RETIRED AND SENIOR VOLUNTEER PROGRAM
OF OUTAGAMIE COUNTY

Chris Jossart
RSVP Director

Volunteer Center of East Central Wisconsin
820 W. College Ave., Appleton, WI 54914
920-832-9360 Fax 920-832-9317

"Providing Our Community with a Valuable Resource — Seniors in Volunteer Service"

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3-26-99

Dear Rep. Gard -

Attached is preliminary information regarding a forthcoming formal proposal to increase State funding for the Retired and Senior Volunteer Program (RSVP) in Wisconsin.

RSVP Volunteers have saved almost $18 million to local, community-based programs, helping several agencies and non-profit organizations. RSVP volunteers age 55 and older, impact all ages of all communities throughout Wisconsin.

Currently the State funds 22% of our RSVP sites. Budget information is also attached.

Thank You

Chris Jossart, RSVP Director
Outagamie Co.
920-832-9360

Odd Fellow Home

1229 S. Jackson Street
Green Bay, WI 54301
920-437-6523
FAX: 920-437-9896

March 25, 1999

Honorable Governor Tommy Thompson
And State Legislators

I am writing in regards to the proposal for a Wage Pass-Through for nursing home employees. I strongly feel this proposal is certainly necessary to prevent a "**state of emergency**" to our health care facilities. Without assistance, such as this, it will become increasingly difficult for us to properly staff our skilled nursing facilities. Many of our nursing homes are in jeopardy already with the budget cuts in Medicaid.

We, at Odd Fellow Home, strive to provide the finest quality of health care services to the elderly who are entrusted to our care. The nursing assistants, nurses, housekeepers, activity and dietary aides are just a few of the personnel who are a part of the resident's lives each and every day. It is because of their hard work and dedication that we have been able to meet the needs of the residents.

By hard work, I mean the nursing assistants who help bathe, dress, and feed the resident and then add a touch of make-up to lift their spirits or mend the residents clothes because they don't have family members to do it. The dietary aide who goes out of her way to pass out nourishments to the residents to assure they do not have weight loss. Even the activity aides who add quality of life to our residents by taking them to the bowling alley or to a restaurant.

By dedication, I mean the aides and nurses who fill in extra hours because we have been unsuccessful in hiring new employees, even though they have families of their own to care for.

Due to the low unemployment level, this leaves nursing facilities with very little resources to recruit from. In addition to this, Medicaid funding has been cut. The nursing home formula was cut nearly $47 million in 1997-99. Medicaid funding is the primary source of payment for the nearly 60% of residents in our facility. Medicare payments to skilled nursing homes are also expected to be reduced by 17% over the next five years.

Add this with the recent increase in staffing levels for skilled nursing homes and it creates a very precarious position. Unfortunately, this has a direct effect on the wages we provide to our employees.

I am proud to say the average wage for nursing assistants in our facility is one of the highest in this area. However, many employees are single parents. The average $9.15 an hour does not go far in obtaining the necessities for them and their families. Do you really feel the average certified nursing assistant (CNA) wage in the State of $8.32/hour is sufficient for the difficult work they do?

Again, due to the low unemployment level, we are competing with fast food chains and retail stores, not only for new hires but for keeping the current staff as well. We continue to try other means of obtaining staff by offering a unique benefit package. Such as bonus pay for extra weekend hours worked, state-of-the-art equipment to make their job a little easier and safer, year end bonuses for good attendance. However, these creative enhancements are not enough to obtain the staffing level we would really like.

We currently have several nursing positions and four CNA positions available for over a year. The wage pass-through would have significant benefits in attracting employees to the health care arena. It would be advantageous to be able to increase the wages and also enhance their benefits so they could receive health insurance, which many of them feel they currently can't afford.

The reduced funding provided through the Medicaid and Medicare programs are not sufficient to allow for recruitment and retaining competent staff. This certainly will impact the quality of care.

I ask you to support the wage pass-through so that Odd Fellow Home, along with many other skilled nursing homes, can ensure that our residents, perhaps your parent or grandparent, will be cared for by competent, compassionate employees.

Sincerely,

Mary Osmond

Mary Osmond
Administrator

VILLA HOPE CSP

OF BROWN COUNTY

2673 Humboldt Rd. ✣ Green Bay, WI 54311-7142 ✣ (920) 469-7030 ✣ Fax (920) 469-5599

Villa Hope Community Support Program

2673 Humboldt Road

Green Bay, Wi. 54311

Dear Joint Finance Committee:

Subject : Title 19

Villa Hope Community Support Program serves chronically mentally ill clients who reside throughout the community of Green Bay. We provide psychiatric and psychological services, case management, and medication monitoring to enable our clients to live independently.

We strongly oppose legislature to discontinue Medical Assistance reimbursement to pharmacies. Without reimbursement pharmacies would not be able to provide blisterpaks for medications. Currently 75% of our clientele utilize blisterpaks. These have a vital role in enhancing medication compliance. Should this service be discontinued clients would receive medications in bottle form, many having 6-10 or more bottles of medications. Certain clients would no longer be able to self-medicate resulting in increased billing of case management services to Medical Assistance. Without the convenience of blisterpaks, some clients will likely forget to take medications and decompensate, resulting in an increase in hospitalizations. Clients who are currently seen daily or twice daily for medication monitoring would have to sort through multiple bottles and determine which medications are to be taken at certain times (case managers may not dispense medications, may only observe medications). Without blisterpaks time billed to Medical Assistance for medication monitoring would increase two to three fold.

Many clients have frequent medication dose adjustments or medication changes. If bottles are used many medications would have to be thrown away (pharmacies can not take back opened bottles). Blisterpaks save a great deal of money because they are packed in individual weekly doses. They can be brought back to the pharmacy to add or remove pills.

In conclusion, pharmacies would not be able to provide blisterpaks or make deliveries without reimbursement from Medical Assistance. This would have a devastating effect on our clientele. Case Manager billing would increase substantially and clients who do not receive daily services will likely have difficulty self- medicating, resulting in additional costly services. These costs could be staggering. Please act now to keep Medical Assistance reimbursement to pharmacies intact.

Sincerely,

Nancy Butler, MS

Nancy Butler
Clinical Coordinator/ Director
Villa Hope Community Support Program

Paul R. Francan BA
Lynne R. Rotzenberg, B.S.
Kaari Nyberg BA
Nydia Esbona
Marcia Baeten
Jeri Fioramanti
Becky Devine, B.S.
Bri Hyttenen, BA

Dear Committee members,

I am writing in regard to the proposed certification biannual fee for adult day centers of $100.00 per site and $20.00 per client. As an adult day service provider, we have always embraced the certification process as a means of quality assurance and waiver program monitoring. In addition we feel the certification process legitimizes the role of adult day centers in the continuum of long term care. We understand the field is growing and the demand for licensing staff is great, however, I have some concern of the affordability of the biannual cost of certification. For example, we are currently seeking certification for an adult day program in the Green Bay area thus making it our fourth site.
If I understand the proposed biannual fee structure, it would cost the following:

Four specific adult day sites @$100.00..... .....$400.00
site1 capacity @70 x $20.00.....$1,400.00
site2 capacity @25 x $20.00.....$500.00
site3 capacity @12 x $20.00.....$240.00
site4 capacity @ 30x $20.00.....$600.00

$3,140.00 biannual $1,570.00

Nearly all adult day centers have budget situations where they either break even or are losing money. Unlike CBRF's who are profit making ventures, many adult day centers continue to exist due to the support of sponsoring agencies and/ or public dollars. We have found that families desire an affordable alternative to the costly fees of CBRF's, adult family homes and/or nursing home placements. A more reasonable consideration would be a flat rate fee of $100.00 per adult day center site, regardless of the size or capacity.

Thank you for you time on this matter. Should you have any questions please feel free to call me at (920) 468-9129 ext. 169.

Sincerely Yours,

Mary Jirak
Adult Day Program Director .

PHONE (920) 734-9871
FAX (920) 734-0731
TDD (920) 734-2569

AGAPE OF APPLETON, INC.

7 TRI-PARK WAY • APPLETON, WI 54914-1661

TO: Joint Finance Committee:
Senator Brian Burke, Representative John Gard, Co-Chairs

Committee Members:
Senators Burke, Decker, Jauch, Moore, Shibilski, Plache, Cowles, Panzer;
Representatives Gard, Porter, Albers, Kaufert, Duff, Huber, Ward, and Riley

FROM: Lee Bishop, Executive Director

DATE: March 26, 1999

SUBJECT: 1999-2000 Biennial Budget

I would like to take this opportunity to address the committee members regarding the 1999-2000 Health and Family Services Budget proposals.

I represent a private non-profit agency which provides supported community living services to individuals with developmental disabilities in the Fox Valley. We currently contract with various county governments to provide the supports which allow nearly 200 individuals to participate as productive, contributing members of their communities.

I will be so bold as to claim to represent the interests and concerns of the vast majority of these individuals, their parents/guardians, and our staff.

We are very concerned about the massive decrease in community aids in the Biennial Budget. These pass along cuts from the Federal Social Services block grant reductions will not only add to current waiting lists, it will result in hundreds of individuals who are currently receiving services being dropped from current programs. Without supportive services many individuals will deteriorate physically, mentally, and emotionally and require much more costly care in the future. The old adage of a stitch in time saves nine would appear to apply in these circumstances.

I would like to address the Governor's Family Care Proposal. I have serious reservations regarding the current plan and its implementation schedule.

I would concur that a revision of the jumble of overlapping, confusing, and unnecessarily restrictive funding mechanisms is in order. Often the least restrictive, most cost effective alternatives are not available to citizens because the "slots" are filled. One funding resource may be depleted while other resources go unused because an individual does not meet that funding sources eligibility criteria. I support the concept of a single stream funding mechanism.

I have serious reservations and many questions regarding the Family Care pilot projects proposed in this budget.

1) Why are we "piloting" more counties than were suggested under the initial implementation plan in the first year? I am concerned that this may be a "back door" approach to the program's full implementation.

2) There is no mechanism for independent review of the pilot projects' effectiveness. We also need a long enough period of time after the pilots are completed to perform this review. How do we go back if those pilots to not work? Are we leaving few options other than Family Care after the pilot?

3) There are no pilot projects of any alternative plans (survival coalition plan). We should pilot all alternatives simultaneously to evaluate all options.

4) Why does the Department of Health and Family Services insist on the legislation implementing all of the statutory language for Family Care if only pilots are planned? Full implementation of Family Care would be a Department decision in the future without legislative approval. If the Department wants only to do pilots, then why are they not satisfied with legislature approval with a sunset clause?

