this. So I'm going to wait for him to tell you why it is so important and why humanly possible, no one can take care of 10 or 12 patients a day -- a certified nursing assistant, there's

no way. I can tell you my own experience, but I'm going to wait until we go into this graphic so we can discuss it.

Thank you.

Thank you, Mr. Chairman.

ASSEMBLYMAN PAYNE: Thank you, Assemblywoman.

I know that you have another commitment.

DEPUTY COMMISSIONER CONROY: I do. I'll get back to you with this.

ASSEMBLYMAN PAYNE: Yes, okay, fine. If you concluded your testimony then, we thank you, and just keep in mind the requests that were made by Assemblyman Cryan.

DEPUTY COMMISSIONER CONROY: Thank you very much, Assemblyman. I appreciate it.

ASSEMBLYMAN PAYNE: Thank you.

Now we'll hear from Mr. William Isele, the Ombudsman for the Institutionalized Elderly. Give your name and title, etc., please, for the record.

WILLIAM P. ISELE: Chairman Payne, Committee members, ladies and gentlemen, good morning. My name is William P. Isele. I have the honor to serve as the New Jersey's Ombudsman for the Institutionalized Elderly.

ASSEMBLYMAN PAYNE: Just let me introduce Assemblywoman Connie Myers, of course.

ASSEMBLYWOMAN MYERS: Late as always.

ASSEMBLYMAN PAYNE: No. No one said that.

Thank you.

MR. ISELE: Since its creation by the Legislature nearly 25 years ago, the Office of the Ombudsman has had a threefold responsibility. First, to investigate and resolve and/or refer complaints of abuse and exploitation of individuals 60 years of age and older who reside in New Jersey's 1050 long-term care facilities -- and I'll get back to why that number is different than the one Mr. Conroy just gave you.

Secondly, to take action to secure, preserve, and promote the health, safety, welfare, civil, and human rights of elderly residents of these facilities. The first of those two is more reactive to complaints, the second is a proactive, as the Chairman indicated earlier, responsibility. And thirdly, to promote, advocate, and ensure as a whole, and in particular cases, both the adequacy of care received and the quality of life experience by elderly residents of those facilities, so a more global responsibility -- that we have to see to it that the quality of life experienced by individuals in our long-term care facilities is an appropriate one.

Our jurisdiction extends beyond simply those facilities regulated by the Department of Health and Senior Services. It does extend to elderly residents of nursing homes, assisted living residences, and programs in residential health-care facilities, which Mr. Conroy mentioned, and I believe the number of those he gave you is 839. In addition, our jurisdiction extends to veterans' homes, specialized hospitals, chronic disease hospitals, psychiatric hospitals, adult day care facilities, and most recently, adult family care homes, as well as the government agencies that regulate and inspect all of these facilities. Some of them fall under the Department of Health and Senior Services, some under the Department of Human Services, some under the

Department of Military and Veterans Affairs. So we have a fairly wide scope, wider, indeed, than the Department of Health and Senior Services and that is why, in response to Assemblyman Cryan's question earlier, our numbers are somewhat different.

In the nearly 25 years that the office has existed, long-term care has changed in a number of ways. Today, nearly 70 percent of all nursing home residents are eligible for Medicaid, the State federal program that provides health care to the poor. Eighty-five percent of nursing home residents have no living spouse. Fifty percent have no adult children. More people than ever before are relying on strangers to provide care in the autumn of their years. Assisted living facilities have grown from only 11 in 1995 to nearly 200 today. Many of the active healthier elderly who might have resided in nursing homes 10 years ago live in assisted living facilities today, leaving a sicker, more debilitated population in our nursing homes.

Developments in medicine over the last quarter century have extended all of our life expectancies. Overall, this is a good thing. But in individual cases, the ability to prolong the dying process does raise serious ethical questions. In 1985, the New Jersey Supreme Court gave the Office of the Ombudsman the responsibility of overseeing the process of end-of-life care decision-making in long-term care.

My work and that of my excellent investigative and support staff brings us face to face with these realities on a daily basis. I provided for you today a series of charts that I think will illustrate the work that we do. We've all heard the expression, a picture is worth a thousand words. So to keep my testimony short, I brought you some pictures.

The first chart identifies the number of cases we've opened each year for the last five years. As you can see, the number of cases has almost doubled since Federal Fiscal Year 1997. Now each case or each investigation that we open may consist of one or more complaints. The second chart illustrates the total number of complaints received over that same five-year period and indicates also the number that were verified or substantiated after investigation. As you can see, not only has the number of complaints tripled over that five-year period, indicating that we're handling more complex cases, but also the percent verified has increased. We were verifying about half, back in 1997. Today we verify almost two-thirds of the complaints we investigate.

What sorts of complaints do we investigate? Because we are funded, in part, by Title 7 of the Federal Older Americans Act, we must report annually to the Federal Administration on Aging in a format designed by them. This format requires us to identify complaints in 17 broad categories, which, in turn, in that report are broken down into 153 more specific subcategories.

Your third chart shows the number of complaints we investigated in each of the 17 broad categories in Federal Fiscal Year 2001. As you can readily see, the largest single category is neglect and care issues. The subcategories in this category comprise such items as falls, response to call lights, adherence to care plans, personal hygiene, pressure sores, toileting, and incontinent care, and the care of feeding tubes and catheters. These are the items that are most directly and severely effected by staffing shortages.

Finally, I'm sure that you are most concerned as I am about intentional abuse of the elderly. The good news here is that verified instances of abuse are comparatively few. If you look at the final chart, you will see that

of the 6900 complaints we received last year, 652, or less than 10 percent, were of physical abuse. Of these, our investigations verified only 147. Now, please, don't misunderstand me, that is 147 too many. We are working vigorously to be able to assure residents and potential residents of long-term care that no abuse whatsoever will be tolerated.

I appreciate the opportunity to testify here today, and I'm happy to answer any questions that you may have.

ASSEMBLYMAN PAYNE: Thank you, Mr. Isele.

I want to introduce Assemblyman Craig Stanley, who is the Chairman of the Seniors Issues Committee, who is joining us today for this hearing.

First, I have Assemblywoman Cruz-Perez -- would like to ask some questions.

ASSEMBLYWOMAN CRUZ-PEREZ: Yes.

I asked the previous person to explain to me how many nurse assistants we have per patient, and he was unable to tell me. Do you have any idea by the complaints that you get, if the people will tell you that-- If you have any idea what the number is?

MR. ISELE: Assemblywoman, it varies all over the lot from 10 to -- we've seen as high as 60 individuals being the responsibility of 1 nurse aide. That, of course, is an extreme situation, but it really varies all over the lot.

ASSEMBLYWOMAN CRUZ-PEREZ: That's why most of the cases are neglect care issues, and the reason is because we have so little staff to take care. I don't know if we have here present someone who will be a nurse assistant with us in here today. Okay. Are you planning to testify?

UNIDENTIFIED SPEAKER FROM AUDIENCE: I guess so.

ASSEMBLYWOMAN CRUZ-PEREZ: Okay, good. Because I want to tell you that when she's testifying, the experience that I had. I did want to provide good and quality care. I treat the person like they were my own family. There's no way that someone can take care of 10 patients and do it right. There's no way. I hear cases, 12, 13. I was meeting with a nurse assistant who told me I have 14 patients, who I have to do everything for them on a daily basis. There's no way you can go back to the first patient and turn that patient around when you're bathing the last one at 3:00 or 4:00 in the afternoon.

MR. ISELE: I absolutely agree with you.

ASSEMBLYWOMAN CRUZ-PEREZ: So ratio is the issue. Shortage in staff is the staff. We should put some kind of numbers to decide how many patients can one person handle.

The Committee -- maybe, Mr. Chairman, you want to take one day, find a nursing home that will allow us to go and walk through. For you to understand what a nurse aide does on a daily basis is a different duty from the LPN and the registered nurse. The nurse aide does everything for that patient. So I don't understand how can we allow, in the State of New Jersey, to have one person handling 10, 12, 16 persons a day -- humanly impossible.

Thank you.

ASSEMBLYMAN PAYNE: Thank you.

I'm sure you have some comments to make following the Assemblywoman's comments.

MR. ISELE: There is no question that there is a shortage.

And Assemblywoman, I can tell you that I have personally gone out to nursing homes, when we've received complaints. I remember in particular one I went to on a Sunday, a 120-bed nursing home where I found three aides on duty. Do the numbers. It's 40 individuals per aide.

ASSEMBLYWOMAN CRUZ-PEREZ: A scary situation.

MR. ISELE: It's scary. It is scary.

ASSEMBLYWOMAN CRUZ-PEREZ: A very scary situation.

MR. ISELE: Fortunately, those kinds of situations, as I say, are extreme. Forty or 60 people per 1 aide are extreme. The kind of situations that you're describing, 10, 12, 14, is far more common.

ASSEMBLYWOMAN CRUZ-PEREZ: It's unacceptable. If you ask me, unacceptable. That's why we have so many accidents. You're rushing someone to actually take care of someone. You're trying to feed someone -- you're not going to tell the person hurry up and eat so I can go feed the other patient.

MR. ISELE: Let me give you an example that we see fairly frequently. A person may be indicated on their chart as a two-person lift. A two-person lift means to be moved from the bed to the wheelchair it takes--

ASSEMBLYWOMAN CRUZ-PEREZ: Two persons to do it.

MR. ISELE: --two aides to move that person. Very frequently, we are called out on situations where a person has been dropped during the course of a lift and has sustained a fractured hip or a fractured leg because the aide tried to do it herself, because she couldn't find someone else to assist her at that time. Those are fairly frequent calls that we get.

ASSEMBLYMAN PAYNE: I think that many of the aides injure themselves doing this. I think there are aides that are working who have bad backs or injuries, etc., as a result of this.

MR. ISELE: Sure. Absolutely.

ASSEMBLYMAN PAYNE: For instance, you said that you'd gone out, I think, on a Sunday and find three aides for 100-and-some folks. How do we monitor that? I mean, whose responsibility is it to see to it that that kind of ratio does not exist? I mean, who has responsibility for that? Is it -- not your job?

MR. ISELE: Well, ultimately, it's the responsibility of the administration and the owners of the facilities to make sure that they're appropriately staffed. If we find that they are not, then our obligation is to refer it to the Department of Health and Senior Services to take -- to find deficiencies and take some sort of licensure action.

The State regulations requires, as Mr. Conroy said, and at the risk of repeating what he said, the State regulations require a certain number of hours of care per day for each individual in a nursing home. Those hours are adjusted by acuity. The base number at the present time under State regulations is 2.5 hours of nursing care contact, and that includes both nurses and nurse assistants/nurse aides 2.5 hours a day. That's adjusted up by acuity. If the person is on a ventilator, if the person have bed sores that need care, all of those are ratcheting up of that 2.5 hours.

ASSEMBLYMAN PAYNE: Do you find in your position that there's adequate monitoring by those who are responsible for monitoring this? These things come to light by maybe a relative visiting sometimes or-- Is there

a sufficient, ongoing monitoring of these facilities, number one? Number two, and the licenses, what goes into licensing a facility?

MR. ISELE: Number one, I believe there is adequate, ongoing monitoring. As Mr. Conroy testified earlier, there are not only routine annual surveys done, but also complaint surveys done by his department. In addition, of course, we go out on complaints. My investigators go out on complaints on a routine -- on a daily basis and at all times of the day, every day of the week.

