# KACCT

Kansas Association of Community College Trustees

Thank you for the opportunity to testify as neutral on SB 453, though most colleges strongly oppose some portion of the bill and believe that further discussion is needed between all stakeholders, the industry, training providers, and KDADS about unintended consequences that might occur if this bill was passed. My name is Heather Morgan and I serve as the Executive Director of the Kansas Community College Trustees Association. I have never testified before on a bill in which such strong feelings exist on both sides with so many complex issues requesting to be resolved so rapidly. I will do my best to relay to the committee feelings from community college faculty on both sides of the issue about who is qualified to train Certified Nurse Aide's (CNA's), share our significant concerns relating to the simulation portion of the bill, and also relay some other areas where additional clarity may be valuable.

Initially when I became aware of the issue with qualifications for CNA course sponsorship I was representing the community colleges on a work group established by KDADS for entities who were teaching Certified Nurse Aide (CNA) courses. That group identified seriously outdated CNA and Certified Medication Aid (CMA) curriculum approved by KDADS as needing to be immediately updated and expressed concern with the length of time it is taking KDADS to approve the curriculum updates which had been long ago reviewed by course providers. In addition to this concern, the group discussed issues relating to temporary nurse aides (the new class of workers established during the pandemic to assist with staffing shortages), how to get temporary aides trained through the CNA classes prior to the emergency declaration ending, and discussed the need for increased flexibility about who could be a CNA course sponsor and teach CNA classes. As I heard the discussion and talked with community college health care faculty it was clear that more flexibility is sought related to registered nurses and above being able to be course supervisors for CNA classes without long-term care experience. Currently, to teach CNA's as a course supervisor, rules require all instructors have a Registered Nurse licensure and two years' experience with at least one year of experience in long-term care. This long-term care requirement does not exist for instructors at any other level of nursing education and prevents otherwise qualified instructors from teaching CNA's. This position is not unanimous amongst the colleges. Some colleges feel strongly that long-term care experience is critical to ensuring that faculty are able to share with students what they will truly encounter in that setting. Some believe that there are some aspects to elder care that experience in the LTC setting allows the instructor to more effectively mentor and teach the students about working in that environment.

One of the concerns frequently heard is that there are highly qualified health care providers who are prohibited from teaching CNA classes. Multiple different community colleges have nursing faculty members who are APRN's or master's trained Registered Nurses. These faculty teach in nursing education and can teach nurses at a baccalaureate level. These faculty may have over 45 years of nursing experience and the others have over 20 years of experience, they generally have over ten years of experience as nurse educators and have extensive experience supervising CNA's in hospital settings. However, they can't teach a CNA class because they never worked within a long-term care setting. Even though one of them even has prior experience working in a Medical Surgical unit in which most patients were geriatric, the regulations do not recognize that as long-term care experience. In these cases of highly trained and skilled health care providers there is no disagreement that the current statute needs to be examined to determine how these individuals could be course supervisors for CNA courses.

With that said, colleges do understand that the Centers for Medicaid and Medicare Services (CMS) has regulations that the State of Kansas must be cognizant of to ensure that whatever changes are made, comply with CMS requirements, to ensure the CNA training standards continue to meet their rules so that the students we train can work in CMS funded facilities. We understand the one year of long-term care experience is perhaps a CMS requirement. Any flexibility KDADS could get from CMS or other flexibilities which could be implemented, many of which are used in other states, which could be implemented here in Kansas we would encourage. Again, we caution the legislature to ensure that anything passed complies with CMS regulations to ensure students are not harmed and their future employability as a CNA is not jeopardized if the training would be deemed to be out of compliance with CMS regulations.

If the regulations have no flexibility colleges would still have to find that RN with one year of long-term care experience to oversee courses. The quality of the oversight of that RN is critical if lower-level providers were allowed to teach. There are significant concerns with the level of supervision RN's would need to be providing to ensure quality if LPN's were allowed to teach. In situations where training providers are dedicated to quality this may not be much of a concern. Unfortunately, sometimes other priorities prevail and shortcuts are taken which could lead to lower quality training being provided.