5) Why does the Department of Health and Family Services believe that a for-profit case management organization is going to be more cost effective in operating programs than county governments? By definition, a for-profit is obligated to do all it can to make a profit for its shareholders. These profits are not available for programs/individuals. There must be a decrease in services available for the same dollar amount comparing a for-profit with a non-profit or governmental agency. At the very least insist that CMO's be non-profits. If for-profits do not make a profit they will get out of the business and who then will operate the CMO's?

6) How will current county government overmatch dollars be replaced in the Family Care Human Services budgets? If Family Care takes the county governments out of the system it must be ready to replace these resources or significant degrading or elimination of programs will occur. Does the Department believe county governments will turn over millions of tax payer dollars to for-profit CMO's without any input or oversight?

7) Family Care is being promoted as a mechanism to give individuals the ability to make choices as to service providers. I question what the reality of this will look like if the funding is decreased; programs curtailed or eliminated; resources allocated to profits vs. programs or small providers getting out of the business because they cannot compete with larger corporations which can afford to temporarily absorb losses to secure the market share. The concept of choice must be backed by the reality of choice.

8) I believe county government has, overall, done an excellent job of providing services to its disabled constituents despite the beurocratic nightmarish system they are forced to work under. Now the Governor and the Department propose to add a whole new layer of bureaucracy to a system inundated with conflicting regulation and oversight. Free the hands of the local governmental organizations to be cost effective and they will be.

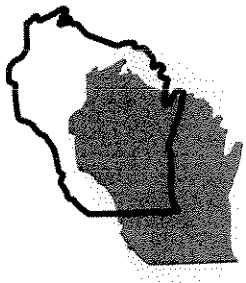
Finally, I have one general observation. I find it incongruent and inconsistent that the Governor of this great State would use a forum in Washington DC to advocate for local control of federal funded programs yet follow a different tact in his home State. He has stated on numerous occasions that those individuals closest to the people should be allowed to decide how to allocate resources. Now the Governor and Secretary Leean seem to believe the local county governments cannot make allocation decisions. They appear to believe that local control stops at Madison, not the local county seat and that the smallest responsible unit of government is the State government.

Thank you for your consideration and the opportunity to express my concerns.

LJB/tb

Where Quality of Life Never Grows Old

Wisconsin Association of Aging Unit Directors



TO: MEMBERS OF JOINT COMMITTEE ON FINANCE

FROM: SUNNY ARCHAMBAULT, PRESIDENT
WISCONSIN ASSOCIATION OF AGING UNIT DIRECTORS

RE: FAMILY CARE

DATE: MARCH 26, 1999

On behalf of the Wisconsin Association of Aging Unit Directors, I am submitting to you a copy of our expanded position paper on Family Care. The Association believes that Family Care is necessary if older persons are to have an ***entitlement to community care***--a principle that we have been advocating for for nearly 20 years.

While we have issues with this legislation, because of its importance for older persons we support the passage of Family Care now. The information obtained through the pilot counties will provide us with the data and experience we need to seek any necessary improvements and changes to this legislation. ***After 18 years of COP, 82% of all dollars spent on long term care for seniors is still going for institutional care.*** We cannot simply expand COP. We need real long term care reform. We ask for your support of Family Care in this state budget.

WISCONSIN ASSOCIATION OF AGING UNIT DIRECTORS
EXPANDED POSITION PAPER ON FAMILY CARE
MARCH 1999

1. Family Care makes community based care an *entitlement*--the issue on which WAAUD has consistently said it wouldn't compromise. An entitlement is not offered in COP, in 51 legislation, in the Oregon system or the Alternative Proposal. An entitlement is a legally enforceable right to the service. Currently the only entitlement the elderly have is nursing home care. If you need community care the state only has an obligation to the extent of the dollars legislated for it. Oregon , which has been referred to as a model program, has never had the number of nursing home beds that Wisconsin has. It has administered its long term system so as to use every opportunity to support community based care. Wisconsin has not had the same legislative commitment to community based care. It would be naive to think we could get it without a reformed system.

2. Without reform the current system will collapse in 2010. The Family Care Plan has been three years in the making with input from every imaginable stakeholder group. If passed now it will just barely be in place by the time the first baby boomers will hit the long term care system in 10 years.

3. Family Care pools dollars drawn from nursing home and community based care into one pot to be controlled at the local level. Funding for the Alternative proposal, which is an expansion of COP, would depend on the willingness of the legislature to increase funding as waiting lists grow. Wisconsin is now spending $900 million on nursing home care, primarily for the elderly.

4. An opportunity for an entitlement to community based care should not be held hostage to the issue of CMO competition and separation. The state should be encouraged to continue working with HCFA to extend or eliminate the period in which counties could operate a CMO without competition and to eliminate barriers created by the separation of CMO's from Resource Centers. However, we can't put local organizational issues before what is good for older people. These concerns should not override our support of the legislation.

5. Family Care does not destroy what we've built in COP. In the midst of all our concerns about who gets to run the program and for how long, we've forgotten that the proposal is built on the principles of more options, greater opportunity for self-direction, choice of service settings and providers, dollars following the individual--all the things we've been striving for in COP.

6. Unlike other target groups, some elderly will always need nursing homes. Family Care promotes appropriate utilization of nursing home services by giving local control in contracting for quality care and offering opportunities for greater collaboration with local nursing homes.

7. Resource Centers have been cited by consumers throughout the state as a critical component of a long term care system. If Family Care legislation is not passed it is unlikely that the legislature will come up with the additional dollars to fund this service.

8. Eligibility is broadened and asset limitations are expanded to encourage participation of more older persons with long term care needs.

9. Family Care removes some disincentives to work for persons with disabilities who wish to remain in the workforce but need access to Medicaid and community based care.

10. Given our support of the legislation we would like to recommend the following amendments to improve the plan for older consumers:

a. Restore the requirement for local long term care councils as described in the plan to assure local accountability and control of this new system, replacing the COP long term care committees.

b. Change the name of the plan. "Family Care" is not something that seniors relate to as a program for them.

c. "Aging Resource Centers" should incorporate the values expressed in the Older Americans Act and the Wisconsin Elders Act.

d.. **We need more money *now* for the Community Options Program, elderly nutrition programs, and increases in the Medical Assistance Personal Care rate to support people trying to remain in their homes**. Elderly and disabled consumers in sixty-three counties cannot wait for the results of nine demonstrations

We have come to understand the position of persons who work with the developmentally disabled, but ***those of us who are advocates for the elderly believe that the Family Care legislation is good for older people in this state.*** It is the elderly and physically disabled that have the most to lose if this legislation is not passed. If it does not meet the needs of the developmentally disabled, then it may be time to separate the funding ties that bind the programs of our respective constituents.

Dear Members of the Joint Finance Committee,

I am speaking to you today, **3/26,99,** as an employee of an Independent Living Center, the Chairperson of the Northeast WI Advocacy Coalition, and a person with a disability.

I would like to address two issues that are separate but in all actuality work together.

The 1st issue is W-2 and it's effects on SSI recipients with children and parents with children with disabilities. W-2 has been a wonderful addition to our state. It has done away with welfare system and is assisting people in the areas of work training, work placement, etc... all to achieve the goal of gainful employment for individuals. Giving them a sense of achievement, pride and the joy of giving back to the community. Yes, it is a plan that is working well with a few minor exceptions that cannot be overlooked.

In my work as an IL Specialist at Options for Independent Living in Green Bay, we have received many calls into our office from parents who have a disability and are on SSI and are not working. They have had their AFDC cut and now get a caretaker supplement (C-Supp) of $100 per child. They have lost 1/3 of their income (which was at poverty level before the AFDC was cut) and are not eligible for W-2 services. They have no where to turn to for assistance and have lost 1/3 of their income! The second group of people negatively affected are the parents with children on SSI. The parents are eligible for W-2 services and would like to work but because of the severity of their childs disability they are unable to find day care to look for a job, or go through training for job placement. They also, because of the cuts in AFDC, now receive a C-Supp payment lowering their income 1/3. There is nowhere for these parents to turn. We had heard and read story after story in regards to parents not being able to pay lights bills or heat their homes this past winter or have had decisions on whether to purchase food or medication.

I could go on but I hope by reading the attached information you will understand the reason I am addressing this issue. I understand the Governor has proposed an increase in the C-Supp to $150 per child. It is my hope that you will support an increase of $250 for the 1st child and $150 for each additional child. This will bring these families much closer to what they were receiving on AFDC. Additional funding could come from the TANF funds. It is also my hope that this committee address the issue of allowing the doors of W-2 services to be opened for SSI recipient who want to work (for there are those with disabilities who will never be able to work) and need child care expenses, training, etc., and that you would also investigate ways to provide child care for the children with disabilities whose parents are W-2 recipients.

The Second issue I bring to you is restoring a minimum of $2.4 million (in GPR funds) over the biennium to the DVR Budget for local employment services. It has come to my attention that for every $1 the state puts into this budget it receives $3.79 from the Federal Government. I see this as a win-win situation all around. DVR is a statewide agency assisting person's with disabilities in achieving their work goals. The 3rd Party match money has been great for the colleges and tech schools but it does not provide the same services in the local communities as DVR. With the funding for DVR being cut over the past two three years, I have seen individuals not receive the services necessary for them to achieve their employment goals. If they cannot receive the services, they do not achieve their goals of employment and so the continue on in the system. I am a DVR client from way back. It was DVR that assisted me in achieving my work goals 14 years ago and I am happy to say I have been working for 13 years at the same organization. It is sad to see that because of the lack of funding, services are being cut back and those who want to work are still in the system. Here we have a chance to receive triple our investment in DVR plus there are further incentives for our state. For example cost saving in placement cost: It costs DVR on average $500 in placement for one individual while placement cost for the 3rd party matches are per individual are approximated at $5,000. Another incentive is reimbursement monies. For each individual on SSI or SSDI who has a successful employment placement, the SSA pays back DVR for placement costs.

Again, this is a win-win situation for our state and I would hope for you support in restoring this funding to allow DVR to do the statewide work they have done in the past. What a good way to use our tax dollars and I as a tax payer am in support of this.

In tying these two issues together...if W-2 is allowed to open it's doors to SSI recipients, these individuals can be assisted by DVR to achieve their work goals. Putting people back to work, building an infra-structure that works for all segments of our society will create stronger families, stronger communities and continue WI as a leader across the nation.

Thank you for your time and consideration.