The problem -- and I don't know that there's an easy solution to the problem -- the problem is in terms of numbers of people to do these jobs. We could require -- and I think it would be wonderful -- if we required a ratio of five-to-one or three-to-one. How marvelous that would be, one-to-one would be great to get one-to-one care. Unfortunately, there are not sufficient--

ASSEMBLYMAN PAYNE: Excuse me. Let me interrupt you. Is your red light on there? (referring to PA microphone)

MR. ISELE: No, sir.

ASSEMBLYMAN PAYNE: Please.

MR. ISELE: I'm sorry.

ASSEMBLYMAN PAYNE: Go ahead.

MR. ISELE: Okay. There are not sufficient nurses and nurses aides to make those kinds of numbers. We're talking just in terms of nursing homes, Mr. Conroy said there are 52,000 beds. That would mean we would need for three shifts a day. Again, it's not just 52,000 staff for 52,000 people. It's three times that, because you're working with three shifts a day. What we really need to do is to encourage more people to come into the profession. And

it is a profession. It is not a minimum wage job by any stretch of the imagination.

ASSEMBLYMAN PAYNE: I'm sorry.

Assemblyman Craig Stanley.

ASSEMBLYMAN STANLEY: Thank you. And let me just commend Chairman Payne for conducting this hearing. This is an issue that is extremely close to myself. I had the misfortune, I guess, of having my father having to go into a subacute -- an acute care facility and then and subacute care facility. I noticed the differences. I noticed the understaffing of the institutions that he was placed in. And if I noticed it and if it happened to someone who is, I guess, somewhat in a position where people would take more care to ensure that the proper type of care was given because of the position I hold. I don't that's fair or right. It's just something that happens in the course of interacting with people.

I know that the average person who has a loved one in a facility like this or in a facility where they're totally dependent on the care given by others for their loved one it's a very difficult situation when you see that there isn't enough staffing, there isn't enough attention being given.

One of the things I just wanted to get clarity on is the 2.5 hours per day care or hours per care per day, I guess, minimum or threshold. I would think that just doing some simple math that if you have to have or that you're required to have 2.5 hours of care per day that the maximum number of people that you could have would be three, unless you're an individual caregiver, unless you give care to two people at one time, which I don't know whether

that's possible or if that's what's meant under the regulation. Can you give a little clarification on what that means?

MR. ISELE: Again, those are the Department of Health and Senior Services regulations. So with that caveat there, they're not my regs. But since I do deal with them on a daily basis, that 2.5 hours per day equates out to less than an hour per shift. So an individual on a-- Again, doing the math, an individual on an eight-hour shift would be able to deal with eight individual, or perhaps 10 individuals, if he did it by a strictly mathematical equation.

ASSEMBLYMAN STANLEY: Okay. So it's not 2.5 hours per shift.

MR. ISELE: No, sir. It's per day.

ASSEMBLYMAN STANLEY: It's for 24 hours.

MR. ISELE: Right. And that's the minimum. Again, that's adjusted according to acuity of the patients in the facility.

ASSEMBLYMAN STANLEY: Okay. And there aren't any guidelines as to when that care would be given, or does it get into any other detail in terms of, like, for instance, I guess, if a patient is awake they would probably need more care during that first or that eight-to-four shift or maybe between eight-to-eight hours or something like that -- 8:00 a.m. to 8:00 p.m.

MR. ISELE: Certainly, the facilities are more heavily staffed during the waking hours, if you will, during the eight-to-eight period than they are at night, yes.

ASSEMBLYMAN STANLEY: How much detail is there for direction as they're given by the Department of--

MR. ISELE: Department of Health and Senior Services.

ASSEMBLYMAN STANLEY: Department of Health and Senior Services, right.

MR. ISELE: The regulations are fairly specific. I don't have them in front of me, but more in terms of the adjustments for acuity and the types of needs that need to be adjusted for.

ASSEMBLYMAN STANLEY: Thank you.

MR. ISELE: Okay.

ASSEMBLYWOMAN CRUZ-PEREZ: Does anybody else have a question?

Okay. Thank you so much.

MR. ISELE: Okay. You're very welcome.

ASSEMBLYWOMAN CRUZ-PEREZ: Now we're going to have Mr. Paul Langevin -- I hope that I haven't killed your name -- President of Health Care Association of New Jersey.

I'm sorry, what's your last name again?

PAUL R. LANGEVIN JR.: Langevin.

ASSEMBLYWOMAN CRUZ-PEREZ: Langevin. Okay.

MR. LANGEVIN: Good morning, Madam Chairwoman, members of the Committee. I want to thank you for the opportunity to appear today on behalf of the Health Care Association of New Jersey, our membership of 285 facility-based, long-term care providers.

Let me call your attention to the packets which I'm having distributed to you now, because many of the things that you have been asking questions about, I think, are answered in the handout I'm giving you. First,

this glossy piece here has a lot of information about nurse aides, the number of professional nurse, and so forth, per patients, where we stand, vis-à-vis, staffing ratios in the state and so forth.

The next piece, which says Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, is actually the first -- about 30 pages, I guess -- the executive summary. Twenty-one pages of what is nearly a 1000-page report recently completed and distributed in December. It talks about how many staff, what's appropriate, how quality increases as you increase the number of staff, and what that will cost. So this is really a very shortened version, but it will give you an idea of the information that's in there. The last piece is a report on general liability and professional liability actuarial analysis done by the Aon Risk Consultants. It has to do with long-term care, and I included in there because I think there's some very important notes and conclusions in there to take away from today's hearing.

And before I move on, I did a back-of-the-envelope calculation. If you had a 120-bed facility in New Jersey and you had your average patient requiring no more than two-and-a-half hours of certified -- that's CNA and/or professional nurse care per day -- it would be a staffing ration of around one-to-ten or one-to-twelve. So, if you look at that number, that's with a CNA. Then you also have an LPN, an RN, and other licensed and uncertified individuals that might deliver care to that person. But that's the rough back-of-the-envelope calculation.

First, I would like to acknowledge the State's commitment to long-term care. This is, as you all know, a very difficult budget year. Governor McGreevey has proposed level funding for Medicaid nursing facilities in State

Fiscal Year 2003. And while we acknowledge this commitment to the 29,000 Medicaid beneficiaries in New Jersey, we are compelled to note that we in New Jersey still hold the unenviable distinction of having the largest discrepancy between what we spend to care for our elderly in long-term care and what we pay those dedicated providers who deliver that care. We lose an average of \$21.11 per patient per day in a New Jersey nursing facility. That was a systemwide shortfall of \$236 million last year. That's the difference between what we pay and we report to the State versus what we get back from the State for caring for patients.

We're going to hear, I'm sure, today, knowing from some of the faces in the room, that we need to increase nurses pay, staff-to-patient ratios, in order to improve the quality. Long-term care professionals realize that there is a direct relationship between high-quality care and staffing. However, nursing facilities already pay for almost one full hour of nursing care per patient per day more than the Medicaid program pays them. Forty percent of the cost of care in the Medicaid program is for nursing care. Merely increasing staffing requirements without providing the resources to recruit, train, and retain those nurses and nurse aides will do nothing for the quality of patient care. It is estimated that changing to a minimum staffing requirement of 4.1 hours per day, that's up from the current 2.5 hours, would cost between \$11.28 and \$12.3 billion nationally. Are we as a State willing and able to pay? It is unlikely in Fiscal Year 2003.

So what can we do? Well, New Jersey has one of the most stringent regulatory programs in the country with long-term care providers receiving a visit from state surveyors on an average of four times a year. We

have an aggressive complaint investigation program. You heard 21 surveyors to cover the health-care facilities in this State and an ombudsman office to ensure that consumers have easy access to resolve problems and complaints. There's an 800-number posted prominently throughout all the nursing facilities in the state to file complaints and call the ombudsman. And we believe when it comes to regulatory tools, New Jersey has a full set.

Before we embark on another round of regulatory reforms increasing the size of the stick, if you will, and before we pump additional dollars into the system increasing the size of the carrot, we have to look at where those funds will be spent. The cost of general and professional liability insurance has skyrocketed. Many of our members have experienced a 100 percent to 500 percent increase in their insurance premium in one year without one major claim filed against them. If we look at the state of Florida, the long-term care infrastructure there has been severely challenged by ongoing frivolous litigation. In fact, one of the largest nursing home providers in the country has sold all of their facilities in Florida and left the state, just for this very reason.

The result of this litigation is that these lawsuits and the resulting insurance premium increases have consumed 70 percent of the Medicaid rate increase in Florida between 1995 and 2000. What does this mean? The government dollars meant for patient care are being spent on lawsuits and settlements. We must enact significant and meaningful tort reform in New Jersey so that when we do have the money to invest in the system it goes to the patients and not the legal system.

There's a lot of good news in the long-term care profession which, unfortunately, never makes the front page. The level of commitment of nurses and other direct patient care staff is unquestioned and well-known. However, there are many unsung heroes and a cadre of volunteers around our state who visit nursing residents every day. They have a huge impact on the quality of life but receive little public recognition. I recently had an opportunity to attend a service recognizing 50 dedicated volunteers at one of member facilities. It's the Seacrest Village in Little Egg Harbor. The leading honoree of that day was recognized for providing 9117 hours of volunteer time in service to the residents. That's for free. These are the contributions that make the difference to residents and their families. I know, earlier, Bill Conroy talked about making a difference by knowing who the people are what their needs are. I think that's where volunteers play a huge role.

We all want to make the health-care system better, but in these difficult financial times, we will have to find creative ways to accomplish our goal. More money and a bigger stick alone won't get the job done.

And in the interest of time, I will close my formal testimony at this point. As I said, I have included two national studies in your packets, and I'd be happy to take questions from the Committee.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

Do we have any questions? (no response)

I just have a comment.

MR. LANGEVIN: Sure.

ASSEMBLYMAN PAYNE: It's just that we keenly aware that there are a lot of people who are doing very positive things. As I said earlier, I think everyone of us in the room have had people, relatives, friends who have been residents of long-term care facilities. We do recognize and notice that there are many people who are working above and beyond what they need to. I think the bottom line is that we're not looking to throw money at a situation. I don't think that's necessarily the solution, but we just want to make sure that what is ongoing now is monitored correctly. We want to make sure that what we have is being utilized most effectively and efficiently and also to recognize not only that there are volunteers out there -- and I think that's great that we do have people that are participating as volunteers -- but also to recognize that those people who are working, doing that hard work are recognized, not only by certificates and awards but also by trying to see to it that they are sufficiently compensated for the kind of work that they do. Certainly, all of us depend on folks who are being paid some low wages for doing some very, very critical work to our loved ones. That's what we're looking for. We're looking not to cause any kind of a stir here, but we certainly want to make sure. As I said, before, we want to be proactive. We want to make sure that we do not end up with a debacle that we could have avoided.

MR. LANGEVIN: We, Mr. Chairman, just as a point of clarification, we in the long-term care community are actually staffing right now. The cost reports based on payroll would reflect this. We're staffing to about 3.4 hours per patient per day now. So we're well above the minimums that are already required in the law. Again, one of the reasons you don't get paid for that is because the law doesn't require it. If you were to actually

increase requirements in some areas, that would actually, in some ways, benefit providers because they'd end up getting paid for what they don't get paid now.

One thing that we are very concerned about, however, is that we mandate something at a level which has a relatively small improvement in quality but basically would put the entire long-term care provider network in violation of the law. Because if we were to go out right now and try and find RNs, LPNs, and certified nurse aides to work in long-term care facilities at 4.1 hours per patient per day or higher, the people just aren't there. We hear a lot about the nursing shortage. Well, the average age of a nurse is 44 years old, one who is working the system now. Unfortunately, the new people coming in that are under age 30 is a very, very small percentage. That's even scarier than the increasing age of the average nurse working. And so, I think there's a lot of things that we will have to look at before we move on and mandate something. I appreciate your sensitivity to that issue.