A CNA is the eyes and ears of every medical provider. They assist in the crucial activities of daily living of patients across the health spectrum. There is considerable interest from the public, particularly among high school students, to become a CNA. This is often a ladder career as these students begin their professional medical career and progress to Licensed Practical Nurses (LPN's) or Associates Degree Nurses (ADN's or RN's). There are hundreds of current openings in Kansas for CNA's. Both long-term care facilities and hospitals are struggling hiring people trained at this level to assist with the healthcare staffing crisis. We believe that carefully examining who can be a course sponsor and teach the CNA curriculum would allow us to hold more classes. However, we don't believe there should be any reason why a student who currently wants a CNA class should not have the opportunity to participate in one. When one college heard another training provider say they had to turn away students on a recent call, multiple colleges and other training providers spoke up and said "We do have colleges and training providers who have excess capacity, who could step into any geographic region of the state to teach if needed. We were unaware there was a need and would have stepped in immediately if asked." During the pandemic there is no doubt finding clinical settings was difficult. However, as the pandemic begins to subside there is no reason facilities should not be open to being clinical settings once again. Occasionally we find that communication could be improved between training providers and the industry related to any training needs that are being unmet. Utilizing KDADS a conduit between the industry and all training providers would assist the industry reaching out to other providers they may not normally work with but who could meet their needs and hold additional CNA classes. Community colleges across the state partner in this work everyday and stand ready to assist in any way possible to address critical health care workforce needs.

If possible, providing flexibility for highly trained RN and above staff to be course sponsors without long-term care experience would be helpful. In addition to this flexibility nursing faculty across the state wish to stress that any instructor needs to have appropriate training and up to date resources and curriculum so they can provide the best possible opportunities for the students. We urge KDADS to complete all curriculum reviews and revisions as soon as possible. The length of time it is taking to ensure Kansas has up-to-date CNA and CMA curriculum is a concern to nurse educators across the state. While no one opposes flexibility to allow RN's or higher trained professionals being course sponsors and teaching the course, there is <u>**strong disagreement in terms of allowing licensed practical nurses**</u> to teach CNA courses. A quick survey of the Kansas community colleges who teach CNA classes revealed that 70% of the colleges strongly oppose allowing LPN's to teach CNA classes. According to Higher Learning Commission guidance, the educational requirement is for people to be trained at one level above the content they are teaching for instructors in the career sectors. So, following HLC guidance the licensed practical nurse (LPN) could be appropriate for a CNA course. However, HLC is not CMS and is not an expert in the provision of healthcare or healthcare training. One nursing director at a college responded to my request for input saying "I would prefer the instructor to be registered nurse but that does not mean that a licensed practical nurse wouldn't be able to teach the course". Another stated that "despite high-quality competent LPN's possibly being able to teach the course and this making it easier to find instructors, my concerns continue to exist". If every school and training provider followed the highest standards of instruction and patient care, perhaps this would not be an issue. However, we know that is not the case and if we wish to stem the tide of the continual CNA turnover issues that plague the field, we need to ensure that they have high quality training from experienced and highly trained health care providers prior to entering the field.

A number of our schools feel so strongly that LPN's are not qualified that they would not lower the standards of who they allow to teach in their program even if this change was approved. The CNA class is a prerequisite class for LPN and ADN/RN programs. Any lowering of the quality of the instruction in this program is likely to cause other issues upstream in nursing programs and could result in students having a more difficult time gaining entry into the nursing program, successfully completing nursing programs, and passing the NCLEX. There are concerns that lowering the qualifications of who can teach CNA classes may lead to additional remedial education responsibilities of nursing faculty and in fact may

potentially require re-teaching some parts of the program. One college states, “while it is not easy, we have had no problem finding RN’s to be instructors. We feel so strongly that this degrades the quality of instruction and therefore patient care that we would not change our standards even if allowed to do so. We have experienced high pass rates within our LPN and ADN programs as a result of the strong foundation built through the current CNA rules and regulations for how training is conducted”. Another school who has amongst the highest quality nursing programs in the state with a very high NCLEX pass rates states, “We do not believe an LPN has the background to teach a CNA course. An LPN is not educated to assess, plan, or evaluate a patient’s care. The RN is educated to assess, plan, or evaluate a patient’s care. The RN is the only person who can check off the skills for the CNA which is stipulated in the bill.” Another school offers the counterpoint observing, “This bill would allow nursing schools across Kansas to hire any Registered Nurse or Licensed Practical Nurse to teach CNAs as long as they are under the general supervision of an RN who has one year of long-term care experience. This change would not lower the educational standards for CNAs nor negatively impact the preparation of CNAs. Instead, it would allow schools the ability to offer more CNA courses thereby meeting the crucial workforce demand. However, another college states “In my opinion the CNA course needs to be taught by a licensed RN, the RN has more leadership and education experience”. Another college shared, all nursing homes have nurses, but the majority of nurse are LPNs. Theses LPNs know the ins and outs of the expectation and job duties of the CNA. However, I would be concerned that these LPN’s work with us as colleges to ensure that no corners are being cut on training due to the facilities RN being too busy to truly oversee this training. We don’ have patients to care for so we can focus on ensuring the high-quality training and oversight which is needed to ensure CNA’s are trained properly. As you can see there are significant differences of opinion on if changes are needed, how changes may degrade the quality of training and care provided, and how changes could impact the CNA workforce in both the short and long-term.