Sandra L. Popp, 1670 Western Avenue, #17 Green Bay 54303
IL Specialist

The following is a snapshot of the AHEC issues and the budget request:

AHEC currently receives $800,000 in state funds. This allocation is supplemented by $763,434 in federal core AHEC funding this year, providing the Wisconsin AHEC with a base operating budget of a little over $1.56 million for FY 99. The AHEC System reaches the end of its eligibility for federal core funding in September 1999. We are asking for a $700,000 increase in the state allocation for each year of the 1999-2001 biennium.

The AHEC program aims to improve the distribution, supply, quality, utilization and efficiency of health personnel in underserved communities. AHECs establish programs in underserved areas, educate medical and other health professions students in community-based ambulatory settings, and provide primary care residency training. AHECs also recruit rural and under-represented minority populations into health careers. In addition, they provide continuing education and career ladder opportunities for health care providers in underserved areas and provide technical assistance for health promotion and disease prevention programs in local communities.

The federal AHEC program provides no more than six years of core funding to each regional center. At the peak of federal funding in 1996-1997, when all four centers were eligible for federal funds, the System had a total combined state and federal budget of $2.76 million. Federal funding for the Northern and Milwaukee AHECs ended in FY 97, and FY 99 mark the final federal funding year for Southwest and Eastern AHECs.

With core annual state funding of $1.5 million, programs that the regional AHECs plan to support in the upcoming biennium include:

1. Development of Rural Training Track residency programs
2. Expanded opportunities for medical and other health professions students to train in rural communities
3. Training in Federally Qualified Health Centers
4. Community-based training in central city clinics
5. Agricultural Health and Safety Center
6. Programs to provide coordinated services for rural elderly
7. Community health systems development
8. Library learning resources for small hospitals, clinics, and public health agencies
9. Technology support for health information resources in local communities
10. Continuing education for health professionals and community health improvement
11. Support for extension of dental services to underserved communities through development of community-based training sties for dental students
12. Physician Assistant, Nurse Practitioner and Certified Nurse Midwife training and recruitment
13. Health careers opportunity programs
14. Cultural competency training opportunities

OUR LEGISLATIVE GOALS FOR SERVICES & PEOPLE:

Strengthen employment opportunities for many citizens with disabilities by:

• ***Restoring $3,733,067 in Wisconsin General Purpose Revenue (GPR) to the biennial budget of the Division of Vocational Rehabilitation to leverage about $13 million in federal funding*** which will expand service options and better address the individual employment needs of each person with disabilities requesting services.

Assist low income parents with disabilities by:

• ***Increasing the Caretaker Supplement Program to $250/month for the first child.*** We support the Governor's request to raise the supplement to $150/month for each additional child.

• ***Expanding the eligibility for W-2 childcare assistance to parents on SSI*** while they are looking for work or participating in education or training leading to employment.

• Maintaining administration and programs sensitive to the need for longer and more specialized training efforts that may be necessary to secure quality employment opportunities for a person with severe disabilities.

Provide desired & least restrictive services in the community by:

• ***Increasing the GPR appropriation for Community Aids by $18,000,000*** to replace lost federal block grant funds and provide for a 3% cost of living increase for each year of the biennium.

• ***Increasing Community Options Program Funds to provide for 1,500 additional regular COP participants and 3,500 COP-Waiver participants.***

SSI PARENTS COALITION

March 22, 1999

LEGISLATIVE ALERT
ON THE CARETAKER SUPPLEMENT FOR FAMILIES HEADED BY A PARENT ON SSI

***Background Information*: Over 10,800 children in 5,547 Wisconsin families headed by a parent with a severe disability have been harshly affected by the reduction in family income resulting from the Wisconsin Works (W-2) Program.** Prior to W-2, low-income parents with severe disabilities received Supplemental Security Income (SSI) for themselves, and a child-only AFDC grant for their dependent children. Since January 1, 1998, they have had their income for their children significantly reduced. Families are in crisis and report they are unable to pay their rent, feed their family or pay basic living expenses. Parents state that they are unable to do anything for their children, that they feel they are being punished for their disabilities, and that the constant worry is affecting their health. The severe disability of the parent limits their ability to bring in extra family income.

"AFDC should not have been taken away from the disabled. We can't work. We can't borrow money. We are in a poverty prison... We did not ask for our diseases or injuries. We should not be forced below poverty."

***Current Status*:** The families currently receive a Caretaker Supplement grant of $100/month per dependent child. The Governor's Budget includes an increase in the Caretaker Supplement to $150/month per dependent child. The increase would occur on October 1, 1999 or later if the budget has a delayed passage.

RECOMMENDATIONS:

1. Provide the families with a stable, livable income by increasing the Caretaker Supplement above the Governor's recommendation of $150/month per dependent child to $250/month for the first child and $150/month for each additional child. The cost of the additional $100/month per family would be approximately $6.65 million of federal TANF dollars. Increase the Caretaker Supplement as of July 1, 1999.

2. Expand the eligibility for W-2 child care assistance to parents on SSI while they are looking for work or participating in education or training

3. Provide all W-2 services (except a cash grant) to Caretaker Supplement families including service coordination, life skills training, transportation assistance, and job search assistance.

4. Include in the Caretaker Supplement program, the child of a minor child when both are living with a grandparent on SSI.

5. Use 100% TANF (Temporary Assistance to Needy Families) dollars instead of a portion of the GPR SSI Maintenance of Effort to pay for the Caretaker Supplement.

6. Protect the families from losing the Caretaker Supplement when they temporarily lose their SSI by making families eligible for a Caretaker Supplement when they receive SSI related Medical Assistance.

ACTION STEPS:

The families with a parent with a severe disability need your help to increase their monthly grant. As the Joint Finance Committee reviews the Governor's budget request, let them know of your concerns for the Caretaker Supplement families.

TALKING POINTS

- Families are living below poverty level and are having trouble feeding and housing their children. An additional $100/month for each family would help the families provide for their children.

- Many of the parents, because of their disability, are unable to work to bring in extra income. To receive SSI a person must have a medically determined severe physical or mental impairment.

- The parents in the Caretaker Supplement program have a wide range of severe disabling conditions including physical disabilities, chronic mental illness, chronic disease (ex. cancer, heart disease), neurological disorder (ex. Multiple Sclerosis, Seizure Disorder), cognitive impairment and/or a sensory disability.

- For those parents who might be able to work, the SSI rules establish barriers to employment. A primary barrier is the potential loss of Medicaid. Without a Medicaid card, a person with a disability may not be able to afford the medications and therapies needed to remain in the workforce.

- Since eligibility for SSI requires that a person have less than $ 2,000 in assets, the families do not have savings that can help them through difficult financial times.

- Aside from basic living expenses, the parent's SSI check of $584/month might also be needed to pay for the parent's disability related costs. For example, paratransit services accessible housing, special diets, and co-payments for medications and therapies.

- Since there is a large TANF surplus, there are sufficient funds to cover the increase in the Caretaker Supplement. The profit to W-2 agencies using TANF funds is estimated to be $33 million dollars.

- The SSI Maintenance of Effort funds should be used to support people with disabilities or the elderly, not their non-disabled children. SSI recipients have not received an increase in the state SSI benefit since 1996, while the federal SSI benefit has increased by a small cost of living adjustment each year. Wisconsin is the only state using state SSI dollars to provide for the children of SSI parents instead of TANF dollars.

- Parents on SSI could benefit from W-2 services and from other opportunities for service coordination. Life skills training helps provide the basic foundation to enable the parents to "understand and manage daily life and family stress in order to succeed in the workplace". Examples of life skills training from the W-2 work manual include budgeting, problem solving/decision making skills, family nutrition/household management, time management, etc. Other W-2 services are childcare assistance, transportation assistance and job search assistance activities.

- SSI parents need to be eligible for child care assistance while they are looking for work. Those participating in the W-2 program or in the food stamp employment and training program are currently eligible for this assistance. SSI parents are also not eligible for child care assistance while in educational or training programs unless they have a 9-month work record and continue to work while in training.

- The W-2 disability hotline and advocacy agencies in Milwaukee report special problems for families headed by a grandparent on SSI. If a minor parent and her child are living with the child's grandparent, and the grandparent is on SSI, the family is eligible for only a single Caretaker Supplement of $100/month. There is no additional money to help care for the infant. The family is not eligible for a kinship care payment nor is anyone eligible to participate in W-2.

For more information, to join the SSI Parents Coalition, or to receive a copy of *Families in Poverty: Parents with Disabilities and their Children*, contact Caroline Hoffman (hoffmcp@dhfs.state.wi.us) or Jennifer Ondrejka (ondrejm@dhfs.state.wi.us) at the Wisconsin Council on Developmental Disabilities, 600 Williamson Street, PO Box 7851, Madison WI 53707 (608) 266-7826, (608) 267-3906 fax.

W-2 AND ITS IMPACT ON PERSONS WITH DISABILITIES

ISSUE STATEMENT:

Now that the "Wisconsin Works - W-2" has been in effect for more than a year, there continue to be great hardships for families caring for a member who has a disability or chronic health condition. Many parents of children with severe disabilities have been placed on the lowest rung of the W-2 income ladder and will soon confront W-2 time limits. Parents who are unable to work due to disability and are receiving SSI are experiencing severe economic hardships. Low income parents with lifelong disabilities who are capable of working, but where the disability affects their ability to move up the traditional ladder of self-sufficiency have also been negatively impacted by W-2 reforms.

BACKGROUND:

In 1997, Wisconsin created the W-2 workfare program to replace AFDC (Aid to Families with Dependent Children). This program created significant changes which resulted in negative impacts on families where a parent or a dependent child has a disability or chronic health condition.

ORGANIZATIONS:

Access to Independence - Deaf and Hard of Hearing Services

Alliance for Deaf, Deaf-Blind & Hard of Hearing

The Arc-Wisconsin

Autism Society of Wisconsin

Brain Injury Association of Wisconsin

Client Assistance Program

Easter Seals Wisconsin

IndependenceFirst

National Multiple Sclerosis Society - WI Chapter

Parent Education Project of Wisconsin, Inc.

Rehabilitation For Wisconsin, Inc.

State Independent Living Council

State Rehabilitation Council

United Cerebral Palsy of SE Wisconsin

United Cerebral Palsy of Wisconsin

Wisconsin Coalition for Advocacy, Inc.