ASSEMBLYMAN PAYNE: Thank you.

MR. LANGEVIN: Thank you.

ASSEMBLYMAN STANLEY: I have a question, Mr. Chairman.

ASSEMBLYMAN PAYNE: Assemblyman Stanley.

ASSEMBLYMAN STANLEY: Thank you.

You say that your staffing today at 3.4 hours per day, and when you say we are, you're referring to whom?

MR. LANGEVIN: Collectively, the long-term care community. Those are numbers that come out of the cost reports that are filed by law by the nursing facilities in the state.

ASSEMBLYMAN STANLEY: Okay. I mean, but the 2.5, that's for basic service. That doesn't include like the higher-- Like you said, it depends on how acute the particular individual is or the type of facility or the type of care each person needs, right?

MR. LANGEVIN: Well, actually, if you looked at the regulations and you took your plain vanilla nursing facility resident with no other notable problems that they would get an enhanced level of care for, they don't have a catheter, they're not on a respirator, or wound care. If you add all those things up, you're still well under three hours statewide on what would have to be delivered by law, and we're already delivering 3.4. So we're well above the minimum requirements as a group, collectively, in the number of nursing hours that we provide to long-term care residents. So increasing it, even by an hour, is -- we're already there.

I mean, the problem is you can't find people. It was alluded to earlier. If you have deficiencies, one of the reasons you staff well above a level that you get paid for where you spend money, if you're a for-profit entity and you're staffing in an hour more than you need per patient, that's profit. Long-term care providers are more than happy to pay that because they have a license at risk. They know there is 12 survey teams ready to come out when somebody calls up and says, "I don't like the care I got." There our customer. We need to deliver what they want. The State is only a short drive away from any nursing facility. So you do that to protect your own license. So we're already doing that now.

ASSEMBLYMAN STANLEY: The other question that always seems to come up, if the reimbursement-- From what I understand, you say

you're currently experiencing a systemwide shortfall of \$236 million. You experienced a systemwide shortfall of \$236 million last year. How is that \$236 million made up, or does that mean that the nursing -- that these facilities lost money last year? I don't understand. How do you deal with the \$236 million shortfall?

MR. LANGEVIN: Well, actually we're down several facilities. We had, I believe, eight bankruptcies last year. Our largest member, which is a public company, just came out of Chapter 11 last December. There's a lot of consolidation. We've probably lost over a thousand residents per year for the last two-and-a-half years in the Medicaid program going out to other alternatives, such as assisted living, which is not supported by the Medicaid program to any large extent. There's only 1500 slots. Essentially, the system is downsizing and people are losing money.

The amount of cash on hand in a facility is going down. The age of the payables, that's how quickly you pay the vendors who you buy things from, that is going up. So basically what's happening is people are not in as sound a financial situation as they were. Some are choosing to get out of the business.

ASSEMBLYMAN STANLEY: Do we have sufficient beds right now?

MR. LANGEVIN: Right now, we do, yes.

ASSEMBLYMAN STANLEY: All right. Thank you.

MR. LANGEVIN: Thank you.

ASSEMBLYWOMAN CRUZ-PEREZ: Thank you very much, Mr. Langevin.

The next person is Neal Gorfinkle from SEIU, 1199. Thank you.
Good morning. Thank you for coming.

NEAL GORFINKLE: Thank you for holding this very important hearing. I regret the fact that I found out about it late.

We normally much prefer to have some of our certified nursing assistant members address some of these issues directly themselves because often hearing directly from caregivers is the most dramatic way to appreciate the seriousness of the problem that we're facing here. This really is a serious crisis that we're facing in the nursing home industry.

A lot of the elements of the crisis have been addressed already. One is the issue of short staffing. A lot of discussion has taken place so far about the 2.5-hour per patient day standard in New Jersey and even the fact that the nursing homes are staffing a bit above that. The studies that have been done on a national level show that this 2.5-hour per patient day standard is about 40 percent below what's recommended in terms of providing quality care, plus the fact as Assemblywoman Cruz-Perez addressed earlier, this standard is an average and there is no enforceability. You can walk into a nursing home, and so many times I've heard our members particularly on the evening or the night shift say that because they're already short staffed and somebody calls out, one certified nursing assistant is left to cover a whole floor of 30 or 40, or sometimes I've even heard 60 patients. There is no way currently to enforce anything about that except to look at the reports turned in and see if over a period of time the average is not lived up to. But there's no enforceability on -- and this is also in response to question that

Assemblyman Payne raised earlier -- there is no way to enforce a regulation that doesn't exist.

One thing that we've been pushing very hard for is a hard and fast enforceable clear patient-to-worker ratio so that that can be enforceable. As many of you know, we've embarked on, I guess, it's been about four or five months now, on a statewide campaign -- I'm wearing the button here (referring to button on lapel) -- the campaign to fix New Jersey nursing homes. We start from the standpoint of the fact we represent about 7000 nursing home workers around the state. But we also know that there's no way to solve that problem by ourselves, so we've developed a campaign to -- in partnership now with over 100 organizations, with now the majority of the State Senators and Assemblypeople who have signed on in support. We've had events. We actually have issued, I think, 11 reports county by county or area by area around the state, and Assemblyman Stanley was with us in Essex County. Assemblywoman Cruz-Perez was with us in Camden. We had nine other of those reports as well demonstrating the lack of quality care in many, many nursing home throughout the state. We need to come up with a plan to address this serious problem.

There are about, I guess, three recommendations that we've come up with that have to be taken care of, have to be responded to, in order to begin to solve this problem. One is the issue of safe staffing. We absolutely need to come up with staffing standards, staffing ratios. The recommendation we've come up with initially is to at least convert the current requirements, the 2.5 hours per patient day, convert that to ratios, so that we know where we stand. We know it's going to be somewhat expensive to improve that. We

understand, as the providers have said -- as Mr. Langevin said -- that there's a serious gap between the amount of money made available through Medicaid reimbursements in New Jersey and what it costs to take care of patients. We need to figure out how to respond to that problem.

We have a proposal that we've given to the governor to set up a task force to bring everybody to the table to look at what the problem is and to come up with recommendations to deal with that problem. So we're hoping that that's going to happen very soon. We have an event coming up -- a press conference coming up this coming Wednesday here in the State House where we're going to announce the support that we've gained for this campaign, and we're hoping to maybe make some announcements about the task force. We're hoping the governor is going to respond to that very soon.

The other issue that's been raised here has to do with the woefully small reimbursement that the workers in this industry get for providing very, very important care. Many of our members and also particularly many of our workers who are not members of our union are in situations where they're paid maybe slightly higher than minimum wage. Most often, they are offered health-care plans themselves where, perhaps, their own health care is covered, but the amount of money that it costs to cover their family with health-care coverage can range anywhere from \$200 to \$300 to \$400 a month in employee contributions, which obviously given the wages that these workers make is impossible to deal with. So essentially they have no health-care coverage for their own families, while they're providing health care for our loved ones.

The issue of the shortage of nursing home personnel of certified nursing assistants. It's true that when people find themselves doing this very,

very difficult job, a job which is considered actually one of the most dangerous jobs throughout the country in terms of injuries, as well as the terrible pressure that CNAs are under in trying to provide the kind of care they've been trained to provide under the short staffing conditions they're under. It's no wonder that when -- many people in this field can find jobs for an equivalent salary at Home Depot or at MacDonalds, they'll go there. We have to work to improve -- to really make this into the career that it is. Because the majority of the people in this field are not there because of the great amount of remuneration that they get, they're there because they really care, but they have to be able to afford to continue to do this kind of work.

ASSEMBLYMAN PAYNE: Mr. Gorfinkle, let me ask you something.

MR. GORFINKLE: Yes, sure.

ASSEMBLYMAN PAYNE: You said that there is a program that you are able to get a lot of organizations and a number of legislators to sign on to. Tell me, is that the three-point program that you're talking about?

MR. GORFINKLE: Yes.

ASSEMBLYMAN PAYNE: What are the three points?

MR. GORFINKLE: The three points are patient to staff ratios and getting there in stages. The second is the issue of good caregiver careers, which is finding a way to improve the amount of money that workers are paid. And the third is Medicaid reimbursement reform, as been referred to before.

ASSEMBLYMAN PAYNE: What was the second point -- the second point was to?

MR. GORFINKLE: Was that good caregiver careers be able to--

ASSEMBLYMAN PAYNE: Upward mobility, training, etc., and opportunities for advancement, etc.

MR. GORFINKLE: Yes, exactly. Exactly.

ASSEMBLYMAN PAYNE: That had nothing to do with the wages or whatever? That has to do with providing training for people and an opportunity for them to move up the career ladder. The third point, I think, was the Medicaid reimbursement, I believe, so to increase the reimbursement -- wasn't that supposed to then enable the owners to pay higher salaries? Does that tie in -- is that what that's all about?

MR. GORFINKLE: Certainly, both provide higher salaries and benefits but also staff to a level where the certified nursing assistants and the LPNs can provide quality care type of care that they've been trained to provide.

ASSEMBLYMAN PAYNE: Do you represent the owners as well?

MR. GORFINKLE: No, absolutely not.

ASSEMBLYMAN PAYNE: You represent the workers?

MR. GORFINKLE: Yes.

ASSEMBLYMAN PAYNE: Okay. The first two points, number one, I think again was what -- because I've seen that three point program.

MR. GORFINKLE: Yes, we had a conversation about it actually. Yes.

ASSEMBLYMAN PAYNE: Number one was what?

MR. GORFINKLE: Number one is staffing.

ASSEMBLYMAN PAYNE: Staffing.

MR. GORFINKLE: Staffing ratios.

ASSEMBLYMAN PAYNE: Number two was career opportunities?

MR. GORFINKLE: Quality caregiver careers includes career opportunities. It also includes adequate remuneration for the work that they do so they can afford to keep doing the work, which is wages and benefits.

ASSEMBLYMAN PAYNE: Who is that program directed towards, the State, the owners, or for whom? In other words, you've got people to join up on this petition type thing. Who is it directed toward? Who is supposed to provide you with these three points?

MR. GORFINKLE: Well, the most immediate change, the most immediate step that has to be taken is since anywhere between 70 percent to 90 percent of the moneys that support these nursing homes come through Medicaid, and the amounts have been increasing over the years. The Medicaid reimbursement system has got to be adjusted and examined, and that's a federal/State match in terms of funds. We're recommending the setting up of a task force bringing everybody to the table because there have been programs put together in other states that have been able to examine all possible sources of funds so that you wouldn't necessarily have to go to the general fund in order to find some money. There may be other sources of funds.

ASSEMBLYMAN PAYNE: Let me ask you a question. Training, career opportunities, etc., to be provided for people who are working so they can move up.

MR. GORFINKLE: Yes.

ASSEMBLYMAN PAYNE: Isn't that the responsibility of the owners of these operations? You don't need any State aid for that kind of

thing, right? They don't need any State aide to provide training, or do they? In other words, what I'm getting at--

MR. GORFINKLE: Okay.

ASSEMBLYMAN PAYNE: --is that the first two points that you mentioned, ratios and the improved advancement opportunities, etc., would be something that the industry, I suppose, would want to provide, if they could for these people. The third point is the increased Medicaid reimbursement, which you're seeking. I think I was told the reason why the employees, these folks, the aides, are not paid adequate salaries or higher salaries is because there's insufficient reimbursement on Medicaid for the owners, and therefore, they cannot-- Is that the reason why the salaries are where they are?

