Bayfield County Memorial Hospital, Assoc. DBA
Northern Lights Manor
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JOINT FINANCE COMMITTEE HEARING
MARCH 30, 1999

WRITTEN TESTIMONY FROM:
GARY D. DALZELL, ADMINISTRATOR
NORTHERN LIGHTS MANOR
WASHBURN, WI

My name is Gary Dalzell and I serve as the Administrator of Northern Lights Manor, a skilled nursing facility located in Washburn, Wisconsin. I represent approximately seventy nursing home residents and ninety-five employees, their families and friends.

I am here today to inform the committee of the major problem that the vast majority of nursing homes in our state face in recruiting and retaining staff. Within the past month, the Wisconsin Association of Homes and Services for the Aging conducted a survey, which revealed that:

1. Over 75% of the facilities reported that their ability to be fully staffed was worse or significantly worse than two years ago.
2. On average, nursing homes have over seven vacant Certified Nursing Assistant (CNA's) positions at any given time.
3. 60% of facilities reported that wages, benefits or short-staffing are the primary reason for extremely high staff turnover of CNA's which averages about 50% to 75% across the State.
4. Some facilities reported that they were forced to suspend admissions during the past year due to staff shortages.

In addition, the Bureau of Quality Assurance reports that a greater number of Wisconsin facilities are being cited for inadequate number of staff to meet the needs of the residents.

Truly, there exists a crisis in our nursing homes, which has a direct impact on the ability of a nursing facility to ensure for the health, safety and welfare of the residents who need nursing home services.

Let me tell you what has happened at our facility. Last Summer, we experienced a severe shortage of staff. We had trouble recruiting and retaining CNA's at a starting salary of $6.15 an hour. Many of our dedicated and caring staff were working long hours to fill the staff shortages to meet the needs of our residents. It was common for many CNA's and nurses to work 10 to 25 hours of overtime a week. Both the Director of Nursing and the Assistant Director of Nursing worked as a CNA and as a nurse often times seven days a week. We had to deny admission to at least two elderly persons who needed nursing home services due to staff shortages. Staff morale was low and burnout was very high.... Not a good combination.

We had to take a major step, as we had been unsuccessful with our recruitment and retention efforts.

Here's what we did. In September, our Board of Directors approved a $1.00 per hour pay raise across the board to all employees. This had an immediate positive impact as it stopped the turnover and within three months, our staffing has improved dramatically and staff morale is high. Since then, our recruitment and retention efforts have leveled off as the pay raise has had a tremendous impact. This process is proof that raising wages will keep qualified staff in nursing homes and will allow facilities greater opportunity to hire adequate number of staff necessary to provide quality care for the residents.

However, we now have a major problem, as our facility will face a $100,000 shortfall in Medicaid reimbursement. In addition, I have learned that the Governors budget includes a proposal that could result in cuts in Medicaid funding which means that over the next two years our Medicaid rates may be frozen, cut, or at best, only slightly increased. If that happens, our facility and many others will be severely affected and the recruitment and retention problem will certainly magnify.

I am here today to ask that the committee make the nursing home staffing issue a top priority and that it appropriates adequate dollars in the budget so we can do our jobs. A coalition, comprised of the Wisconsin Association of Homes and Services for the Aging, the Wisconsin Health Care Association, AFSCME Councils 40 and 48, Wisconsin State AFL-CIO and Service Employees International Union, Local 150 recommends legislation to enact a 7% wage pass-through for nursing home employees effective July 1, 1999. The purpose of the Coalition is to promote efforts to avoid severe staffing problems that exist in many Wisconsin facilities. Although facilities are pursuing multiple strategies to address staffing issues, these efforts must be complimented by the appropriation of additional Medicaid funds for nursing home caregivers.

We at Northern Lights Manor support the efforts of the Coalition and I promise you that the committee will hear from our staff, residents, their family members, and members of the Board of Directors of Northern Lights Manor about this critical issue.

Respectfully Submitted by;

Gary D. Dalzell, Administrator
Northern Lights Manor

State Budget Hearing
Ashland, March 30, 1999

How we spend our money shows what we really value.

My State Representative has expressed doubt that my concerns for the care of frail elderly requiring Nursing Home care could be addressed because **voters** value being tough on crime and nearly half of available State dollars will go to building 4 new prisons this year.

But what are we doing to Prevent crime? Please consider how investing in Long Term Care has impact at multiple levels, including the crime of abuse and neglect of elders!

The "rotten apple" cases of abuse or neglect of nursing home residents has resulted in a huge regulatory load in nursing homes. Having watched this grow larger and larger over the 16 years I've worked in nursing homes, I'm convinced that investing in direct care givers allows them to "slow down, " and attend to the personal details that enhance life, and prevent abuse in a way the regulatory load fails to do.

