Dear Members of the Madison, WI., Health Care& Public Health Workforce Subcommittee, Health & Human Needs Committee:

I have personally and recently, been reached out to by a small group of contacts, about forming a group for elder supportive care outside of existing systems. Specifically, these friends are not wealthy, likely have some health issues, are single, may have family distant, and who wish to find a way to live together within reasonably independent quarters with some shared elements. As I am a retired RN, Critical Care x 42 years, still pretty darn healthy & active - nearing 70, I have a fair grasp on most of the complexities therein.

For example, a quadplex is often mentioned as a start, but a standard quadplex is not set up for conjoined living in terms of service supply (single vs x4 - elect/water/computer/heating-cooling...). A more workable scenario might be multiple bedroom/studio spaces with 2 shared kitchens, or fragmentary kitchen elements within a unit (sink/microwave unit), and access to a full kitchen shared kitchen (ideally 2 fuller kitchen workspaces), and communal full bathroom with individual basic partials dependent on size of group. Parking and shared vehicle access can be expected. The idea is the members choosing to work together in aging, do so as a sort of family unit.

Coming from a family of eleven siblings, I am familiar with all the ways that this sort of setup could fail, AND I am very clear on all the ways in which it can work.

End of personal 'introduction' to Committee Members.

Public comment section:

I am curious about is community/governmental support for citizens like myself, of modest income, who may or may not be able to afford a co-housing arrangement, yet want to be in close community with friends who can then help each other within aging process. That also suggests roles for community wellness, care & oversight involvement (eg periodic Visiting Nurse, Social Work contacts for setting assessments/support - not disciplinary roles). This communication is about that subject.

IS there a role for Govt (Local/State...) in supporting this potential direction in transitional & supportive self-care for elderly? I'd prefer to take my chances with friends than move into a distant neighborhood institution where elderly are warehoused. I know I must plan to accept and work within that option if it evolves for me, nonetheless, and I will work to make it as successful for myself as feasible.

I have no dependents - and I don't belIeve in relying on dependents to assume these responsibilities. A close friend is currently doing 24/7 elder care (neighboring county) and is unable to find qualified caregivers that qualify under his Mother's old age Insurance policy, which she's had for at least 30 if not 50 years. The policy requires CNA to be personally certified, not adequate to be certified by an outside agency where they might also work. Everyone requests $ under the table. Pay is poor and work is hard. No family members (undetermined to what depth - third cousins, fourth cousins...Insurance Co says anyone who is related (including anyone married into family & their relatives - - six degrees of separation applicable here)...so in a smaller community in a rural county settled in 1850-1900, almost everyone is related somehow. That makes this long term Insurance policy useless and unaccessible, and so one individual family member is left loaded with a highly unrealistic - and dangerous load (safety for both, over-workload for caregiver). I have asked this individual to call the Wisconsin State Insurance Board for advice in some resolution or comment on 'interpretation' by Insurance Agency, on what terms

a 'relative'. The reality is that the available care-givers are not out there, and population trends do not support growth within that market - quite the opposite.

SO, how do elders work to care for each other in our aging process, and how can organizational support be garnered - somewhat outside of the *ball & chain only 'for-profit' market*? Aging resources seem unable to deal even with simple trials/challenges (support options), as again, the realities are too overwhelming for practice as usual, and funding and care options lag severely. If Institutional care is the only available answer, we have a problem. WE HAVE A PROBLEM.

IS there room for a conversation directed at how something friendlier might evolve? Am I missing something that already exists - something that is within a healthy aging centric design outside of the corporate care market? I'm happy to be more informed. I've worked in health care, RN in Critical Care > 40 years, so I do understand the serious lapses in spoken promise and reality, bedside. The suggestion/idea, to simply stick with what exists...and tough - you die soon anyway, has significant and severe limits.

Elders can - likely with limited targeted support, including housing structure, design, flexibility in 'no more than two unrelated individuals'...any sort of restrictions that limit senior options. Senior needs are unique as with all age-related needs. Elder assisting oversight and care may only supply so much, but if that supply includes the caring community, eyes with oversight & concern, and critical contacts that best avoid Emergency Rooms (obvious exceptions) and support self-directed goal setting: Let me survive in active community, with normal evaluation and care option advice and intervention, yet minimize the 'catastrophe ' of inevitabilities (the inevitable, death, is not a catastrophe - it can be a rich and fulfilling time for the dying and those attending to/caring for. There's ETHICS buried in there, obviously, in choice process and discussion, preparation for 'inevitability', joy as possible until that happens, and as needed, in situations of growing physical disability and dementia, increasing levels of assessment and discussion regarding proper intervention - even institutionalization at that point if best/required.

Help give the elderly more options for self-derived caring, in life and in passing beyond into Cosmos.