MR. GORFINKLE: That's one very important reason. Medicaid is not the only source of funds for the nursing homes. There is a certain proportion of private pay, a certain proportion is Medicare, and the largest proportion is Medicaid. There's actually a threat coming down the pike very soon as well dealing with the federal level with Medicare, who we'll be paying attention to very soon.

There's something called the Medicare cliffs where there's been a certain amount of funding that's been providing and that funding is going to drop off possibly come this fall. So we have to be vigilant and be fighting at a lot of different levels to make sure, first of all, there is enough funding being provided from all sources, but second of all, that there is accountability to make sure that that money goes to the direct care, which is what you're probably referring to. There's no requirement for a lot of the owners to open the books entirely to show exactly where everyone of their dollars is going.

We know that some nursing home owners are doing better than others, as far as fulfilling their obligation to provide quality care and also to provide quality jobs, but we think that the whole industry has got -- the quality has got to be improved and the ability to pay a living wage-- I mean, right across the river in New York, people are being paid 50 percent more for doing the same work. The cost of living is not 50 percent more across the river. We feel that our people in this state earn the work they do the \$15, \$16 an hour, they should be paid. And we have to work out a plan to get them to that level.

ASSEMBLYMAN PAYNE: I agree. There are people that have been working for 10, 12, 15 years who are -- started out at \$6 and end up making \$9 an hour now.

MR. GORFINKLE: Absolutely. Exactly.

ASSEMBLYMAN PAYNE: The only reason, my confusion, as you know, I didn't sign on to that. The reason why is because I didn't quite understand how your group -- you're representing the workers -- how the marriage between the owners and the workers came about. You said that all of the nursing homes, they're not obligated to open up their books so you really can't see where the money goes and what ratio, etc. Should there be an obligation on the part of the owners who want to be licensed for this? Do you feel that there should be a requirement that their books be open so that there can be some understanding as to whether or not some of the owners, in fact, do have sufficient resources to pay higher wages but are not doing it? How do we know that? How can we tell that? Is there some way that we can do that? Because now you have a marriage between the owners and the workers. They're all saying now, "Let's all get together now. Let's go down to the State

and tell those guys that they have to increase our Medicaid reimbursement.” And in the past, some of these same workers have said to me that we believe that the owners have sufficient -- and are paying us. Now it’s interesting that we have -- everybody is all coming together saying, “Let’s lock arms, owners and workers.” So we can go to the State now. The State is the bad guy. Let’s go the State and tell them to increase the reimbursement, so then the owners will pass on to these workers higher salaries. That’s the way it seems to me now.

MR. GORFINKLE: Well, there’s certainly some significant accountability under the operation of the Department of Health, as Mr. Conroy raised earlier. We don’t think that that’s necessarily a perfect system, but it certainly is a system where it gives an opportunity to monitor where a lot of the money goes and to make sure that nursing homes are being accountable for the money that they get. We respect the fact that there’s been a lot of very serious studies done at a national level and state by state looking at what it costs to provide nursing home care and New Jersey is actually, in terms of the Medicaid reimbursement system here, is actually below surrounding states. No matter what we feel about what the owners may or may not be doing, very objectively there are some things that have to be done in order to bring New Jersey Medicaid reimbursement system up to a point where it can provide the kind of reimbursement necessary.

Beyond that, it’s up to us as a union to make sure that as we negotiate contracts that we get a fair shake as far as making sure that our members -- that the owners are accountable for the funds, and the people who provide direct care get the money they need to support their families.

ASSEMBLYMAN PAYNE: There is legislation in now that has been introduced or reintroduced, I suppose, to increase the salaries. I think the salaries by \$1, I believe.

MR. GORFINKLE: That's in home care. That's a separate issue.

ASSEMBLYMAN PAYNE: That's in home care?

MR. GORFINKLE: Yes.

ASSEMBLYMAN PAYNE: Which is another area that I want to talk about.

MR. GORFINKLE: Yes.

ASSEMBLYMAN PAYNE: People that go out to provide health home care, right? That's another area.

MR. GORFINKLE: It's an area where we're very involved with as well. The whole long-term care industry in the system is we have to take a step back and take a look at it, because there's a lot that has to be done, both in terms of quality care as well as in terms of quality jobs, as well, because they both go hand in hand as we've found out.

ASSEMBLYMAN PAYNE: Home health-care aides or nurses or whatever, providers, did testify at our public hearing. I'm on the Budget Committee and did testify at a number of public hearings regarding what they felt were their conditions in this situation. Can you address any of that since you do represent them as well? Could you just kind of give an overview of the situation with the home health-care aides.

MR. GORFINKLE: I'm less an expert on that area because our involvement has been more recent, but there is a major statewide campaign to try to bring home health-care workers up to a standard where they also have

a decent job to support their families. Their average wage is actually probably \$1-plus lower than the nursing home workers. And by and large, the home health-care workers have no benefits at all, no vacations, no holidays, no health insurance, no pensions. So there's a lot to do in terms of making the home health-care profession into one where workers doing that work can survive.

ASSEMBLYMAN PAYNE: Are they different companies? For instance, those operators that provide home health-care aides, they are owned by recruitment -- what kind of companies are those?

MR. GORFINKLE: They're a mixture. Some are for-profit and some are nonprofit. There really is a sort of a hodgepodge of different kinds of home health-care providers. Their funded basically through each county is my understanding. And part of what we hope to happen as a result of the organizing campaign we're involved with, as well and in partnership with the administration, to reorganize the industry is to make sure that a much larger proportion of the money that goes into the home health-care industry goes actually to the caregiver, to the worker, so that their salaries can reflect the cost of living and that they can provide for their families. So this is a big issue that the whole industry has got to be taking a very serious look at, because we think there's a lot of waste and also a lot of money into going into the profits of agencies that perhaps could be looked at. Maybe there's a lot fluff in there, a lot of money that could be going to direct patient care that not being. But this is again, this is not an area that I'm personally as directly involved with as I am with nursing home care. There's material that we've generated which we can share with you all.

ASSEMBLYMAN PAYNE: Who do they contract with? Who do these people -- they contract with the State to provide this service in the homes?

MR. GORFINKLE: I believe they contract with the State, but often it's through individual counties as well. The counties take the responsibility for contracting with a lot of the home health-care agencies.

ASSEMBLYMAN PAYNE: And what does the county provide per hour for these? They must break it down somewhere. Does the county provide--

MR. GORFINKLE: My understanding is that, on the average, is between \$15 and \$16 per hour is provided to cover home health care and that less than half of that actually goes to the worker.

ASSEMBLYMAN PAYNE: Six dollars or something.

MR. GORFINKLE: Seven or eight, but it's still extremely inadequate, particularly where there are no benefits involved at all. It's a straight salary without benefits. So it's really unconscionable given the fact that the kind of care people are trying to provide to people who really need the care and can't provide the same care to their own families.

ASSEMBLYMAN PAYNE: What do you think we as the Legislature should or could do in that particular -- talking about home health-care providers now?

MR. GORFINKLE: Well, there are several proposals that are being discussed with the Department of Health at this point. I think we've got to sit down and take a serious look at other models that have developed around

the country, which I think could sort of point the way. There's a California model where the home health-care aides are actually directly employed by the county or by a county agency, essentially making them public employees, and the amount of overhead involved with that is cut dramatically. So there are a number of different models that the State can take a look at, but there's a mixture of different kinds of home health care for different kinds of home health populations. These are the areas that I'm not personally as conversant with as some of the people who work with me on our staff. There will be times, hopefully, where that information could be provided to you in a much more detailed fashion.

ASSEMBLYMAN PAYNE: I would hope so. I would certainly request that whoever is in your organization that has the expertise in this area, you talk about some models that we can adopt here or adapt here. I'd like to see that information.

MR. GORFINKLE: Sure.

ASSEMBLYMAN PAYNE: You mentioned the two separate areas of home health-care aides, and they're being paid less than on the average than the people who work in nursing homes.

MR. GORFINKLE: Absolutely. And also, even with the home health care, there are different types of home health care for different home health populations -- the disabled, the elderly, those who can take partial care of themselves. There are different types of agencies that provide different kinds of care, and it's important to break this down and figure out how to solve all the different problems to make sure no one gets -- nothing falls through the cracks, that every problem is properly addressed.

ASSEMBLYMAN PAYNE: So there's a hodgepodge. We have to find out what we can do as a Legislature to correct that or at least address it more specifically, and also there's a shortage, I think, of geriatric-trained providers as well. We need to look into that. So, if your organization-- What other organizations are you in? What are you -- 1199 SEIU?

MR. GORFINKLE: We're 1199 SEIU. We're actually, within the past week, in the process of developing a partnership with 1199 AFSCME. There are representatives of their union here as well. Actually, it's, in part, as a result of our discussions with the governor, that the governor has let us know that we are trying to accomplish the same things. We should be working together. We sort of put together an historic agreement this week. The governor has met with the international presidents of both of our unions, with Andy Stearn (phonetic spelling) from SEIU and with Mr. Mackatee (phonetic spelling) of AFSCME. So partly as a result of our conversation with the governor, I think we're on the verge of a real major historic coming together of different unions working on the same areas.

ASSEMBLYMAN PAYNE: I'd like to be kept abreast of that.

ASSEMBLYMAN STANLEY: I have a question?

ASSEMBLYMAN PAYNE: Assemblyman Stanley.

ASSEMBLYMAN STANLEY: What type of training is out there for persons who are working either as nursing aides or who are home health-care providers? Do we have sufficient available training from the higher education institutions in our state or what is available?

MR. GORFINKLE: Well, for nursing homes most often -- I think it was referred to by the last speaker -- the nurses aides as they get hired are

normally given training by the facility. The facility normally covers the cost of the training. I think it's 40 hours or 48 hours or something in that range, I believe. I'm not an expert in that area. My understanding is that we don't currently have a major problem with the training, but I'm sure, as always is the case, there are probably improvements that could be made in that. The problems we run into is that often when a CNA completes his or her training and goes to work, they're unable to put into effect a lot of the things they're trained to do because the staffing is not there, and they're either running helter-skelter from one patient to another providing, which to them is minimal care, because they're not able to spend the time with an individual resident to really provide the care they need to provide. The training itself is not the problem. The problem is being able to apply it in a situation where the staffing is not adequate. In home care, I'm actually less aware. I know there's a training requirement for certified home health aides, but I'm not sure exactly what that is. I haven't been directly involved with that area myself.

ASSEMBLYMAN STANLEY: Thank you.

ASSEMBLYMAN PAYNE: Thank you, Mr. Gorfinkle.

ASSEMBLYWOMAN CRUZ-PEREZ: Mr. Chairman, something that I want to share with you, and I'm sure Neal is aware of. Camden County has a program where we're working with the Work First New Jersey clients. We are providing-- We are in the third class now. We graduated 11 last week, which my -- I went over to the graduation. My only concern is we're getting these people. The people are interested in going into the field. It's keeping the people.

MR. GORFINKLE: Yes.

ASSEMBLYWOMAN CRUZ-PEREZ: When they enter.

MR. GORFINKLE: Absolutely.

ASSEMBLYWOMAN CRUZ-PEREZ: They graduated. We have probably already 25 working in different nursing homes in Camden County, but the problem will be keeping these people interested enough to stay in that position. We actually graduated people, CNA and home health aide. It's a training of 12 weeks, and is provided by the county. But if we don't solve the problem of providing proper pay, medical insurance to these people, they're not going to stay in the field.

MR. GORFINKLE: That's precisely the situation we're finding ourselves, exactly.

ASSEMBLYMAN PAYNE: Thank you very much.

Thank you, Mr. Gorfinkle.

MR. GORFINKLE: Thank you.

ASSEMBLYMAN PAYNE: Next is June Duggan, New Jersey Association of Non-Profit Homes for the Aging.