Wisconsin Coalition of Independent Living Centers

Wisconsin Council for Persons with Physical Disabilities

Wisconsin Council on Developmental Disabilities

Wisconsin Rehabilitation Association

POSITION:

W-2 issues for parents who have children with special needs:

- The childcare assistance program should be expanded to include children ages 12 to 18 who have special needs or chronic health conditions that require supervision after school and during school vacations. The subsidy amount and the eligibility criteria should be the same as for children under the age of 12 ($1.5 million federal TANF dollars in each of FY00 and FY01.
- An eligible W-2 parent who has a child who is terminally ill should be allowed to provide full time care of their child as their work requirement.
- Parents of newborns in neo-natal intensive care units should not be subject to work requirements until their child is in the home for 12 weeks. This will enable the parent to have time to bond and to learn to care for their special newborn.
- The W-2 T level and the CSJ level should receive the same grant amount. A parent who has been placed in W2-T due to a family memberís incapacitation should not be penalized by receiving a smaller monthly grant.
- A childís special need SSI income should not be counted as household income for childcare assistance, or W-2 program services. Family Support income and other income earmarked for disability-related costs should not be counted as available household income or assets.
- There should be clear statutory language or administrative rule that enables families caring for a member with a special need are eligible for extensions to the 2 year W-2 work program time-limits. The language can be similar to that which allows extensions to the five-year limit.
- The W-2 statute should be changed so that a W-2 participant ímay beí required to search for unsubsidized employment throughout his or her participationí instead of stating that a participant íshall search". For some families with a member who has a special need, job search may be temporarily inappropriate. Counties report that they have been told that all participants must participate in job search.

POSITION:

Issues for adults on SSI who have dependent children:

- Parents who receive SSI for their disability should receive their pre W-2 grant amount for the care of their dependent children through Temporary Assistance to Needy Families (TANF) funds. This amount received prior to January 1, 1998, along with the parentís SSI grant, protected and insured a dependable income for the care of their children. This requires $26.3 million in FY00 and $26.3 million in FY01.

- Parents who receive SSI for their disability and a caretaker supplement for their children should receive integrated comprehensive service coordination that enhances their access to social, financial, medical, educational, work, and other needed support services. Under W-2, caretaker supplement families are denied access to W-2 case management services.
- SSI recipients enrolled in Social Security work incentive programs should be allowed to participate in and receive all the W-2 services except a W-2 cash grant. These individuals are categorically denied W-2 program benefits under the current law.

POSITION:

W-2 Issues for adults participating in W-2 who have special needs and their families:

- In those cases where the DVR agency can demonstrate to the W-2 administrative entity that for a client with multiple significant disabilities, an extended training program is necessary for economic self-sufficiency to meet family and disability related costs, the DVR plan should become the W-2 employment plan.
- There should be clear statutory language or administrative rule that parents who have a barrier to employment due to disability are eligible for extensions to the 2 year W-2 work program time-limits. The language can be similar to that which allows extensions to the five-year limit.
- An eligible W-2 parent who is terminally ill should be allowed to stay home with his or her children as their work requirement.

POSITION:

Issues for adults participating in W-2 who have a family member with special needs:

- W-2 participants should be allowed to receive a W-2 T grant while caring for an immediate family member who needs in-home care because of their special needs. The criteria for W-2 T should be changed to include individuals ineeded in the home because of the illness or incapacity of another member of the immediate family or the Wisconsin works spouse). Immediate family would include parent, grandparent, or sibling in addition to the W-2 group (children and

ACTION REQUIRED:

1) Support legislation to increase the grant for dependent children of parents on SSI to the pre-W2 amount. Join the SSI parent coalition organized by the Wisconsin Council on Developmental Disabilities.

2) Support legislation to change the Childcare Assistance Program to allow eligibility for children with disabilities between the ages of 12 and 18.

3) Support legislation and administrative rule changes to the W-2 program to ensure the protection of families caring for a member who has a disability.

VOICES OF FOUR PARENTS WITH DISABILITIES

"It is the 19th of the month and I literally have $.78 to my name. Any my checking acct. has $1.45 in it. My $122.00 in food stamps are gone. I do have food in the freezer. Thank God. But we will be without milk by the 21st or 22nd and I have o money until the 1st of September...I have a doctor's appt the 26th. The only reason I am able to go is they are allowing me to postdate my check. I gave up counseling. I couldn't afford the $2.00 co-pay. I am tired of not making it. I have No money to get my daughter any school clothes. I have had to sell even the littlest things to make it. I've robbed my baby's piggy bank to do laundry...Do they have any idea how much the other $148 I use to get would help. I get $677.78 a month. I pay $405 a month rent. That isn't including gas, electric, phone or food...Let's not forget personal care items, cleaning supplies, laundry supplies, and laundry fees. Clothes, shoes, haircuts, doctor's visits (co-pays), gas for car, school fees, school supplies, toilet paper, toweling, tissues, asprin, medications not covered by MA, vitamins or any and everything else. Skip the idea of entertainment. I suffer from severe depression, ADD, post traumatic stress disorder, insomnia and chronic back pains and migraines. This financial pressure are dragging me down further and further. Why don't the people behind the change try to live on what I have and pay what I do our and see if they would make some changes."

"Before AFDC went out I was able to feed, clothe, house, meet all my 17 year old daughter's needs, besides me...I am physically disabled with arthritis in my muscles, joints, and tissues. Plus a bad digestion desease (sic). I am a special diet. And am very sick at times where I have to go in for treatments to relieve pain or to be able to eat again. When AFDC went out, we lost $171. My rent went up 9.00 my food stamps went up to $87 for one month then got cut to $57 due to the $77 grant given in place of AFDC. The Section 8 raised our rent from $134 to $154. No reason given. Due to my diet disease, my daughter is given the $77 for her food for the month. That leaves $577.78 for rent, phone, electric, school need, child needs, toiletries and <u>whatever</u> is left is my food money. Sometimes I get $50, sometimes $30. For the month of April, there is no money <u>at all</u> for my food. I will live on steamed rice. And herb-decaf tea...We live in America! Life should not be this way! The physically disabled are physically sick. We did not ask for deseases (sic) or injuries. We should not be forced below poverty and we should not be punished and our family's punished for our sickness. AFDC should not of been taken away from the physically disabled. We can't work. We can't borrow money. We are in a poverty prison."

"Who figured out that a disabled parent can raise a child on $77 per month. That is less than it would cost to place my children in foster homes and it is assumed that the foster home has at least one working parent. I would be glad to work, even at a minimum wage job. I apply repeatedly for work programs but no one will give a woman in a wheelchair who can not breathe without oxygen, and has frequent bouts of difficulty breathing with oxygen, a chance. My daughters are 12 and 14 years. I am fortunate to have the experience of parenthood when I have been ill all of my life. I have been divorced since they were preschoolers. Their father has evaded the law and pays no support. What can $77 a month buy for a teen? Even if I could obtain food for a family of three on the $144 food stamps I can receive, food stamps can not buy: toothpaste, shampoo, toilet paper, dental floss, or sanitary napkins, shoe laces, school supplies, haircuts, bus fare, laundry soap, washer and dryer money etc. Clothes, even bought at thrift stores, cost at least $15 a month per child. You cannot buy underwear, socks, stockings at thrift stores. Two dollars and fifty three cents a day per child, $77 a month. That would hardly pay for lunch eaten at school each day. Fortunately there is free school lunch but that may be cut next. Do we have cable? No. Nitendo,Sega, Playstation? No. Do we eat out or see a movie? Not often. What about birthdays and Christmas, or don't children with a disabled parents need gifts? I am discouraged. AFDC still left me below the poverty level but I could scrimp by."

"I rented out a room for $50.00 a month in hopes it could help out a little bit, but when I reported it to my worker, my food stamps went down $22! It seems like the harder I try, the worse it gets. My food stamps are $85.00 a <u>month</u>. Most people spend that much or more weekly. How do I survive? I buy cheap food- mostly soups, day old break, etc. These foods I save for my son. A friend introduced me to 'dumpster diving'. When no one is around, I get my food out of dumpsters behind restaurants. Now that the car quit, I no longer can go unless I can talk somebody into taking me. Apparently dumpster diving is considered 'stealing'. I'm below poverty, I honestly don't know what I could do.

WELFARE REFORM AND CHILDREN WITH DISABILITIES
March 1, 1999

Issue: W-2 Time Limits
Current law does not take into account the need for ongoing support for individuals with permanent disabilities. There are no guarantees that a parent, who in good faith participated in the employment and training opportunities of W-2, will continue to receive help when time limits expire. Parents may be caring for their child with a disability at home with the intentions of rejoining the workforce when they are able to leave their child or when their child goes to school. While there are case-by-case exemptions to the W-2 time limits, there is no guarantee concerning who will be eligible and what will happen if too many people need an exemption.

Recommendation: Change the statutory language or administrative rule to clearly allow extensions to W-2 work time limits for parents caring for children with disabilities.

Issue: W-2 Transitions Placement
W-2 laws and guidelines provide that participants determined to be unable to work because of a family member's incapacity are eligible for a W-2 Transitions placement. However, it is up to the individual W-2 agencies to determine work placement. The lack of specificity in the law has resulted in parents being required to work more hours than they can manage while properly caring for their children or being required to look for unsubsidized work inappropriately.

Recommendation: Change the W-2 T criteria to include parents needed at home because they are caring for children with special needs. Increase the amount of the W-2 T grant to equal that of the Community Service Job category. Families should not be penalized because of a family member's incapacity by receiving a smaller grant.

Issue: W-2 Job Search Requirements
The W-2 statute should be amended to read that a W-2 participant "may be required to search for unsubsidized employment throughout his or her participation," rather than "shall search..." For some families with a child with a special health need, a job search may temporarily be inappropriate. Counties have reported that they have been told that all participants must actively search for jobs.

Recommendation: Amend the W-2 statute to state a W-2 participant "may be required" instead of "shall search" for unsubsidized employment.

Issue: Work Requirements for Parents of Newborns

Currently, parents are subject to work requirements after their child is 12 weeks old. For babies who are born with complications and are in neo-natal intensive care units, it may be unrealistic to expect a parent to return to work that soon.

Recommendation: Parents of newborns in neo-natal intensive care units should not be subject to work requirements until their child is in the home for 12 weeks. This will enable parents to have time to bond and learn to care for their newborns.

Issue: Childcare for Children Ages 12-18 with Special Needs

Many older children with disabilities or special health care needs cannot be left alone after-school and during school vacations. Parents should not have to leave their children unsupervised or in unsafe conditions in order to fulfill their W-2 work requirements. Childcare for these children is often difficult to find and expensive.

Recommendation: Approve Governor Thompson's proposal to make children with disabilities who are under age 19 eligible for W-2 childcare assistance. Ensure that the eligibility and co-payment schedule for children over the age of 12 is the same as for children under age 13.