After trying to lay out all the differing opinions on the who can train portion of the bill, we do have much more agreement on the simulation portion of the bill. About **95% of colleges responded that they are in strong opposition to the simulation portion of the bill.** The 5% who responded favorably toward simulation, did so with the following caveats: “Simulation is a great teaching tool if it is utilized appropriately. The instructor needs to know how to run a "true" simulation and have appropriate equipment and supplies. Simulation is a safe place for students to learn, make mistakes without harm to patients, and opportunities to complete tasks that they may not see in a clinical site. 25% would be a good maximum amount for simulation so that students are getting more hands-on patient care.” They went on to say that simulation does not mean on-line simulation but hands on in-person simulation in a lab provided by the college with appropriate teaching tools. The other said, “The National Council of Board of Nursing recently completed a national study in which our college participated, the study provided “substantial evidence that up to 50% simulation can be effectively substituted for traditional clinical experience in all prelicensure core nursing courses under conditions comparable to those described in the study” (NCSBN National Simulation Study, 2010 pg. S38). With this said, I would recommend that our programs use less than the 50% maximum since there are so few hours of personal clinical contact in clinical. The research has another caveat to be considered. “These conditions include faculty members who are formally trained in simulation pedagogy, an adequate number of faculty members to support the student learners, subject matter experts who conduct theory-based debriefing, and equipment and supplies to create a realistic environment. Boards of Nursing should be assured by nursing programs that they are committed to the simulation program and have enough dedicated staff members and resources to maintain it on an ongoing basis.“ (NCSBN National Simulation Study, 2010 pg. S38). Unfortunately, community colleges who generally meet this standard are not the only CNA training providers in this state and many providers would not meet this standard.

Other than those two colleges, all other vigorously oppose including the simulation change being proposed in statute. COVID was an emergency, the official state emergency declaration is over, the national emergency declaration will hopefully end soon as we move past the pandemic. Colleges do not believe that statute should be changed based on the situation we just faced. KDADS worked with providers to allow this simulation flexibility during the emergency. This should not become a standard course of business. I have heard a proponent say that this simulation flexibility is for up to 50% of the training. We are highly concerned that some providers will choose what they perceive to be an easier path and use the maximum simulation percentage which will not provide students the training they need to be successful. Additionally, the following comments were provided by Kansas community colleges:

- The department does not support this proposal. The Nursing & Allied Health Advisory Committee and local work force has already expressed concern regarding students who were not trained in patient care areas (used simulation) during the pandemic closure. This is a technical program which needs hands on interaction with an

instructor, clients, multidisciplinary teams and peers to be effective. The current statute allows for 20 hours of training face-to-face in the skills lab. With the remaining 25 hours completed in the long term care facility. Another college states:

- We STRONGLY prefer to keep the clinical portion of the training completely "live" or face-to-face with residents at a long-term care facility, with a RN instructing. We believe the lab portion of the training should be in an educational lab with mannequins - as we currently do. During Covid the State allowed simulated clinicals. Student feedback was very negative. Most students trained this way did NOT go on to gain employment in the field. Many didn't even take the certification examination. They were not prepared and they did not feel comfortable.
- When an RN is teaching CNA courses, 50% simulation might be ok. However, ff an RN is not teaching the CNA courses, then we do not support simulation. To be a preceptor, you have to have two years' experience in the area taught. Therefore, the RN should have at least two years' experience in the area taught.
- I do not think this is a good idea. During the clinicals in the LTC setting, the students interact with the residents, giving them firsthand experience of what it is like to care for people from all walks of life, with different disease processes, and different personalities. Each experience is unique, and it is impossible to simulate those interpersonal connections online. I feel like the students would not even have enough of an idea what it is like to actually be a CNA once they finished the class, and they would not be prepared enough to enter the workforce.
- I do not agree with 50% online simulation, it is not realistic. The students should have ample clinical time in the Nursing Home setting with the elderly residents. This allows the student to learn how to physically care for the resident and how to communicate with them.
- I do not believe allowing up to 50% simulation should be the norm. I also believe that 50% is extremely high. We already have a major gap in students being clinically ready for an entry level position. Now we're talking about the potential to widen that gap.
- I do not support simulation experiences to replace portions of the CNA course. The best way for students to learn is to be hands on with the population of people they will be caring for.
- This is concerning to us that it may affect the quality of instruction and care given. Virtual clinical and hands-on simulation are two very different types of clinicals. Hands-on simulation can be of benefit, but a totally virtual environment without a hands-on aspect would not support quality patient care or critical thinking and clinical judgment skills.
- I am not in support of changing the current requirements for in person clinical delivery to lab simulation or online simulation. Please see below a sample of reasons why I am not in support.
    - Students cannot comprehend the actual cognitive impairment that often accompany LTC residents through simulation. Without person contact training students will be unable to provide the cognitive care which coexist with the physical care.
    - Lab simulation or online simulation only provides an attitude and culture of "get the job done" task check-off oriented work, whereas person to person contact learning reinforces supportive care approach & builds on teaching person centered care.
    - Lab simulation & online simulation will not provide an opportunity for the student to engage emotionally & practice recognition of subtle facial & body language cues that are so vital to provide appropriate personal directed care, especially for those with advanced conditions who require an even higher level of personal perception and comprehensive care.
    - Use of, or more artificial care training over person contact training limits the student's ability to fully understand and recognize care and assistance needed for elderly.
    - Increasing artificial training over person contact training limits the student's ability to overcome the perception of real elderly care and will limit a student's ability to see how their care can positively impact and older adult.

As one can see there are many concerns with the simulation portion of the bill. In addition to these concerns the other suggestions were offered.

- "I would like to add that there is not a time frame noted in SB 453 that an uncertified person would be able to work. At this time when someone completes the 40 hours and checklist, they are only allowed to work for 4 months from the date that they started the training before they must be CNA certified or be terminated. Without a timeframe

set like this, there is no incentive for someone to complete the CNA training and become certified, thereby greatly decreasing the training of patient care workers which directly affects how the residents are care for." This might be currently set out in rule and regulations but if this statute is being amended should this be something considered for inclusion. Also there is nothing written about an opportunity for those that do complete the 40hrs and checklist to go back and start at part II of the CNA training to complete. Therefore, anyone wanting to become CNA trained would have to repeat part I (40 hours and checklist) all over again. Again, if this is in current rule and regulation should this be included in statute?

- Another college had similar concerns, "If Jane Doe wanted to find a job at an adult care home they could come in off the street, complete the 40-hour requirement and be done. There would be no enticement for Jane Doe to come back and complete the CNA 2 and get certified?" Again this may be in rule or regulation but should it be in statute?

- Page 2. The first line refers to 40 hours of training. This needs to be more clearly defined. Currently, the KDADS curriculum requires 20 hours of lecture on basic skills, 20 hours of lab on basic skills (and check-offs), 25 hours of clinical lecture on disease processes, and 25 hours of supervised clinical training in a long-term care facility. The bill is UNCLEAR which 40 hours of training they are referring to confusing training providers in the field if other changes are also made to existing practice/policy.
- Page 2-3 (B) It reads as if the goal is to have LPNs teach the training program, but have a RNs "supervise" and "evaluate" the skills check list. The word evaluate needs to be defined. Otherwise an RN could just sign off on a skills check list that was performed by a LPN.
- Page 2 (B). This seems contradictory as this paragraph refers to *supervision* by a registered nurse. Does this \ mean in Kansas that a LPN can teach the course under the "supervision" of a RN? Is this like a graduate assistant teaching a course at the university and the actual professor "supervising" the graduate teaching assistant? See CFR §483.152 *Requirements for approval of a nurse aide training and competency evaluation program.* It is item (5i) in the following link. https://www.law.cornell.edu/cfr/text/42/483.152

  **(5)** Meet the following requirements for instructors who train nurse aides;

  **(i)** The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;

In conclusion, there seem to be differing opinions on various aspects of this bill. Additional flexibility is desired as long as it complies with CMS regulations and ensure high quality training and patient care, colleges generally view the simulation suggestions in the bill as unnecessary and often may have negative impacts on students actually entering the workforce and being successful, and colleges have questions and believe additional clarifications are needed related to some definitions within the bill. We stand ready to work with any groups to tackle these issues in a thoughtful way with the appropriate time for all voices to be heard and the various issues addressed by the people on the group providing the training.

Questions contact: Heather Morgan, Executive Director of the Kansas Association of Community College Trustees, 785-221-2828, hmorgan@kacct.org.