JUNE DUGGAN: Good morning, Assemblyman Payne and member of the Committee.

ASSEMBLYMAN PAYNE: Good morning.

MS. DUGGAN: My name is June Duggan, and I'm the President of the New Jersey Association of Non-Profit Homes for the Aging. On behalf of the association and its members, I'd like to thank you for the opportunity to provide testimony on the critical issues affecting the nursing home industry today.

Although many of you are very familiar with the association, it is important to note that NJANPHA represents over 140 not-for-profit facilities across the state that span the entire long-term care continuum. These include nursing homes, assisted living residences and programs, continuing care retirement communities, residential health-care facilities, board and care homes, and independent senior housing facilities. In addition to basic nursing, rehabilitation, assisted living, and personal care services, many of our members also independently sponsor an array of programs including medical and social day care, Meals-On-Wheels, congregate housing services, and intergenerational child care. As mission driven organizations, the majority of our membership maintains some type of religious, philanthropic, government, or fraternal sponsorship. Because a majority of our members maintain a mission to serve the low-income population, over 75 percent of the facilities that we represent participate in the Medicaid program.

In addition to being the oldest association of its kind in the nation, many of our members have been in existence for over 100 years providing high-quality health care and social services to New Jersey's elderly residents.

As you've heard from my colleagues in the Department of Health and Senior Services and the Ombudsman's Office, regulatory oversight of nursing home operations is extensive. The vast array of statutes and regulations governing nursing homes are extraordinarily complex and comprehensive, and they are intended to supply the industry with the guidance required to provide high quality health-care services to New Jersey's elderly residents. While considerable debate has been heard on the ability of the regulations to accomplish this goal, the fact is that the vast majority of nursing

homes provide high quality care to the residents in their care. This is an amazing accomplishment given the fact that the regulations do not provide the necessary funding to pay for the skyrocketing costs of nursing and long-term care services, nor do they recognize or provide adequate protection from the increased liability in the provision of such care.

The workforce shortage within the health-care field is arguably the biggest issue facing the long-term care industry in New Jersey and throughout the country. Since there is not sufficient time to address the issue in detail today, I have taken the liberty to include a copy of a study entitled, “Who Will Care for Us,” conducted by the Urban Institute and Institute for the Future of Aging Services, an affiliate of the American Association of Homes and Services for the Aging. While numerous factors are cited in the study for contributing to the creation of the shortage, probably the greatest is the inability of long-term care facilities to pay nurses competitive salaries and the low wages paraprofessionals, such as nursing assistants, home health aides, personal care workers, etc., have historically been paid.

This situation in New Jersey has been compounded by inadequate Medicaid reimbursement rates nursing homes have received from the State over the past eight years. As you know, NJANPHA and its colleagues have raised this issue with the Budget and Appropriations Committees and would respectfully request the support of this Committee’s membership during this year’s budget negotiations. While neither the study nor I wish to suggest that funding is the sole reason for the staffing crisis, it is a significant contributing factor to its problem.

An additional financial burden for nursing homes that could be alleviated by some action of this Committee involve the enormous liability insurance premium increases facilities have been hit with recently. In some cases, the premiums have doubled and tripled. These increases have been felt most severely by nursing homes and other health-care providers, however, you should be aware that providers of senior housing have been hit with equally harsh increases. Obviously, organizations that are not paid for the full cost of services they provide find it difficult to absorb these increases. Few organizations could survive under these conditions before they would be forced to make compromises. These factors add further strain to a payment system that is strained beyond its limits.

I have focused on three factors this morning: Staffing, reimbursement, and liability insurance premiums; because they are the most predominant issues today. However, I would be remiss if I did not note there are many other issues attributable to burdensome regulatory requirements, which might, perhaps, be addressed at a later date.

One factor I did want to raise, too. In the testimony of Mr. Isele this morning, we talked about the increases and the number of complaints that have been filed, and one of the things that I think has to be factored into when you're reviewing those numbers that, over the past several years, there's been a tremendous public information effort that's been initiated by the federal government to make certain that people know where they can go to report abuse cases. So I think that that needs to be taken into consideration when you look at those statistics.

Thank you, and I'd be happy to answer any questions.

ASSEMBLYMAN PAYNE: Thank you. Thank you very much.

I have just one. You said the skyrocketing cost of care. What are some of the areas where the costs have skyrocketed to the point where we cannot keep up with them?

MS. DUGGAN: Well, certainly staffing and liability insurance are the two most notable issues today. You have the routine increases of other supplies, etc., that you use, but we're no longer just competing within ourselves between other nursing facilities or competing with hospitals for staff or competing other home-care providers. In some parts of the state, you're competing with the casinos or you're competing with Macys or Home Depot, as was noted, because the benefits are the same or even better, and there are better working hours, etc. So, right now, probably the most skyrocketing costs are liability and staffing issues, certainly not managed under the current reimbursement system.

ASSEMBLYMAN PAYNE: The other thing is you said there are burdensome regulatory requirements.

MS. DUGGAN: The long-term care providers in the state are subject to a vast array of regulatory oversight. We talked briefly this morning about the survey and certification process. You have the Ombudsman's Office. You have other requirements that they're required to meet as well. And what happens very often is when you have all these regulatory requirements converge, there's tremendous confusion, potentially duplicative expenses that should be addressed at some point in time.

ASSEMBLYMAN PAYNE: There is a required ombudsman and people like that -- that was brought about, I suppose, out of necessity to

monitor early on to look into some of the concerns that people have, I suppose. I guess you're saying that it has grown out of proportion, that there are just too many regulations or what have you.

MS. DUGGAN: Yes.

ASSEMBLYMAN PAYNE: Are they in place to try to assure that the long-term care will be adequate or at least quality kind of care given to our citizens?

MS. DUGGAN: I think every provider strives to provide the highest quality of care that they possibly can. I think it's questionable that more regulation always improves outcome, and I think that's what we need to look at. We need to look at what the ultimate outcome is. The outcome should be the patient care, the patient progress, not regulatory compliance. I think we should take some comfort in the fact when we look at, for example, complaint investigations with the vast majority of those complaints filed were filed by the administration of those facilities themselves. So I think there is an indication that the facilities themselves are really trying to provide a high quality of care and to make certain that they're obeying the laws and regulations to the full extent possible.

ASSEMBLYMAN PAYNE: And just finally, do you believe that the increased number of complaints is simply because people are more aware of where to go to complain or whether or not there is justification for the complaints? Maybe they were there all the while or just--

MS. DUGGAN: I think it's probably a combination of both. I think that sometimes there probably, if it were some individuals who didn't realize that they had opportunities to offer complaints, but I also think that the

public education effort that CMS, and formerly HCFA, put forth really made a tremendous difference in terms of making sure that families, as well as the employees and the residents themselves, know where they can go to report complaints.

ASSEMBLYMAN PAYNE: I would like to say, I was impressed with the amount of information that was given. One of my recent experience with a nursing home long-term care facility, the information given about patient's rights and things like that posted in their rooms, and things like that, that's just a matter, I suppose, of many instances as people familiarizing themselves with those kinds of things.

Thank you very much for your testimony.

MS. DUGGAN: Thank you.

ASSEMBLYMAN STANLEY: Question, please?

ASSEMBLYMAN PAYNE: I'm sorry. We have a question from Assemblyman Stanley.

ASSEMBLYMAN STANLEY: I'm sorry.

Thanks for coming today. We appreciate your testimony.

MS. DUGGAN: My pleasure.

ASSEMBLYMAN STANLEY: Liability insurance, that's been brought up a couple of times. What's the reason for the liability insurance increase and maybe you can shed some light on that? I know this isn't the Insurance Committee, but it is certainly something that effects the delivery of care because of the cost impact?

MS. DUGGAN: Nationally, what has generated I think the huge increases we've seen in liability insurance is the types of settlements, etc., that

have been paid out across the country. As a result, the insurance companies need to be or want to be, strive to be compensated for their risk exposure. As a result, premiums have gone up -- doubled, tripled. So you're talking about potentially hundreds of thousands of dollars to facilities. It's maybe more understandable in nursing homes and long-term care facilities where you're delivering health care, maybe it's understandable there. However, when you think that senior housing providers, people who are providing apartment complex managers, their liabilities and premiums are being swept along and increase at a dramatic rate as well just because they care for senior citizens. They're just being swept along.

Certainly, we are in the health-care associations, we're doing everything we can to work with our members to try to minimize the risk exposure through risk management, through trying to find insurance products, but there aren't a lot of insurance products at a less costly basis out there available to providers. Certainly, we're still trying to address the issue every way we can. There are many national efforts that are moving forward as well in Washington to try to address the issue, but it's been, unfortunately, a slow process.

ASSEMBLYMAN STANLEY: Isn't insurance regulated from state to state--

MS. DUGGAN: Yes.

ASSEMBLYMAN STANLEY: --more so than nationally?

MS. DUGGAN: It is.

ASSEMBLYMAN STANLEY: Have we seen increased, I guess, liability on the part of our nursing home facilities or our long-term care

facilities? I mean, have there been large settlements in New Jersey that have impacted the way we're working?

MS. DUGGAN: In New Jersey, we haven't seen the type of settlements that we've seen in other states, but certainly the insurance providers are concerned about their exposure overall, not just their exposure in a given state. But we have not seen, for example, some of the settlements that you've seen in Florida or Texas that have forced people to go without insurance yet.

ASSEMBLYMAN STANLEY: Are we seeing in New Jersey people suing nursing home facilities more and more and have we seen cases where facilities have actually lost a lot of these cases? Have we seen any increase or any trend that says that insurance companies in New Jersey need to be compensated for their risk?

MS. DUGGAN: I certainly don't have statistics with me today that can talk to anything in terms about cases won, etc., and what's happened in New Jersey, but you just have to open up your local newspaper every day where nursing homes in particular are identified in ads, etc., for potential litigation.

ASSEMBLYMAN STANLEY: Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

Eida Segana, CWA Local 1040.

E I D A S E G A N A: Right.

Okay. My name is Eida Segana. I work as a CNA, and I have been working 27 years. I would like to speak about what a CNA does directly.

When we go in the morning, the first thing we do is we make our

rounds, make sure that our patients are dry, and we get them ready for breakfast, wash their hands and faces. We wait for the trays to come out. We roll up the beds and everything. We get their breakfast ready. We cut up whatever has to be cut up and fold them up, make sure they're comfortable and everything. After that, if we have to go to the kitchen for anything, make sure that they have the right breakfast in case they are diabetics or a light diet or whatever. Sometimes that takes time because by the time we make the phone call we do it sooner by going ourselves to get it.

While they eat their breakfast, we do the feeders. Some patients take longer than others. Some might take an hour. Some might take maybe 10 minutes. It depends how fast they eat. That's very time consuming. After that, we pick up the trays and then we go for report. They tell us what patient has been sick or one needs more care or whatever. Then we do our direct care. We make sure that they're all comfortable and everything. We usually start, like, maybe around -- between 8:30 or maybe 9:00. They always tell us to try to get the patients ready by their lunch time so they can be more comfortable. Sometimes that's impossible because one patient might need more than another.

One person was here saying a ratio of two or four or whatever. To me, that's not true, because I do this directly. One patient might take maybe 45 minutes depending if you got to position that patient in a certain way. You have to put the pillows here and between the legs and you have to put the things on therapy and that takes a long time. Sometimes we need extra help. We need somebody else to do it with us because we don't -- you can't do it by yourself.