Issue: Counting a Child's SSI as Income in Determining Eligibility

Under current law, a child's SSI or Family Support income that he/she receives because of the associated additional costs of having a disability is counted in determining a family's eligibility for W-2 and eligibility and co-payment for W-2 childcare assistance. It is state policy to count SSI income even though kinship care benefits, foster care benefits, and W-2 work program benefits are not counted.

Recommendation: SSI, Family Support and other income earmarked for the disability-related costs of a child should not be counted as available household income or assets for W-2 or childcare assistance.

Executive Summary

November 1998

While having a low income and caring for children can be a challenge for any parent, the challenge is compounded when the parent has a disability and is unable to increase the family's income. This report presents a picture of families in crisis- parents who are struggling to meet their children's basic needs.

- There are 5,941 Wisconsin families headed by a parent with a severe disability who are caring for 11,452 dependent children who have been affected by the ending of AFDC and the start of the W-2 and Caretaker Supplement programs.

- Prior to W-2, low-income parents with severe disabilities received Supplemental Security Income (SSI) for themselves and a child-only AFDC grant for their dependent children. W-2 replaced the AFDC program. Since W-2 is a work-based program, it could not require work from adults on SSI who have been deemed unable to work. The replacement for AFDC for families headed by a parent on SSI is a new program, the Caretaker Supplement (C-Supp) Program.

- SSI is a federally and state funded program which provides a cash benefit to the elderly and disabled. To be eligible for SSI, people must be too disabled to be gainfully employed and lack income and resources. The maximum total 1998 SSI monthly grant to an individual is $577.78/month, and to a couple, if both are disabled, is $873.05. An individual's grant may be less if they have other income.

- The Caretaker Supplement provides a monthly grant to support the dependent children of parents on SSI. From January through June 1998, the grant was $77/month per child. On July 1, 1998, the grant was raised to $100/month per child.

COMPARISON OF AFDC AND CARETAKER SUPPLEMENT

Number of Children	Maximum AFDC Payment (before 1/1/98)	Caretaker Supplement 1/1/98 To 6/30/98	Caretaker Supplement After 7/1/98	Income change from AFDC to Caretaker Supplement (at $100/mo)
1	$249	$ 77	$100	60% reduction
2	$440	$154	$200	55% reduction
3	$517	$231	$300	42% reduction
4	$617	$308	$400	35% reduction
5	$709	$385	$500	30% reduction

- *Families in Poverty: Parents with Disabilities and Their Children* presents the findings of the WCDD survey of 2,242 parents, WCDD interviews with 374 parents, and the letters and comments received by the WCDD from over 300 parents.

- The families on the Caretaker Supplement program reside in every county of the state with a majority living in Milwaukee County. A single female parent who is non-white, above the age of 30, and caring for 1or 2 children heads most of the families. The parents have a wide range of disabling conditions with the majority having a mental disorder, physical disability, or chronic illness.

- The disparity between income and expenses was poignantly expressed in letters sent to the Wisconsin Council on Developmental Disabilities. Families described being unable to pay their rent, feed their family, or pay basic living expenses (ex. clothes, shoes, toothpaste). Many parents wrote that they felt they were unable to do anything for their children, they felt they were being punished for their disabilities, and that their constant worries was affecting their health.

- 80% of the parents interviewed said they would like to work at some type of job. There are a number of barriers that prevent parents on SSI from working. The barriers include the severity of the disability, SSI work disincentives, exclusion from W-2 employment services, lack of access to childcare assistance, and the lack of employment opportunities.

- The programs established to help the families—SSI, Caretaker Supplement, food stamps, housing assistance, child support—often conflict with one another. A gain of income in one program often results in a reduction in income from another program. The result is that many families have an inadequate dependable monthly income.

- Parents reported being unable to pay the rent and utilities bill. A Dane County survey of parents on SSI reported that 32% were headed toward a housing transition because they were unable to pay the rent. 77% of the parents interviewed had been living in their current residence for less than 5 years.

- 60% of the parents reported that they could not afford to buy enough food for their families on their current income. Although 73% of the parents were on the food stamp program, the food stamps were insufficient to meet their family's food needs. Parents wrote of the basic items that they needed that food stamps can't buy (ex. diapers).

- More than two-thirds of the parents interviewed reported that they could not afford to clothe their family on their current income. 30% said that their housing was not warm in the winter.

- The drop in income with the start of the Caretaker Supplement Program has placed the families at risk for losing their housing and for being unable to provide the basic necessities for their children.

To receive a copy of the report, contact the Wisconsin Council on Developmental Disabilities.

TESTIMONY
JOINT FINANCE BUDGET HEARING
BROWN COUNTY
MARCH 26, 1999

Thank you for traveling to northeastern Wisconsin for a legislative hearing. Thank you too for continuing to monitor the effects of W-2 which was officially implemented on September 1, 1997. From day 1, there has been a willingness on the part of legislatures to look at what is working and what could be changed to assure the success of the legislation. With this commitment in mind, I commend the governor's proposals and ask that you support the following:

- Lowering the maximum parent co-payment for child care from 16 percent to 12 percent of a family's income.

- Increasing the initial financial eligibility for child care to 185 percent of the FPL, rather than the current 165 percent, is a positive step for working families. This will support them on their road to becoming self-sufficient.

- The asset test has deprived families from qualifying for the child care subsidy, Wisconsin Shares. Eliminating this test will make a positive difference to Wisconsin families who are trying to get ahead.

- Establishing child care eligibility for parents with disabled children ages 13-18 is necessary. These families need a helping hand to overcome the child care struggles once their child reach age 13.

The governor proposed an **Early Childhood Excellence Initiative** to develop state-of-the-art child care and education centers in the state. I believe he suggested there be 5 such centers. A new center being built by Encompass Child Care is in the position to be one of these models. Plans, location, vision and the children it will serve directly fit the criteria specified by the governor. The building will be funding through a community wide capital campaign; however, help is needed with the *high cost* of *high tech.* Even if northeastern Wisconsin is not chosen as a site, I ask you to support this initiative.

The T.E.A.C.H. Early Childhood program is a successful model and can have great impact in improving the quality of child care. Our dream is to have a qualified and stable child care work force. This program gives us hope for the future of the profession.

I thank you and the governor for making our children a part of the 1999-2001 Wisconsin budget. Wisconsin is known as one of the 10 best states for child care. With your support of the governor's proposed initiatives, we can even be better.

Thank you for your time.

Rose M. Dobkoski

Rose M. Dobkoski
Executive Director
Encompass Child Care, Inc.
1300 Bellevue Street
Green Bay, WI 54302

THOUGHTS ON STATE BUDGET PROPOSAL FOR 1999-2001 PERIOD.

Why is there such an increase in spending?

With all the savings in W2, there should be a large reduction in spending. An increase of 6.7% in spending and an increase of 6.9% in taxes (revenue) just don't fit the picture of what should be happening. An increase of 2% in people is also unexpected when there should be reductions in welfare support. I understood the initial increase in spending when this program started and I now expect to see the results in my tax bill.

The tax cut is too small!

As one of the highest taxed states in the Union, we should be getting more of a reduction. All this talk about such a small amount is just a bunch of rhetoric and doesn't do much to help any taxpayer. For someone making $18,000 a year the tax cut is $6.90 a month. For someone making $60,000 a year the tax cut is $9.33 a month. Lets get a tax cut worth something.

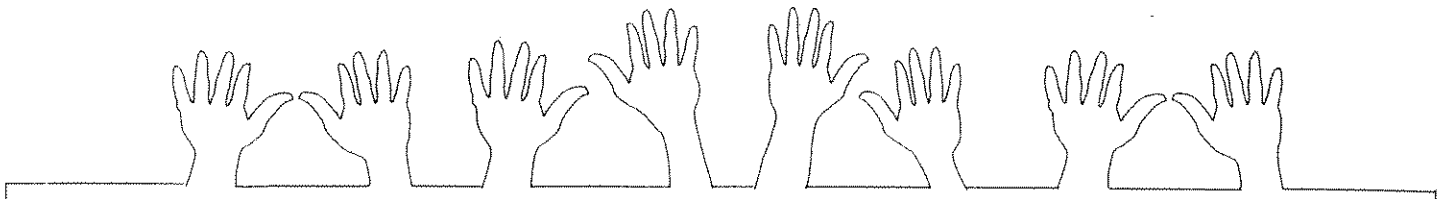
What about the tobacco cash?

Starting new programs that require ongoing funding with these funds is foolhardy. The funds were intended to reimburse the state for funds already spent and for future expenses. Using the money for programs like Badger care with only cost us more money in the future.

So where can we cut money from this budget?

Take a look at W2. If it did indeed reduce the workload and the dollars being spent, has the budget reflected this appropriately. Lets stop buying property. The DNR plan for helping communities is just pushing up prices and takes any negotiation opportunity away from them. The experience Green Bay had with Baird Creek Parkway is one that cost us as taxpayers many more dollars than if Green Bay was able to negotiate a price and then get help from the DNR. Don't fund the Stewardship Resource Fund until these changes are made. Without the resource fund we may be able to reduce DNR staffing. Stop funding the capital portion of the school budget. The current 2/3 cost of education to most people means operating costs. The use of state funds to cover the capital costs of schools is promoting unnecessary building as local districts see the state money as free, where I see it as my tax dollar.

Frank S. Bennett Jr., 2400 Ingold CT., Green Bay, WI 54313 920-499-7866 fbennett@netnet.net



The Gathering Place

624 Doty St. • Green Bay, WI 54301 • (920) 430-9187

E-Mail: gather@gbonline.com

Web site: www.gbonline.com/org/gathering

March 26, 1999

Attention: Governor Thompson

Re: **The cut in pharmacy reimbursement in the 1999-2001 state budget plan**

My name is Susan Mader and I am writing on behalf of the members of The Gathering Place, a center for adults with serious mental illness in Green Bay. We voice a strong concern and opposition to the cut in pharmacy reimbursement in the 1999-2001 state budget. As a person with Schizophrenia in recovery, I and many of our members rely on the professional and outstanding services of Streu's Pharmacy. The pharmacists at Streu's are very knowledgeable about medications and they care!

Streu's believes in medication compliance (which is crucial for a person with mental illness who needs to take medications daily for the rest of their lives.) Streu's packages the medications in compliance packs which divides doses of medications into a daily calendar. It works! I don't miss a dose. Without this needed service, I fear that many people with mental illness would miss several doses of their medication, which could lead to a relapse and possible hospitalization. The compliance packs also provide a safety net preventing people with depression from taking an overdose. Streu's also offers home delivery. What a service to those who can't get out!

Please eliminate the cut from consideration entirely! It could devastate pharmacies across the state, especially Streu's which has been a family owned business for 35 years.