Respectfully,

John Steines
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I will contact Ald Grant Foster about this subject in some form as well (decided to cc). Also, SS Mayor. Thanks. j

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I have been a inpatient hospital RN for nearly 40 years. Every night or day sleep would be a problem for me as I kept hearing the IV Pumps beeping and hard to turn your brain off. I could solve that with relaxation techniques and steaming calm sounds or music.
Post Covid on top of Lean Staffing(cut staff to make more money) is ugly everyday. My peers are crying every shift due to stress, time constraints, patient and family behavior problems, short staffed and overall frustration!

We do not want to turn into alcoholics or substance abusers but the lack of support, respect and staff can not be relaxed away. Suicides are up amongst healthcare workers. Human Resouce Departments are less than helpful when no one answers the phone or calls back. Wellness programs take time to exercise and plan and cook healthy meals. Time away from work is so limited with so much turnover and shifts not filled. New ideas and methods need to be tailor fit for this level of constant stress.
Instead of covering holes with Traveling RNs and Internal Traveler inticements, listening to staff ideas for moral, respect and a safe patient to nurse ratios need's to take legs and reestablished. In the short run until our for profit system of healthcare delivery ecconomically rewarding nondirect care administrators is turned around trauma recovery programs need our attention and funding.
Nurses that use to love their job, end a shift satisfied that they made a real difference are contemplating another profession. Our desire to help people is being taken advantage of in the name of better bottom lines. Guilt tripping and begging for Xtra shifts from overused staff is the norm. Budgets have a cycle, a start and finish. This shortsighted accessment tool does not focus attention to the chronic chipping away of their most valuable resource NURSES! If a nurse does not want one of her family members admitted to her hospital without a 24 hr private healthcare trained advocate then what does the average patient get?
We cannot keep this pace up and have shone it by voting with our feet.
This crisis needs relief YESTERDAY!!
Thank you for your thoughtful attention to this matter.
Sincerely,
Ann Louise Tetreault RN

Good evening,

My name is Justin Giebel, a registered nurse in the Trauma and Medical ICU at UW Health where I have been a nurse for nearly 3 years. I want to thank you for hearing my comments once more. I wanted you to hear my words, but I'm on a much-needed vacation at the moment so written will have to suffice. I'm hopeful that this committee is still dedicated to creating the trauma recovery program, as the experiences that I told you about a few months ago still ring true. Though the number of COVID-19 patients has decreased, we remain overworked, understaffed, and essentially running on empty in many cases. Daily messages from work asking for staff, anticipating unsafe staffing, and low morale have become part of the norm for many of my colleagues.

We currently draw support from one another, medications, therapy, or maybe some more unhealthy coping mechanisms. Notice I never mentioned our facility and leaders. That's because the resources provided fall under at least one of these adjectives: inaccessible, inadequate, or ineffective. My vision is that this committee help fill in those gaps.

I firmly believe this is of the utmost importance for our community, and even our state. UW Health and other area hospitals are beacons of care for our state and other communities surrounding us. Our ability to provide exceptional, and dare is say "remarkable" healthcare is being bled out in the form of RNs leaving the profession entirely, leaving to travel, or going to other facilities with better pay, benefits, and quality of life.

When I became a nurse, they had already prepared me with all the statistics in school. By the time many RNs get to 5 years of experience, they're looking for a way out of the profession. At that time, I thought that sounded ridiculous; why would I work as hard as I have and spent as much money to get a good

education just to leave? But now I’m in that statistic. The thing is, I don’t want to be. I want to continue to care for patients. However, the environment in which the provider is giving care is often so unhealthy for the provider that we have trouble providing healing to others.
The leaders of our hospitals and this committee, partnered with nurses and other healthcare providers, have the ability to change this. The work will be hard but it must be done. Thank you for your time and I look forward to working with you.

I have worked as a CNA for the entirety of this pandemic. I have seen so many people walk away from the healthcare field because of the issues that came with it. Remember when we were the essential heroes? Now it seems as if the world has just fallen apart and we are left to deal with the mess. I still come in day in and day out because if I am not taking care of my people who is? With the staffing shortages I say up worrying about them. Things that would greatly help me out would be some affordable daycare. I would be more willing to pick up hours if there was incentives such as a bonus for me to take a step away from my personal life and then not have to turn around and hand it over to a daycare provider for both of my children to be full time in the daycare this summer it would be roughly 2800 so at my current rate of pay at 21.25 I'm working 131 hours a month just to pay for daycare leaving me with 50 hours that would be my take home pay 1050 which is not even enough to cover my rent plus the price of gas and food it's impossible. I actually work three jobs. I bartend part time on the weekends and work at a restaurant part time.

Gloria Serio