Now patients that we have to lift up with Hoyer lifts, usually we need two people for that because you have to roll and pull and everything. So you need two people for that. To lift a patient out of bed, sometimes you need two, three people because patients are scared to go on the Hoyer lift. So we got to use body people. So we have to take two people on top and one on the bottom. That takes time because you got to find them. If you don't have the correct help with the amount of girls that you need for that, it's impossible to do it. Sometimes we have to leave them in bed because we don't have the help.

Usually we tell administration to help and sometimes they call somebody else to do it because either they don't want to do it, or I don't know what the reason is. Plus, sometimes I ask to get somebody else, and they don't help us. Some do, some do not.

Now somebody also mentioned before that the nurses get on the floor and do half. I'm sorry to say that is not true.

ASSEMBLYMAN PAYNE: The nurses do what?

MS. SEGANA: The nurses go on the floor like they might do half of the care. That is not true. We do the direct care completely from washing, to getting up, to going back to bed, to changing, to whatever. The nurses do their meds, their paperwork, and treatments and all that, but we basically do the direct care from top to bottom. Whatever has got to be done for the patient, we do. We have to handle the lights, take them to the bathroom, ladies room, mens room, whatever. Sometimes they have accidents. That takes a long time to do. A lot of patients are embarrassed because they don't want two people there. So, if the patient is heavy, you have to struggle by

yourself because they don't want somebody else in there. They just want you alone and that's it. I respect that people have a right to your respect and dignity, you should have it. You should not have a lot of people in there.

Direct care is not the only thing involving patient care. A lot of patients have no families. Actually, sometimes they put them there and forget about them. That's mean. They should not do that. So they depend on us. We become their family. I would take a patient and the patient would tell me, "Please don't leave me." So, of course, you're not going to leave. You're going to stay there and talk to them.

In the meantime, you have other patients waiting for you. So you try to explain to the patient I'll be back and you try to make them happy, fool around with them a little bit until they feel comfortable. You come back to them again later, then you go back to another patient. And by the time you're done, forget it. It is impossible to sometimes go back to the other patient, but you try to do it because you know they're waiting for you and you force yourself.

A lot of girls don't go to lunch or they don't go to break. We still have to punch out because they tell us we have to. So we punch out even though we don't take our lunch because we know somebody is depending on us and we feel this way -- that could be our parents there. So we have to do it, no matter which way you look at it.

Now somebody also mentioned before about health care. This person is correct. The health care has gone up so much that a lot of people -- CNAs cannot afford it. So they have dropped out of it. They cannot afford to take home maybe \$200, \$300 a week and then you have the insurance that

you have to pay maybe. If you have families, forget it. I think it's \$165 a week. So you don't have it. So they drop out of it, and then they go in this New Jersey KidCare, or something. They have children, and sometimes they cannot get it because they make maybe a dollar or two more, so they cannot get it. It's very hard. I think they should be getting something for that.

Also somebody mentioned about training. When we do the training, usually the person, the staff coordinator or whoever trains or goes upstairs with them, they show them videos and everything. Then they come downstairs and we train them. That's slows us down because we have to explain to them step by step, step by step what they have to do. So we have to do patient care ourself plus also train somebody else. You cannot do it. It's time consuming, and you're taking time away from the other patient because you're trying to explain to this CNA what you have to do here and here and here and here. So it's impossible. We do it because we are told to do it, and if we refuse we could be terminated, so we have to do it. We do not get paid extra for this. This is another job added onto us.

There are patients there that are totally, totally complete. A patient like that would be-- There's a patient where I work. She's a young woman. She must be in her fifties. She is on a special bed. She's like maybe an hour to do because she got it here, here, here, all over. She's really contracted. She knows what's going on so you have to be careful. You have to make sure that, "Are you comfortable? Do you want anything else? Tell me what you want? Do you want to go that way or this way and all that?" It's hard to do patients like that. It's basically only one girl to do this, like I said, unless you have enough help and that's very rare.

Let's say when we had a blizzard, we had on my floor -- there's 58 patients. It was only three of us to do total a.m. care. I'm sorry to say that management did not get on the floor to help us. Nurses did not get on the floor to help us. It was only up to the CNAs to get the 58 people ready for the day. Families come in to check -- you have to make sure that they're comfortable. You don't want families to come in and say, "My mother is not right." So you have to make sure that this is all done.

You have to excuse me, I'm a little bit nervous being up here. I've never done this before.

ASSEMBLYMAN PAYNE: You're doing very well.

MS. SEGANA: Patients are very demanding. Some of them are very abusive. They don't mean to be, but even the elder patients are like that. The patients that are confused you don't mind because you know they really don't know what they're doing. But you get a little aggravated when a patient is hollering. They tell you, "Well, that's what you're here for," and then they curse you out. You have to take it. You don't go back out there, you cannot abuse them. So we try to calm them down. Sometimes they just go overboard and then we just report it to say that this is what the patient did and all that. Actually, you cannot really be mad at them because like I said, if that was your parents, you can't. You have to do the same thing for another patient, as you would do for your parent.

Sometimes like the girls at the jobs, they work a lot of overtime. It's the only way that they can make ends meet. Sometimes they go from one job to another nursing home to do two jobs. I know a girl there that works actually-- She works where I work, 37.5 hours, then she goes to another job

to do another 40 hours. She has basically no time for her family because she is not getting paid enough. It's a shame -- 8.15 an hour is not enough for a person to live by.

ASSEMBLYMAN PAYNE: How much?

MS. SEGANA: Eight-fifteen.

ASSEMBLYMAN PAYNE: You said the girls, girls, girls, are there any men?

MS. SEGANA: Oh, yes. There's a few men also. I'm sorry. There's a couple, but it's not many. Where I work I think, as a CNA, there's only one, one man and that's on the 11 to 7 shift.

ASSEMBLYMAN PAYNE: Thank you.

I think Assemblywoman Cruz-Perez has some questions for you.

ASSEMBLYWOMAN CRUZ-PEREZ: I have a few questions. Ms. Segana, you're telling us you do everything, bathing, for a patient?

MS. SEGANA: For a patient, direct care.

ASSEMBLYWOMAN CRUZ-PEREZ: Everything. You told me that one time there was 58 beds and you did 19 patients. Were you able to care for those 19 patients the way you should be?

MS. SEGANA: No.

ASSEMBLYWOMAN CRUZ-PEREZ: Impossible.

MS. SEGANA: When it's short like that, you have to cut corners. You do the main stuff, and you cannot do everything. Then you cannot go back to them like you should because there's not enough help.

ASSEMBLYWOMAN CRUZ-PEREZ: Probably you were trying to rush, and that's how accidents can happen.

MS. SEGANA: Yes. Yes.

ASSEMBLYWOMAN CRUZ-PEREZ: I have a question for you. How many patients do you have on a daily basis to do everything for that patient?

MS. SEGANA: Eight to ten.

ASSEMBLYWOMAN CRUZ-PEREZ: Do you think that's enough?

MS. SEGANA: No, it's not. We need more girls, because like I said before, a lot of patients are time-consuming, especially critically ill patients. You cannot really do everything for them that you should. Then you have the alert patient that wants you there every minute, and they call you. If you don't go, they get mad. So it's hard. There should be more help, and we don't have the help.

ASSEMBLYWOMAN CRUZ-PEREZ: So what we're dealing with is that you do everything. They have patients that you have to do completely everything--

MS. SEGANA: Yes.

ASSEMBLYWOMAN CRUZ-PEREZ: --from trying to get them up in a sitting position to take them down to the bathroom and do everything. For them to go back and trying to switch a patient that needs to be switched because they have a sore in the back, it's impossible.

Thank you so much, Ms. Segana for explaining what you do on a daily basis.

MS. SEGANA: Thank you.

ASSEMBLYMAN PAYNE: Thank you very much. We appreciate it.

Let's see, we have Leslie Beicht.

LESLIE BEICHT: It's pronounced Beicht.

ASSEMBLYMAN PAYNE: Beicht.

MS. BEICHT: Hello.

ASSEMBLYMAN PAYNE: Hi. Can you identify yourself and your organization, etc.

MS. BEICHT: Yes. My name is Leslie Beicht. I'm with Fix New Jersey Nursing Homes, and I'm also a former CNA.

I've been with a campaign called Fix New Jersey Nursing Homes for the past six months. One of the things that we're doing is trying to make the -- not only the Legislature, but also the community aware of the crisis that we believe is going on today in the nursing homes. Staffing shortages is definitely number one on our list of things that are causing the problem.

You touched on a lot of things today, and I really just want to add to them and add my point of view on this also, as not only somebody who is involved in--

ASSEMBLYMAN PAYNE: Excuse me. Excuse me. Could I ask you to please--

MS. BEICHT: Oh, thank you so much.

Somebody who not only works to try to find out what's wrong with the industry, but somebody who has also worked in the industry. Part of our campaign is to look at staffing ratios, Medicaid reimbursement, and disclosure on the ratios themselves. I heard you talking earlier a little bit more

about the ratio problem. It's true. You really do have to be basically a rocket scientist today to find out what staff-to-resident ratios are today when you talk about 2.5 nursing hours. It's something that the workers themselves, the resident or consumer or the public in general could never figure out for themselves to find out whether or not their family member is going into a nursing home that properly staffed. Nine times out of ten, it probably is properly staffed, but is that number a number that's adequate and something that would give quality of care to our residents today.

I worked 10 years as a CNA working all three shifts during the 10 years that I had on the job. There were more days than not that I did not get my work done. And by me not getting my work done, then I was not providing the care that I should have. I was the person who was neglecting my residents that day by not getting the job done that I was there to do. I consider that one of our biggest crisis today.

When we talk about neglect, neglect is not giving them the care that they need. It's not necessarily neglect by hurting them physically or mentally or any of those things. I believe it's not giving them the care that they need. It's not being there every two hours to make sure that they're not sitting in their own urine and feces. It's being there to be able to do more than just go in, spend 10 minutes washing them, and walking away. These are human lives. We will pay people, as suggested earlier, more to work at a Home Depot or MacDonaldis than we will to work with our elderly, who have basically forged ahead and made a path for us. We are their only line of defense I would think, and I certainly hope that if I ever become sick, and sooner or later elderly, somebody will care for me.

I'm open to any questions.

ASSEMBLYMAN PAYNE: Thank you very much, Ms. Beicht.

MS. BEICHT: Thank you.

ASSEMBLYMAN PAYNE: Theresa Edelstein, please, from the New Jersey Hospital Association.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Mr. Chairman, Ms. Edelstein had to leave. She had another meeting, but she did leave her testimony with your staff and sends her regrets.

ASSEMBLYMAN PAYNE: Thank you very much.

Mr. Tom Bruno. Please identify yourself and your organization, please, Mr. Bruno.

THOMAS BRUNO: Good morning, Chairman Payne and members of the Committee. I'm Tom Bruno. I am Chairman of CWA Local 1040's Privatization Committee, and I'm an organizer for the local as well.

Obviously, the news about the working conditions of home health aides and certified nursing assistants and nurse, in general, I guess, has bubbled up here. I guess that's bad news for some, good news for others. As an organizer, I've come into contact with numerous employees of the various nursing homes and care facilities. Usually, the people come to us in an act of desperation they've had. The working conditions are so poor, and there are many instances -- I'm not saying this across the board, but in many instances, it's so poor. They live in such fear of being terminated if they say anything, if they complain about it, that they come to us in desperation. Of course, the employer rather they didn't come to us in desperation, they'd rather they'd stay away from us.