Sincerely,

Susan C Mader

Susan C. Mader
Co-Chair of The Gathering Place

Enclosure

Testimony to the Joint Finance Committee
IN SUPPORT OF A WAGE PASS-THROUGH
March 26, 1999 - Green Bay

Ladies and Gentlemen:

My name is Mary Ann Kehoe. I am the Executive Director at Good Shepherd Services in Seymour. Our organization runs a skilled nursing facility, a community support agency, a rehabilitation agency and a child day care center. We also house the community senior center which is the senior nutrition site for our area. We are the second largest employer in the community and the only long term care organization in our service area of sixty thousand people.

I would like to respectfully address the committee on the Wage Pass- through.

The proposal in the Governor's budget to re-base the Medicaid formula is of major concern to the staff at Good Shepherd. Employee wages and fringe benefits are the largest part of our annual expenses. The state budget, in its current form, will significantly cut our reimbursement through the Medicaid program. In our skilled care facility, currently 65% of the residents have exhausted their resources and rely on Medical Assistance. Good Shepherd's Medical Assistance population is below the state average of 68%. Nevertheless, we lost approximately $28 per day or over $500,000 in the last biennium from the Medicaid program.

Good Shepherd has always admitted residents on the basis of our ability to render quality care. Currently we are ranked among the top 15% of skilled care facilities in the nation because of the care we deliver.

We have never set quotas for the number of Medicaid residents we will accept nor have ever rejected anyone for service because of their inability to pay.

While we are sensitive to the pressures that affect the legislature when it comes to budgets, nevertheless, our organization has seen continued cuts in government funding over many years. We know your job is not an easy one and we than you for doing it. We have never come before you before to simply "whine" for more money.

We fully recognize the problem of rising health care costs both at the state and national levels. We also recognize that many groups rightfully feel they need more dollars.

At Good Shepherd, we have taken cost containment seriously, but we refuse to compromise quality resident care in the process. Through a unique provider alliance of eleven not-for-profit, organizations called Wellspring (see attached), we have implemented revolutionary organizational restructuring and collaborative, cost saving efforts. We have empowered our line staff employees to implement nationally defined best practices.

We have given our employees the tools and the equipment to make daily critical decisions that positively impact the residents they serve. We have flattened the organizational structure, enhanced the work environment, and given our line staff decision making authority. Wellspring members have cut costs while investing in staff education and retention efforts. The results have been extremely favorable both in the improvement of resident outcomes and in staff recruitment and retention.

During the past year, despite all of our efforts at staff empowerment, education and retention, we have seen the supply of individuals willing to care for our frail elderly and disabled steadily dwindle. The state's strong economy has created havoc with the pool of people available to employ. As you know, this isn't a problem just affecting our industry.

Because of heavy reliance on government funding, however, we are unable to adequately compete in the marketplace. The crisis is growing and addition funding cuts will mean a **significant erosion in quality care for our frail and elderly.**

Our employees are competent, educated and caring. Their work is extremely difficult and yet they have lower wages that fast food workers. If long term care is to survive, regardless of the setting in which it is rendered, we have to have human beings to care for other human beings. **We must have a Wage Pass-through in the budget for our employees.**

I know that many of you may have run for office on the basis of cutting property taxes. I applaud your efforts, but enough is enough.

I am a taxpayer. I am a voter. I say to you today, **I AM WILLING TO PAY MORE PROPERTY TAXES IF IT MEANS THAT OUR ELDERLY RECEIVE THE CARE THEY DESERVE.**

I AM WILLING TO PAY MORE INCOME TAXES IF IT MEANS THAT OUR EMPLOYEES CAN MAKE A DECENT WAGE.

You might feel that these statements are self-serving since I work in long term care, but the next time you mail surveys to your constituents, ask them if they would rather have lower property taxes or cut the wages of those who care for their elderly loved ones. You may be surprised at the results.

I implore you, don't take the easy way out and turn your backs on this issue. There is nothing else to cut. We have no where else to turn.

Thank you very much.

Mary Ann Kehoe

WELLSPRING: Innovative Solutions for Integrated Health Services

OVERVIEW

November, 1998

The Reason For the Establishment of Wellspring: Survival In A Changed Environment Through Cost Effective Improvement of the Care Delivered

I. **Background**: Changes in the long term care environment led to the formation of Wellspring Innovative Solutions, Inc. In 1997.

A. The effect of DRG's in acute care settings

Since the implementation of DRG's in the early eighties, the focus of long term care has dramatically changed. While the hospital prospective payment system may have saved Medicare hospital dollars, in actuality this new system shifted costs from acute care hospitals to long term care facilities. Hospital lengths of stay were dramatically shortened for the elderly which led to nursing home admissions of individuals "quicker" who are "sicker". This phenomenon has impacted nursing home costs in many ways. Increased cost was incurred to upgrade staff skills and purchase additional equipment and supplies to handle a more acute population. In Wisconsin the acuity level of nursing home residents has dramatically increased since 1985.

B. OBRA 1989

OBRA implementation in 1990 was the second major change that led to the formation of Wellspring. The RAI (resident assessment instrument) process pointed the industry in a new direction and mandated that we see our residents as individuals with different needs than in the past. The RAI expectation is that all nursing home residents will attain or maintain the highest level of function possible. This changed the care focus from custodial to rehabilitative. While Wellspring members embrace the OBRA philosophy, the new process has stretched staff by creating additional paperwork. The Medicare PPS system will add additional stress.

Wisconsin nursing homes received an advantage when the Center for Health Care Policy and Research (CHSRA) at the University of Wisconsin was awarded the contract to study the impact OBRA actually had on the quality of nursing home care across the country. This choice gave us easy access to the knowledge that was learned from the case-mix demonstration project.

From CHSRA research in Kansas, Maine, Mississippi, South Dakota, New York and Texas twelve "domains" of care were established. Within these domains, the project identified 175 indicators of quality care. These indicators are known as "The Quality Indicators" and are being utilized nationally to identify and encourage quality care as well as to identify and correct questionable care practices.

A lessor known development also had a major impact on the events leading to the formation of Wellspring. The federal Agency for Health Care Policy and Research (AHCPR) was established as part of the 1989 Budget Reconciliation Act. AHCPR conducted significant research into the medical effectiveness of care delivery and established the AHCPR Clinical Practice Guidelines. These guidelines establish "best practices" in eleven long term care related areas. Wellspring has condensed the AHCPR guidelines and the clinical Quality Indicators into eight training modules, and are testing the practicality of utilizing this research at the line staff level. The goal is to improve care and to save money through more effective and efficient practices.

C. **Conversations between Good Shepherd and Evergreen**

By the end of 1993, it was clear that long term care had changed and that the world around us would never be the same again. It was equally clear that the environment would continue to change.

At Good Shepherd we could see that our organization was being stretched to its limit because of this evolving scenario. Our resources were dwindling. The labor pool is limited in our rural location; our staff were unhappy with the increased demands of caring for a more acute population. Staff turnover was at 110% for CNA's due to burnout and not much better for other staff. "Work time lost" accidents and worker's compensation premiums were out of control. Something had to change.

Good Shepherd initiated a strategic planning effort that identified the need to partner and collaborate with others as a way to survive in the future. The board of directors recognized that they needed to network with other boards to embark on this new course.

At the same time the board and President of Evergreen Retirement Community in Oshkosh were going through a similar process; the two organizations began a dialogue regarding future possibilities.

It is important to note that during the two years prior to the initial meeting of the Wellspring group, both Evergreen and Good Shepherd had embarked on staff empowerment initiatives. While the two systems and methods used to reach the goals were different, the two organizations were basically following the same path.

D. **Founding Assumptions**

The networking between Good Shepherd and Evergreen revealed that each organization had made similar basic assumptions about the future of long term care and that we had similar belief systems. These common principles were explored during several meetings between David Green, President of Evergreen and Mary Ann Kehoe, Executive Director of Good Shepherd during 1994 and culminated in a joint Board meeting on 9/28/94.

The assumptions were

1. In the future, the health care system will integrate acute, institutional and community based services.
   a. In the short term, for-profit long term care organizations will have an edge because their "product" is lower priced.
   b. In the long run, the consumer/customer will demand quality long term care at a "reasonable" cost.
2. Public policy must advocate for a system that will ensure an adequate supply of human resources by paying reasonable wages and benefits. This will help to ensure a stable work force. In turn, a stable workforce translates to continuity of care and continuity of care translates to quality care.

3. The obvious trend is toward managed care, but not all individuals are served well in a managed care environment, especially those with chronic or severe health or behavior problems. In the end, community based services may be too costly for many currently served in institutional settings.

E. **Fundamental Principles**

1. We are driven by our missions to serve others; we would rather close our doors than compromise the quality of care rendered to the individuals we serve.

2. Quality care is the center of our universe. Our goal is to continue to provide quality care in a most uncertain future.

II. The Formation of an "Alliance"

A. The decision to expand the conversations

As discussions progressed, the executives of Evergreen and Good Shepherd realized that if we were to thrive, two organizations collaborating and cooperating might not be enough. We then jointly compiled a list of not-for-profit organizations in northern and eastern Wisconsin with which we were familiar. We knew that each of these organizations had missions similar to ours, and that there was a degree of compatibility between the current CEO's of those organizations and ourselves.

The next step was simply to call each CEO and invite them to an exploratory meeting. This meeting took place on March 28, 1995 at Evergreen in Oshkosh[1].

B. Forming a group

These initiatives gave us some clues as to ways in which we could chart our own course for the future. The constant goal of that course is to provide quality care at reasonable costs.

The original name for the group was the Northeastern Wisconsin Long Term Care Task Group; the first meeting was held on March 28, 1995 at Evergreen in Oshkosh. We spent several meetings just bonding as a group and determining whether or not we wanted to continue in some joint efforts in the future. Most of the meeting time in 1995 was spent educating each other on our individual organizations (meetings were held at each member organization) as well as what was currently happening in area health care. We invited several informed speakers on topics which ranged from overviews of managed care to capitation to the PACE and ONLOCK programs. The group also listened to several presentations by Wisconsin managed care organizations. Members further defined the array of services and capabilities within each organization.

Over the year we determined that long term care organizations needed to take an active role in defining the integration of future health care systems and that we were no longer satisfied to be "the last members in the health care feeding chain". The idea of the formation of a long term care provider network began to emerge.