We've had occasions where-- I personally had a case where, up in Brooklyn, there was a nursing home actually in Gloucester Manor, but it was-- They had a management group that was doing all the hiring. They had an address in Brooklyn, New York. Part of my investigation into the background of the company, as I went up there to Brooklyn, and it was a beeper sales storefront. Upstairs they had a little place where they had about 25 different business titles, business cards, invoices, blank invoices. So they just routinely, just kind of went from one agency to another, all in house. They were all paper companies, but all of the same address. So, if there was any kind of employees trying to organize a union, they would just switch hats and, "All right. We're not company A and more, now we're company B." It's frustrating from a union perspective.

ASSEMBLYMAN PAYNE: It was a home health-care agency? What was that?

MR. BRUNO: It was actually a nursing and a home health-care agency. They had nurses and they have home health aides.

ASSEMBLYMAN PAYNE: They provided the providers?

MR. BRUNO: Yes. They supposedly did the hiring, and they were supposedly agency nurses, but the company was owned by the same nursing home people. So we were able to establish that in the National Labor Relations Board when we had the hearings, but it's a problem. But anyway, that's from a union perspective.

But there's a journal of nursing that just published a study that indicates that unionized hospitals have a better mortality rate than nonunionized hospitals by about almost 6 percent. It's about 5.8 percent, I

think, they said. And the assumption is that there is a certain level of continuity that occurs when somebody feels that they're secure in their job. That's what that union contract kind of brings to the table is a certain amount of security and a certain amount of benefits that are not just arbitrarily dismissed or taken away. They have to negotiate those things. So there's empowerment. It's important.

We get into a lot of -- the 2.5. I'm hearing a lot of the 2.5 as the standard or the lower threshold. The reality is -- and I've worked in a developmental center myself for 24 years, so I can tell you that no matter what the so-called standards are, you don't have enough. The standard is just that. It's the cellar. I don't think we should strive to reach the cellar. I think we should be striving to get to the top floor, and 2.5 isn't that. That's the bottomline.

I kind of digressed off my written testimony, but I appreciate the opportunity for allowing me to speak today at this discussion.

ASSEMBLYMAN PAYNE: Thank you very much, Mr. Bruno.

MR. BRUNO: Thank you.

ASSEMBLYMAN PAYNE: Mr. Ray Stever, 1199 AFSCME.

RAY STEVER: Good morning.

ASSEMBLYMAN PAYNE: Good morning.

MR. STEVER: I'm relatively new to my position with AFSCME. I just came on board this week. What I have to say today is basically from the heart just as a pure union organizer and a union member. We have some problems in the home health-care industry. One of the main things that I was

hoping to have here today was a few workers to speak with you. They didn't seem to make it, so I'm going to take the pitch.

Last year, there was a dollar raise allocated to the workers in this industry. It seems that the money has not made it down to these workers. The industry itself has basically kept the money and there is much concern as to what they're doing with it. They've basically told the workers that the money is theirs and that it's for their administrative aspects to run their organization. Some of the workers may have seen raises as much as a quarter. Some have seen a big whopping raises as a dime, and the vast majority haven't seen any at all. This has become a very, very, very strong concern.

I've come on board, and I've been speaking to some of the health-care workers this week from other organizations who are totally up in arms about this. Now from the union's point of view, we have concerns that the industry itself by keeping this money and not giving it to the workers because -- believe me, I think you've heard enough. I clearly support SEIU and CWA and HPAE in all these issues from home health care to the nursing homes.

The workers aren't making enough money, and they don't have medical coverage. They themselves have to have much training even regarding dealing with their patients. Injuries are its utmost high. They even say in the industry that 70 percent of the home health-care workers become injured. With this concern in mind, we're also concerned that the industry is using this money that they decided to keep and not pass on to the workers to use in antiunion campaigns. It just basically helps fund their point of view to make

sure that these workers don't have an opportunity to have a union. This is even a larger concern within the industry of the labor movement.

Now I speak as a member of AFSCME 1199. I also am the Executive Vice-President of the Passaic County Labor Council, where SEIU, AFSCME, CWA, and HPAE belong. I'm also a Vice-President at the Bergen County Labor Council where these unions belong. I'm also a member of the Legislative Committee of the New Jersey State Industrial Union Council, another organization where everyone belongs. These three organizations that I can speak for clearly support all these unions to making sure that their workers and workers that have not joined a union yet get a fair and just opportunity to make a decent wage. I won't call it a living wage because at \$6, \$7, \$8 an hour it's really hard to take care of your family. And then on top of it without medical coverage, the costs are astronomical.

There is a bill that I would like to take an opportunity to speak on that's coming to the Assembly and to the Senate. The Senate Bill is 1496 and the Assembly Bill is 591. And basically, it's for an amendment to the Fiscal Year's 2002 budget, which happens to deal with this dollar raise that was supposedly going to the workers. It reads, "The additional moneys provided here and above to increase the salaries of home health-care aides and related direct care staff shall be passed on to such staff in its entirety and none of the money shall be retained by the agencies that employ such personnel. The Department shall require such agencies to attest in writing that any moneys received by such agencies will be used exclusively to increase the salaries of home health-care aides and related direct care staff."

ASSEMBLYMAN PAYNE: That's legislation directed toward -- for the benefit of home health-care aides. I remember that Assemblywoman Bonnie Watson Coleman did introduce that again, and that will be coming before us. Hopefully, we'll be able to be able to pass that so that dollar that was supposed to be designated last year or during the year will, in fact, happen.

Thank you very much for your testimony.

MR. STEVER: Thank you.

ASSEMBLYMAN PAYNE: Let me see, I have Jean Alan Bestafka. Jean, not Jean as in French.

J E A N A L A N B E S T A F K A: Right. And my real name is Eugenia, so I don't use that, that's worse, right. (laughter)

Is this one on when that one's on? (referring to PA microphone)

ASSEMBLYMAN PAYNE: Yes. Just give your name and organization, etc.

MS. BESTAFKA: Hi. I'm Jean Alan Bestafka, and with me is Ken Dolan. I'm the Executive Director of the Home Health Services Association; Ken is the Executive Director of the Home Care Council of New Jersey; and the third member of the Home Care Coalition is the Home Health Assembly of New Jersey. We represent the home care industry in the State of New Jersey.

Before I even start my written testimony, I do want to make something clear, and I'm sure you've heard it from the Department of Human Services, from Bill Ditto, who is the Executive Director of the Division of Disability Services. The \$1 increase that was mandated in the 2002 budget was a program increase. There were other separate increases for other direct

care workers outside the Medicaid program in PCA that effects home care, but it is inaccurate and inappropriate for the union to say that was a \$1 raise for the aides. It was a programmatic increase. The Department has testified to that fact and Disability Services has testified to that fact.

New Jersey's long-term home care system is primarily financed with State Medicaid funds. Over the past 10 years, 1991 to 2001, the State had pursued a policy of severe restrictions on reimbursement increases for long-term home health-care services. Between July 1991 and July 2001, the Medicaid reimbursement rate increased 3.57 percent. By contrast, over the same 10-year period, the Federal Department of Labor reported that the employment cost index in the northeast increased by 32.36 percent.

In New Jersey's highly competitive labor market with some of the lowest unemployment rates in the nation, home care agencies have increased home health aide wages at a far greater rate than the State's Medicaid program provided. In the 10-year period referenced above, the average starting wage for home health aides increased 31.76 percent from 5.78 to 8.47 an hour. In general, across the street, the average is between \$8.50 and \$9.00. The total starting wage increases granted to home health aides between 1991 and 2001 were more than 8.5 times greater than the Medicaid reimbursement rate increase.

Because home health aide wage increases have been significantly greater than the Medicaid reimbursement increase over the past 10 years, it's inappropriate to ask for that \$1 back. Many of the agencies, despite what you've heard, have already given either all of that \$1 or a significant part of it. I'm just saying that that's an inappropriate bill and it's an inappropriate use

of funds. Many suburban agencies have given the dollar and many have not. It depends on other things. If you have to pay an aide almost \$30 a day in travel expenses, that's part of it. That's in the suburban areas. In urban areas, we have to pay for security companies to go in with the aides.

Many agencies have also had to install telephone attendant services and systems. They are all now required to pay for HIPPA. On an average, home health aide wages and associated employment benefits represent between 60 percent and 65 percent of the total cost of providing home health care. It's unreasonable for the State to mandate then that \$100 of the rate increase be allocated to home health aide wage increases.

How will you determine about those agencies who have already given the increase? Does the \$1 include the mandatory taxes and insurances that we have to pay on salaries? Home care is a difficult and convoluted system, as you know from all of the discussions that have gone on. Determining which program applies to which clients, which providers are enrolled in which programs, which aides work for which providers make this an impossible task to separate out these aides. If you're going to say, "Oh, an aide who works for a Medicaid agency needs to get \$1 more an hour if they're in this particular program, but not in those other programs."

Home care services in New Jersey are funded by a wide variety of programs. For New Jersey home care agencies, the percentages of Medicaid funding to home care services varies in some agencies from 10 percent to almost 90 percent. It would be a logistical and scheduling nightmare for home care agencies to segregate their aides by payor source.

Medicaid reimbursement for long-term home care services is based on a fixed fee for service. The fixed fee for service rate is an all inclusive rate, which was stated in the budget, intended to cover all agency costs for delivering services including but not limited to employee wages and benefits, employee transportation costs, state and federal government mandates, nursing supervisory salaries, administrative salaries, rents, utilities, liabilities, insurance, auditing and legal fees, office supplies, and equipment.

Wages and associated employment benefits are the biggest cost center for home health-care employees. If the State mandated wage increases for home health aide employees, the fixed fee for service reimbursement system must be replaced by a cost-based reimbursement system, or a COLA. Now, I will say, in discussion with Medicaid and the Department of Human Services, they're not in a position to add additional manpower to put in a cost-based system that would require cost reports and inspections and evaluations.

A cost of living increase that would be based on one of the statistical wage indexes such as the employment cost index would be an appropriate way if it was understood that part of that has to go to improve, increase the administrative costs that everyone else talks about goes on with agencies. We definitely agree you can't support a family on \$8.50 to \$9.00 an hour. I think this state and most states -- we want everything in the world in home health care, but we're not willing to pay for it. It shows up across the board in all this testimony today. And in a budget crunch, I think that all of you have to be fiscally responsible, but I think this is a problem of a larger proportion than just what are we going to do with one rate increase and where

did this dollar really belong. I think this a philosophical problem that has gone on forever.

ASSEMBLYMAN PAYNE: Thank you very much. It's convoluted. It's complex, etc., etc. The bottom line, though, is that people who are working as providers in this field are, I suppose, underpaid, and need an increase in salary. Now, what's your solution to it? You say that you don't think that's it appropriate for the \$1 to be passed through to the actual worker.

MS. BESTAFKA: Well, remember, they're wanting to do this retroactively to the dollar that was given last year to support all the increases that the agencies have occurred over the past 10 years. Going forward, I think a COLA would be an appropriate way with a percentage of that as a direct pass through. If you were to say that 60 percent is an employee cost. It costs us 60 percent of what our costs are to pay our employees and pay their mandatory taxes. If we looked at a portion of that as going directly to the employee that would be appropriate, but--

KENNETH DOLAN: I'd like to address also. Again, my name is Ken Dolan. I'm with the Home Care Council of New Jersey. We represent the nonprofit homemaker and home health agencies.

Jean had mentioned earlier that over a 10-year period we had received total reimbursement increase of 3.57 percent. That's not per year, that's over 10 years. That's basically a third of a percent per year over 10 years. At that same time, we increased wages by 31 percent on average, starting wages. So that's 8.5 times greater than the State gave us in reimbursement increases.

ASSEMBLYMAN PAYNE: What were the salaries before you increased them? You say you increased them eight times?

MR. DOLAN: It was originally--

MS. BESTAFKA: Eight-point-five times.