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[1]Coincidentally this meeting occurred around the same time that the Health Issues Committee of WAHSA was exploring the Quality Indicators project with CHSRA, and the Committee was also learning about the AHCPR Clinical Practice Guidelines. Good Shepherd's Executive Director was chair of the Health Issues Committee working on these initiatives. As the work of the Health Issues Committee progressed, the writing of Quality Monitoring Pathway Tools became a means by which to audit "best clinical practice" and to improve care outcomes within WAHSA organizations.

The group determined to form two tracks upon which to base future directions. The first track was to learn as much about managed care as possible in order to come to negotiations with managed care organizations from a position of strength. The second track was to ensure that all members were and would continue to utilize current "best practices" in providing resident/customer care. We determined that the "customers" of our organizations would change in the future to include managed care organizations. We finished 1995 with interviewing several candidates to facilitate our tracks toward the future. The Alliance selected Leslie Saltzstein Wooldridge, a Geriatric Nurse Practitioner with many years of long term care experience from the CNA to DON levels, to guide the track on clinical practice.

The second facilitator selected in the spring of 1996 was Stanley York. Stan is an attorney, clergy person, former administrator with the State of Wisconsin and the first full time Executive Director for the Wisconsin Association of Homes and Services for the Aging.

Current Wellspring membership is comprised of eleven urban and rural organizations operating nursing homes ranging in size from 63 to 415 beds. Wellspring members offer an array of health care and other services to their respective communities ranging from skilled nursing facilities to child day care.

Wellspring members are characterized by an entrepreneurial spirit and are willing to **fully** cooperate and collaborate with each other. The goal of the alliance is not to clone a set model, but to create a new model for elderly care.

By the summer of 1997, we formed a Wisconsin non-stock corporation named Wellspring Innovative Solutions, Inc., and decided to use the name "Wellspring: Innovative Solutions for integrated health care" informally.

III. The Philosophy and Practice of Wellspring

A. Values: Wellspring and its members collectively and individually will

1. Deliver to our customers the best service of which we are capable on an ongoing basis, utilizing best practices, being the best we can be today and in the future in spite of reduced resources.

2. Empower our employees to have pride in the work they do.

3. Measure and communicate outcomes of care while improving processes and results.

4. Ensure that our services and improvements are cost effective.

5. Be proactive with ourselves, other providers, regulators and policy makers to enhance the quality of care provided to the citizens of the state.

B. Vision: Wellspring and it members collectively and individually will

1. Be able to market services and sell successful outcomes in our new future.
2. Share resources to save costs.
3. Create new and higher minimum standards of care that will be challenging to others.
4. Continue to be separate entities and yet work so closely together that others can trust each of us based on the performance of the rest of us.
5. Have managed care appeal, be able to quantify quality, utilize common programs and tools and deliver uniform quality care.
6. Attempt to break the paradigm of vertical management structures and convert to horizontal integration. Line staff share and have a vested interest in the success of the organization. Line staff are closest to the "customers" and are viewed as our most valuable resource.

IV. The Heart of the Program: Clinical Training

A. Modules

1. The efforts of early spring 1996 were focused on establishing "modules" for training clinical staff.

2. A "module" is a package of activities designed to develop a set of "best practices" in one of the eight areas of concentration (e.g. continence/elimination), train staff in their use, implement them in each member nursing home, measure the outcomes of implementation, and then improve on improvement.

3. The package of module activities includes
   a. a two day training seminar for "care resource teams" based on "best practices" as found in the CHSRA Quality Indicators, the federal/state survey process, the AHCPR and AMDA Clinical Practice Guidelines and the latest available research on care of the elderly in nursing homes,
   b. development of facility implementation of "best practices",
   c. three and six month visits to each facility by the nurse consultant(s),
   d. a one day workshop for care resources teams six months after the seminar,
   e. development and refinement of tools for implementation.
   f. data collection to measure outcomes
   g. use of Quality Monitoring Pathway Tools as part of the care auditing process

4. In setting the schedule of the eight areas, we decided that we should tackle the toughe problems first and then move through the other six, all within eighteen months. The eight modules and the seminar dates are

a.	module 1	Elimination/continence	April 1996
b.	module 2	Behavior management	September 1996
c.	module 3	Skin care	December 1996
d.	module 4	Falls/accidents	April 1997
e.	module 5	Restorative care	September 1997
f.	module 6	Physical assessment	September 1997
g.	module 7	Nutrition	November 1997
h.	module 8	Pain management	September, 1998[2]

5. A tentative training schedule was established and elimination/continence was chosen as the first module because, by consensus, we determined that it was one area where each organization could improve care. The first module on elimination/continence was held at Cedar Campuses on April 19 and 20, 1996.

B. Care Resource Teams

While each member felt that the quality of care delivered within their organization was excellent, we all felt that we could do better. Each organization had had previous experience with training programs. Most, if not all programs had proven unsuccessful for the long term. Most often these programs were run from the top down, i.e. from administration down to line staff. Traditionally there had been no line staff "buy-in" to new initiatives and thus the failure to succeed in a meaningful fashion. Each of our organizations was also faced with the problem of limited resources so we needed to find an effective, efficient means to improve the quality of care. ***Care Resource Teams as we have them today are the result.***

Care Resource Teams consist of teams of professional and line staff who receive intensive training by qualified practitioners based on the AHCPR and AMDA "Best Practice" clinical guidelines. The teams not only learn the best practices, but are also trained in how to train others. After a two day education seminar (including an overnight so that the teams can bond with one another and with the teams from the other Wellspring facilities), the teams return to their respective organizations and are responsible for implementation of the module within their facilities.

There is one consistent staff member for all modules. This person is an RN with responsibility for the oversight of the implementation of all modules and is called the "coordinator". This coordinator serves a "coaching" role and is generally responsible to keep administration informed of what's happening. In some facilities this individual is the in service education coordinator, but team make-up is left to each individual organization.

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[2]In the fall of 1998, a physical assessment module was added. Current consideration is being given to the development of an initial module for management staff on organizational change and staff empowerment.

Generally **Care Resource Teams** consist of at least four staff members from various shifts, depending on the particular module. Larger organizations may send more individuals. The make-up of each team varies depending on the module being taught. For example, dietary staff make up a large portion of the team for the module on nutrition.

It is not the team's responsibility to "do it all" when they return from training, but rather to teach the other staff members the "best practices", and then to serve as "care resources" for the future. Before each team leaves the seminar site, they are expected to have a plan worked out for implementation of the module at their facility. It is the expectation of each organization that each Care Resource Team will be given time to implement the module when they return.

The Team's first assignment on returning to the facility is to schedule a meeting with appropriate administration members to discuss what they have learned and suggest a course of action for implementation of the module. During the meeting, the team presents their plan to administration and seeks agreement from administration on how implementation will take place. Facility commitment to enable staff to implement the new programs is an essential part of Wellspring membership.

Teams are strongly encouraged to network with their peers in other Wellspring organizations, and they receive ongoing support from the nurse consultant. Team "follow-up" meetings are also held in the facility at regular intervals to review progress and/or problems.

The DON's, Coordinators, the two facilitators and one CEO meet quarterly to facilitate the process, ensure that the modules are being implemented appropriately, the time spent in implementation is reasonable, and to approve the date collection process.

Keys to implementing "best practices" in Wellspring nursing homes include self-directed teams, permanent staff assignments to groups of residents, standardized protocols, empowered line staff and management "letting go".

V. Accomplishing The Reason For The Establishment of Wellspring: Survival In A Changed Environment

A. Steps Wellspring has taken to accomplish its goals include

1. We have attained the ability to resolve issues and come to common understandings in the three years since inception while honoring our significant diversity.

2. Wellspring members agree on common goals

3. We have defined our organizational structure

4. We have hired consultants

5. Wellspring has incorporated as a Wisconsin non-stock corporation and are applying for 501(c)(3) status with the IRS.

6. We have elected officers

7. We have educated our boards of directors and have board buy-in

8. We have been educated on the current marketplace

9. We have educated regulators

10. We have improved communication within Wellspring member organizations

11. We are in the process of "product" development to teach others.

B. Current Wellspring Members (Wisconsin)

Evergreen Retirement Community - Oshkosh
Good Shepherd Services, Ltd. - Seymour
Cedar Campuses - West Bend
Christian Home - Waupun
Fond du Lac Lutheran Home - Fond du Lac
Iola Nursing Home - Iola
Northland Lutheran Retirement Community - Marinette
Sheboygan Retirement Home - Sheboygan
Odd Fellow-Rebekah Home Association - Green Bay
St. Paul Home - Kaukauna
Lutheran Homes of Oconomowoc - Oconomowoc

C. Benefits members have seen from membership

1. Positive resident outcomes through increased staff awareness of appropriate methods and processes of care which results in improvement in care and "customer" satisfaction.

2. Improved results on Quality Indicator reports which are statistically verifiable and provide objective measures of quality care.

3. Stronger supply of human resources

4. Improved work by the QA Committee

5. Focused efforts to conserve resources and reduce cost.

6. Common use of tools among Wellspring members for assessment, evaluation and documentation of resident care resulting in improvement of federal/state surveys.

7. Potential for saving operational costs while maintaining quality of care in a managed care environment.

8. Enhanced public relations and tangibly demonstrated improvement in the quality of care delivered to customers.

HUMAN SERVICES DEPARTMENT

Brown County

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Human Services Director

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FOR THE WISCONSIN LEGISLATURE'S JOINT FINANCE COMMITTEE

Written comments submitted as testimony from Mark Quam, Brown County Human Services Director, Friday, March 26, 1999, pertaining to Long Term Care Redesign, and also Caregiver Background Checks.

March 23, 1999

Dear Members of the Joint Finance Committee:

Thank you for the opportunity to submit information to you on two topics; Long Term Care Redesign, or Family Care; and also a previous law that the Budget Bill revisits, Caregiver Background Checks.

I am Mark Quam, the Brown County Human Services Director. My comments to you are with the knowledge and approval of County Executive Nancy Nusbaum, and the Human Services oversight committee.

A number of very serious concerns still exist with the Long Term Care Redesign proposal. This Budget, if left unchanged, will enact by statute only one method of revamping our long term care system. The Budget will then begin to institutionalize a flawed plan from the Department of Health and Family Services. We would strongly encourage the Budget Bill be modified to allow an alternative model during the pilot process.

Some of the flaws in the Department of Health and Family Services model are as follows:

1. Despite a stated intent to simplify the system created by State and Federal laws, it creates a more bureaucratic and confusing system by creating two separate entities that the public will pass through – a "resource center" and "care management organization." This process as envisioned will be more confusing than the existing system, and will thus be a step backwards.