MR. DOLAN: No. It started out at--

MS. BESTAFKA: Five, seventy-eight.

MR. DOLAN: --5.78 an hour. That was a starting wage. Last year the starting wage was 8.47 on average. Okay. The one thing that the State never seems to realize is they've put in what they call unfunded State mandates. We're required, under the regulations of the State Medicaid program, to provide nursing supervision to both the patients and the aides. That's not paid for. That has to come out of that average hourly rate that the State reimburses us. Now that's the minimum supervision. Many times an agency will have to go in two or three times in a two-month period because there's some crisis that the patient is having or some crisis the aide is having. So they go in. The State also doesn't pay for the mandated 12-hour in service that has to occur every year.

Mr. Chairman, you asked earlier about the training programs. There is a requirement that in order to become a Board of Nursing certified homemaker, home health aide, you have to have a 76-hour training program. That's always paid for by the agency. Either they do it internally or they contract out to, like, a vocational school. Now it's gotten to the point that most vocational schools don't even have these programs anymore, so the agencies have to run them at their expense. This is not something that they charge the aides. They pick up the cost of this. So these are costs they have.

They have to meet the OSHA for blood-borne pathogens. They have to ensure that the aides have gloves and protected devices to keep themselves from getting splattered with blood. That's all a cost that the agency has to incur. They can't charge that to the patient, and they can't charge that to the aide. That's a cost.

So to say that all the reimbursement increase should go to an aide's salary flies in the face of logic when you consider what over the years we've increased wages, the cost we've occurred in other things. Things go up. Nurses salaries go up. We have to do that regardless of whether we're getting-- These are things that we are mandated to do.

MS. BESTAFKA: We haven't had the major increase in liability insurance that we've heard about today. We have had two or three providers, though, leave the state. So then when agencies have to go-- I would say I've heard some agencies have a 50 percent increase, and that's significant but it's not as significant as we're hearing earlier. That's why I mentioned if we're going to do something like COLA, it has to be with an understanding that we all believe that health-care workers are not paid appropriately. Part of the problem with the shortage, including nurses, LPNs and CNAs and home health aides is we don't want to pay what health care in general really costs. We want to pretend that it's okay to use the lowest bidder. And that has to change.

ASSEMBLYMAN PAYNE: We don't want to pay? Do you mean, the state doesn't want to pay, or who doesn't want to pay?

MS. BESTAFKA: In general, the State.

MR. DOLAN: Well, if you consider that over a 10-year period reimbursement only went up on average 3.57 percent over 10 years, that's not

much of an increase. That doesn't cover near what the real true cost of delivering the service is.

ASSEMBLYMAN PAYNE: I would think that the agencies would go out of business if, in fact, it was that critical.

MR. DOLAN: Well, they have. In my members, five of my members in that period of time in the last six years went out of business -- five agencies, nonprofit agencies that had 40-years-plus business. They've been in business for 40 years and more. Five of them went out of business in the nonprofit sector.

MS. BESTAFKA: And the number of Medicare certified agencies have shrunk in the same period. We've had a major consolidation in those agencies who were licensed by the Division of Consumer Affairs. There were some other reasonable things I mentioned because you're looking for some solutions. It's not part of this Committee, but we need transportation reform in this state. Our aides can't get to work. A home health aide today is required to have a car because you can't get to where you need to go. So, if there was something done with transportation, that would help the situation of the aides.

I got a memo from the Department of Human Services on Friday saying that those people who were covered under the family care program who were adults and are employed now, as of September 1 will no longer be eligible for the program. Well, I'll tell you what? We got a large number of our home health aides under the family care program and now they're saying, "Well, sorry, we didn't know so many people needed home health care. We're backing it out," and now they can't have these services. That was an important

thing for home care that those aides could go and be part of the family care program and now they're not going to be eligible. Their children are still going to be eligible. So that's something else that needs looking at.

It is a very complex issue, but especially since the other gentleman spoke specifically to the bill, the information that was given was inaccurate.

Any other questions?

ASSEMBLYWOMAN CRUZ-PEREZ: Mr. Chairman, if I might?

ASSEMBLYMAN PAYNE: Yes.

ASSEMBLYWOMAN CRUZ-PEREZ: You mentioned the transportation, and again, something that can the counties do in not only providing training but providing placement to those people that graduate from the training. And some of the things we offer the Camden County Improvement Authority is transportation because we realize if we don't have transportation, what good is it going to do to have the certification if you can't get to work. This is the work force people that we're trying to get out of welfare to go in the work force. We are providing transportation. I wish that many counties will copy what Camden County is doing in terms of helping these people and helping the nursing field.

Something that I want to mention. Ms. Duggan mentioned it -- the problem is funding. And unfortunately, we were left, this administration, with the biggest crisis that the State of New Jersey ever had in the history of New Jersey. This is something we have to deal with and be responsible. We have to realize that we have to work together. I'm not blaming the nursing homes or any institution because they're not. We really want to provide this quality care to the senior citizens because they deserve it. They work very

hard, and at the early ages they deserve the best care we can provide. This is something we have to work together. This is not a fight against unions or the institutions or the nurses. This is something that we have to come to the table and do it together. We need to do it. We need to do it soon because this is a problem, a safety problem. It's not any more a money issue. It's a safety issue, and we have to do it together.

Thank you so much.

ASSEMBLYMAN PAYNE: Thank you. Thank you very much for your testimony.

MS. BESTAFKA: Thank you.

MR. DOLAN: Thank you.

ASSEMBLYMAN PAYNE: Kathleen Flannery. Ms. Flannery, identify yourself and your organization, please, for the record?

KATHLEEN FLANNERY: I'm Kathy Flannery. I'm from Bayada Nurses. We are a national home care company that headquartered in Moorestown, New Jersey. We have 21 offices throughout the State of New Jersey. I'm here today to talk about basically what everyone has talked about -- the severe shortage we have in the certified home health aide area. It's hitting all branches of health care within the state, specifically home care.

I wanted to talk a little bit today about what that means for the home care patient. Dramatically, over the--

ASSEMBLYMAN PAYNE: Excuse me. Excuse me. Could you please take that outside? It's distracting for the people testifying. Thank you.

MS. FLANNERY: The number of home health aides in the State of New Jersey has dramatically decreased in the last five years. It's due to a

number of different things, one being, as we've heard from other speakers, Home Depot, MacDonalds, Macys, other fast food restaurants have all been more of interesting for that employee to take employment with those companies, and we've lost dramatically. We've also lost a number of home health employees through the criminal background checks, which was a good thing. That was a very good thing. But that number has decreased dramatically, and we are having a difficult time now servicing certain populations within the State. There are a number of home care providers in New Jersey who are no longer providing services to the Medicaid waiver program and the PCA programs because of the reimbursement. When it comes down to if you only have a limited number of home health aides and then our nurses pretty much traverse the state with 21 offices, we probably have just under 1800 home health aides employed with our company throughout the State of New Jersey.

It becomes exceedingly difficult to service certain types of clients. It's become a real issue for a lot of home care companies. I think the two speakers we just had before talked about that. There are agencies that have left the business or are not seeking certain portions of the business because of the reimbursement.

Over the last 10 years, we did not get what we would consider to be normal raises in the reimbursement from the State, but for the most part, agencies did continue-- And I could only speak for myself, we continue to give raises to our employees, but that's not something that a lot of companies can continue to do. We want to take a look at what we can do for the home health aide. We've gone and talked to Senator Allen. We talked to numerous

legislators. I talked to one of your legislative aides a couple of months ago, Assemblywoman Cruz. What can we do? A COLA maybe? We're even promoting a tax rebate, maybe something on the aide's income tax form that would get them -- if they put their license number that's issued through the board of nursing, they would be able to get some type of rebate or tax credit, something on those lines. But something does need to be done. There's no two ways about it. We get reimbursed 15.50 for most Medicaid programs in the state. Our average salary is between \$8.50 and \$9.00 an hour. The rest of that expense is taken up from the \$8.50 to the \$9.00 to the 15.50. But we really need to do something.

Liability insurance, even though it is not the same issues as in the nursing home industry, liability insurance is also becoming an increasing problem in the home care industry because it's just now that people are aware of what they can do and what they are able to litigate for -- there's just an increase in it. That's nothing that any of us can really do to prevent that. We would like you to take a look at that. We would like to support whatever we could to increase the home health aide employees in this state, but it's becoming very, very difficult.

ASSEMBLYMAN PAYNE: Are you saying that one of the ways to address this problem is through COLAs maybe?

MS. FLANNERY: Some type of cost of living increase. I mean, we did get the dollar last year, which was the first time in many, many years. But there needs to be a COLA, I think. There are programs within the state, the various departments, that do give COLAs. I think that's one way to reasonably address it and now allowing companies to pass on some of that to

their employees. Right now, after a 10 year -- where we basically got just a little over 3 percent, it's very difficult for agencies to keep up with cost of living increases.

ASSEMBLYMAN PAYNE: You say you did get the dollar last year?

MS. FLANNERY: We did. We did get a dollar. It went up to 15.50.

ASSEMBLYMAN PAYNE: And that part of it went for administrative--

MS. FLANNERY: It was a program increase, as it was explained to us. I also want to talk to you about the wage pass through. It's my understanding, through the Department of Human Services and Bill Ditto, that currently with the way that the department is set up, they would be unable to enact a wage pass through. I'm not exactly sure why, but I have sat in on testimony with Bill Ditto where the Human Services Department could not enact that. So, if they can't, we have to think about what's another way to get some money back to get to these employees. But at this point in time, they're unable to do that to enact that wage pass through.

ASSEMBLYMAN PAYNE: So, if the bill is passed, then you're saying that they're not--

MS. FLANNERY: They're saying they can't enact it, even if we passed it, is what the Department of Human Services is saying. And specifically, Bill Ditto has been the person who's testified to that. So what we're saying is if they can't do that, can we think of some other way that this money could pass on.

ASSEMBLYMAN PAYNE: Right.

MS. FLANNERY: We're suggesting maybe a tax rebate, something on those lines. A COLA which we could pass on.

ASSEMBLYMAN PAYNE: Thank you very much.

MS. FLANNERY: Any other questions? (no response)

Thank you very much.

ASSEMBLYMAN PAYNE: Thank you for your testimony.

That completes the list of people who have signed up to testify. I think what we've learned today is what a lot of what we already knew. As you can tell, I was looking for any kind of suggestions or that you might recommend the solutions. We need to find what ways that the Legislature can act, what kind of legislation may be necessary to be enacted to address the problem of, number one, the shortage, address the problem of low wages, to address the problem of, perhaps, insufficient training, etc., and career advancement, etc. It's a very critical area.

As I said earlier, at the opening of this hearing, that we on this Committee and in the Legislature do not want to sit on the sidelines until some major kind of crisis does develop whereby we will see people that are the least able to care for themselves in our society victimized. What we need to do is remain vigilant, try to find ways, number one, and to address the needs of the health care workers themselves. We're asking these workers to do for us what many of us cannot do or are not willing to do.

It was mentioned earlier that a number of the clients or patients in nursing homes do not have family or family have more or less abandoned them. So the people who are providing the work and care for them are serving

also to fill the need that they do not get from their own families. Personal experience tells me that a number of the people who work in these categories go above and beyond the work that their job description may require in order to provide the comfort to those patients who may be alone in the world. We just need to find a way, even during this crisis that we are facing, a way to adequately provide the compensation and the benefits to those people that are doing this kind of work.

If any of you have any suggestions or recommendations that we need to consider, believe me, we welcome them. We will continue to work to try and find solutions to this situation that we have discovered.

Thank you all for taking your time to come today to testify.

This hearing is concluded.

(HEARING CONCLUDED)