2. The Long Term Care model is essentially an insurance industry model of a "resource center" authorizing how much it wishes to pay for a patient's care; and then the "care management organization" implementing services. This model is rigid and tends to emphasize this type of approach is exactly the opposite of what the elderly want and historically Wisconsin has stood for.

3. Department of Health and Family Services has promised new "entitlements" for the elderly to help them live safely outside of nursing homes. This is a wonderful goal. But as Senator Cowles recently noted in his Press Gazette comments about hidden program costs, this program has huge hidden costs. It isn't realistic to discuss new entitlements without cold evaluation of what those costs are truly going to be. It isn't fair to the elderly to make a promise in these pilots that may not be affordable; or would have to be paid for by denying services to the disabled.

   The alternative pilot model is a good approach, worthy of your consideration.

   If our goal in Wisconsin is truly going to be reducing our dependence on the nursing home, we already have proven and popular well established programs in the Community Options (COP) and Community Integration (CIP) Programs. These programs have been well researched as to their cost effectiveness; have an established and proven infrastructure; and are already regulated by the State.

   What they lack is a requirement that no Wisconsinite should enter a nursing home until COP or CIP have been tried. This would be a simple process, since all counties operate these programs. What would change in a few pilot counties is that prior to a nursing home admission, COP or CIP would be required to do an assessment. They would then have the service dollars needed to provide a service and avoid a nursing home placement. The service dollars could come from the Budget dollars designated for the pilots.

   The advantages of this approach are numerous; from its popularity and acceptance by the groups it's already serving; to its cost effectiveness as proven by Department of Health and Family Services studies; to its comparative simplicity to enact. The Department of Health and Family Services Redesign requires as yet un-obtained federal waivers; establishment of a new quasi-governmental entity to administer redesign while creating a myriad of problems in union contracts; and creation of an entirely new system with unclear practices yet to be designed.

   We encourage using an alternative to the Department of Health and Family Services model to bring long term care into the year 2000.

I would like to briefly comment on the Caregiver Background Check law.

This law was well intended as it sought to mandate more thorough background checks on people who provide care in hospitals, nursing homes and other similar centers.

Included in the process were county child abuse/neglect records, which has turned out to be an error. Counties investigate and substantiate whether danger to a child rises to the legal level determined by the Legislature. The focus is on child or victim protection. The Caregiver law takes this one step further and says whoever created the risk should be subject to the caregiver law. The problems we have begun to find in conducting this service include:

1. Child abuse/neglect findings are of a lesser legal standard than that for criminal behavior. People are tagged with a "child abuser" label under the caregiver law that affects their ability to work, but our Chapter 48 legal standards aren't nearly as stringent as criminal law.

2. It is common that children abuse other children, often times sexually. We're not sure it was the law's intent to put the "abuser" label on children, later seeking jobs in adulthood.

   We would encourage confining this law's implementation to those persons convicted in the criminal system of abuse or neglect, to assure a consistent approach to this issue.

Thank you very much for your time and especially for conducting the hearing in Green Bay.

Mark A. Quam
Human Services Director

msf

March 12, 1999

LONG TERM CARE REDESIGN: AN ALTERNATIVE MODEL TO TRY IN THE PILOT PHASE

The Wisconsin Department of Health & Family Services has begun the process of piloting one model of LTC Redesign: a risk-based managed care approach which will require special federal approval and will offer the private sector an opportunity to compete against county governments for the right to run the LTC System at the local level. Statewide disability and aging organizations have joined with the Wisconsin Counties Association to develop an Alternative Model, which we believe should also be piloted in multiple counties. Then there should be an independent evaluation of all the pilots, before the legislature makes a binding decision on which model to implement statewide.

The Alternative Model is simple – it's based on the premise that we can achieve the LTC reforms we all want by building on the current system, which would be preferable to blowing up the current system and starting over. The Alternative Model aims to achieve the same goals the Department has identified: simplify the system, pool the funding streams, include all the populations that need long term care, end waiting lists and the institutional bias of the current system, and provide consumers more choice.

The big difference between the two approaches is in how to achieve these goals. The Alternative Model would continue the 100 year tradition of county-based human services in Wisconsin, enabling consumers and families to continue their existing relations with county workers and with local elected officials who oversee the system. This model would also expand and consolidate the Community Options Program with other effective existing community programs, rather than eliminate good programs simply because they are under-funded.

Key Features of the Alternative Model:

- Existing Medicaid waivers programs (e.g., COP and CIP) would be consolidated and expanded to serve people on waiting lists, with rates increased to cover actual costs. Statutory responsibility of counties (as in Chapter 51 for people with developmental disabilities) would be broadened to include elderly people and people with physical disabilities.

- As in Oregon's LTC Reform, a) Wisconsin would need no additional federal waivers beyond the standard Home and Community Based Waiver we already have, and b) Wisconsin would assure the same eligibility and entitlement for community-based long term care as for nursing home care.

- The Alternative Model will cost no more than the Department's model, and counties would continue to invest local tax dollars in the system. The core funding is the same federal-state matching funds for both models, eligibility is the same, and neither model proposes a more expensive package of individualized services than the other.

- The Alternative Model includes many of the features of the DHFS model: pre-admission screening for institutions; Resource Centers; a consumer-directed support option; outcome-based quality assurance; continuity of service; independent advocacy; and an opportunity for people currently in institutions to move out and receive community services.

POINTS OF AGREEMENT
COALITION OF WISCONSIN COUNTIES AND ADVOCACY GROUPS

1) The Coalition isn't interested in killing the reform of the Long-Term Care system and wants to maintain the momentum towards change.

2) Although the department's Family Care proposal still needs modification to make it practical, if there are additional pilots, those pilots should include a fair representation of alternative non- managed care based models including models based on the Coalition's model. The minimum number of models should be nine as presented in the department's budget with more if practical.

3) The Coalition insists on a county-based system of operations.

4) Only legislative language necessary to implement the pilots should be considered at this time. Remain all state wide implementation language from any legislation.

5) The Coalition will work to insure that all pilots are equally and adequate funded to insure the highest likelihood of success.

6) Reform of the Long-Term Care system must include all disability groups.

7) There must be an independent organization used to collect standardized, agreed upon data from all pilot models.

Hello my name is Mary Westphal.
I work at Good Shepherd Home in Seymour Wis.
I have been a C.N.A. Since 1983. I believe
that the care that is given to our residents
is the kind of care that we all deserve that
is: we do for them, what we would want or
except done for ourselves. Our home is really
a home. It is not a shelter that houses the
elderly. We as parents would think nothing
of paying for good quality care for our children
yet when it comes to the elderly & frail we
tend to hesitate. Is it because they are
not here long? or unable to tell us of bad care.
These are the people that gave us life. and
with out them we would not be sitting here
today. I cant imagine having any other
Caregiver then a C.N.A. It is more then just

a job - it's a calling. You don't wake up one day and decide that you want to be a C.N.A. It is a feeling inside you that continues to grow. My executive Director told me that the governor is proposing to cut the money the nursing home receives to care for the elderly. I can't imagine what that will do - or could do to the wonderful reputation Good Shepherd has. We have been deficiency free for four straight years. And are very proud of this. With these cuts. I'm afraid of what that could mean, fewer staff members. and less benefits for employees. I would hate to think that Wisconsin could be one of those homes featured on the news. Staffing at times can be a major problem. When help finds out what we do, or how hard it is, they usually stay only short term saying - for what they do - they are worth more then is. and that there is easier work

for more pay else where. With that, the quality of care is at jeopardy. I to made financial sacrifices. And Stayed in long-term care knowing I could make more money else where. If there are cuts - I don't know if I could stay in long term care. if that meant sacrificing my family's needs or the needs of the residents. In closing, I ask that you please consider what I said and ask the legislatew to also consider a wage pass through for long-term care employees.

Thank you for your time

Mary Westphal

March 25th 1999

To whom this may concern;

Finance Commission of Wisconsin

You must not cut back on financing of nursing homes, they need all the help they can get for nurse's, L.P.N.'s, cleaning, kitchen administrators etc.

There is excess money and there for other things, first start with our senior citizens who need skilled nursing home care, they are not baby sitters they are unpaid care givers for & to our loved one's because we as parents or spouse's can no longer care for them at home by our self.

My husband is at Santa Maria nursing home, has been for two (2) years & two (2) mon's., I had him home from the hospital for two years after a severe stroke, my health could no longer take care of him (Sonny), so I am asking that you reconsider your spending & help our nursing-home care!

Thank You — Sincerely

Mrs Leo (Virginia M.) Mero
1820 Ridgeway Dr. Delavan, Wi. 53115 — 920-336-3205

State nursing homes face staff cutbacks

Low wages make it hard to keep jobs

By John Dipko
Press-Gazette

Two groups representing almost every nursing home in Wisconsin suggest staffing shortages due to fewer state dollars could result in some patients being left out in the cold.

The Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging Inc., said today that a recent survey shows nursing home operators can't keep wages high enough to draw and keep qualified staff.

As a result, some may need to cut back on the number of people they admit, said the agencies, which represent the interests of almost all of Wisconsin's 466 nursing homes.

In 1998, 17 out of more than 200 nursing homes surveyed chose to cut back on admissions because of staffing shortages, according to a summary of the survey, which both organizations conducted.

"Telemarketers, door-to-door salespeople and some fast-food restaurant workers make more than the dedicated individuals who care for our parents and our grandparents," John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging, Inc., said in a statement to be issued today. "This is a disturbing state of affairs, and unless we act now, the situation promises to grow significantly worse."

The situation is particularly troublesome for certified nursing assistants, who have the most direct contact with the patient, the agencies said.

The average wage for such staff is less than $8 an hour, the survey stated.

Four of five nursing homes reported the ability of their facility to be fully staffed was worse or significantly worse than two years ago.

The concern has many nursing homes calling for more state dollars, which would allow them to pay better wages. The state reimburses nursing homes a portion of what patients can't pay for themselves, mostly through Medicaid dollars.

"What we're asking for, and what we're saying, is we need more money to pay for the care of the most frail people in society — the elderly and the disabled," said Mary Ann Kehoe, administrator of Good Shepherd Services Ltd., which operates a nonprofit nursing home in Seymour. "That's the bottom line."

Good Shepherd, for example, takes a loss of up to $15 a day for each Medicaid resident, Kehoe said. Sixty-five percent of the home's 97 patients are on some form of medical assistance, she said.

Good Shepherd still has been able to operate without too many problems at this point, Kehoe said. She said she's not aware of any area nursing homes that cut back on admissions last year.

But demands for more staff will increase statewide, as does the number of elderly in the state, Kehoe said.

"There's just not people out there to get," she said. "It's getting scary."