In a rural non-industrial area such as ours Nursing Homes are MAJOR employers. I believe that jobs that enable parents to support their families at least a little above the poverty or more importantly above the welfare benefits level **prevents crime**. They allow parents to spend time with kids not available to them if they have to have more than one job to provide the basics. I have written testimony from several employees sharing what it is like trying to live on what a not-for profit nursing home is able to pay. It is unthinkable that no increase or possible cutbacks in this State Budget will jeopardize those **families.** A small increase in cost of health care family benefit has put a number of employees into panic. We are not talking about any padded costs or fraud here.....we are talking about people who want to be taxpayers and care for their families basic and health care needs. Please consider the tremendous impact Nursing Home jobs have simply as **jobs.**

Right now there are four employees in our nursing home who have recently been in trouble. Every one of them is showing exceptional ability to be kind and effective in care of residents. Every one of them is supporting a family, and as many other employees, some as a single parent. Over the years I have watched how tragic it is when people who are throwing tremendous energy into "making it" personally, as well as the high amount of energy it takes to be a direct care giver of demented and frail elders, and enjoying feeling good about bringing smiles and comfort to them, get discouraged and then angry about how sparsely their income meets their BASIC needs and slip back into negative coping and lifestyles again. Recently our staff intervened with a fellow worker who literally had become suicidal because the individual hadn't met expectations of family members to be a success (defined as **something more** than a nursing assistant)

It makes me furious that we need to pay so little to direct caregivers and thereby devalue them and their inestimable human service. And make no mistake, nursing assistants are at constant risk of unexpected attack by very strong residents in the current regulatory sanctions against medicines to impact dangerous behaviors.

To me it is a crime not to value efficient long term care, both for the sake of the residents who need caregivers who have **time** to give them personal care safely (i.e. afford enough caregivers) and for the sake of the taxpayers who enjoy and are skilled in meeting elders needs but cannot make a basic living doing so.

We show that we value the future for our children by adequately supporting their teachers.
We must show that we value what happens at the end of our parents and grandparents and ultimately our own lives by adequately supporting long term direct caregivers. It is essential AT A MINIMUM to pass the wage pass through being proposed for those caregivers and AT A Minimum M maintain nursing home reimbursement at a level which reflects the actual cost of care.

Submitted by Laurel Gilbert
Director of Nursing
Northern Lights Manor Nursing Home

Laurel Lawn Gilbert

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PORTAGE COUNTY
HEALTH AND HUMAN SERVICES DEPARTMENT

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MEMO

TO: Members of Joint Finance

FROM: Judy Bablitch, Director

DATE: March 31, 1999

RE: Proposed State Budget, 1999 - 2001

Thank you for the opportunity to comment on the Proposed State Biennual Budget (1999 - 2001). These comments are specifically directed toward the Family Care Legislation contained within the proposed budget.

Portage County was chosen by the Department of Health and Family Services to pilot both major components of Family Care: Resource Center and Care Management Organization. We have been piloting our Resource Center(s) since April of 1998 and have been planning for CMO implementation since October of 1998. We are very pleased to have been chosen for both initiatives. It has been a tremendous challenge for us to operate existing long term care programs while initiating Family Care planning and operation.

There is no question that the capability and capacity of the current Long Term Care System in Wisconsin must be enlarged and enhanced if we are to adequately and safely serve the needs of existing participants; individuals waiting for services; and the projected large number of individuals who will require long term care services in future years.

Long Term Care service waiting lists exist in Portage County for the:

- Community Options Program (60 individuals)
- Family Support Program (30 individuals)

- Community Integration Program (20 individuals)
- Funding of Community Based Residential Facility (CBRF) care (30 individuals), and
- Vocational Rehabilitation Services (20 individuals)

Community Options Program fiscal requests from the 60 people waiting for services totals over $900,000 annually.

There have been minimal state increases for the Community Options Program; no state increases in the Community Integration 1B Program for nearly 10 years; and no increases in the Family Support Program in five years. This has forced Portage County to use Community Aids or County tax levy dollars to supplement these programs while at the same time receiving reductions in state Community Aids.

We understand that fiscal considerations are certainly driving the planning behind Family Care, and are anxious to pilot the proposed program to see if a redesigned system can provide continued and enhanced quality Portage County residents have come to expect; to see if we can offer expanded opportunities for individuals to remain in their own homes rather than entering institutional care; and to see if we can serve the large projected number of individuals who will be seeking Long term care services in future years.

We do, however, have some serious concerns and reservations about the proposed Family Care Legislation. They are:

1) That the Family Care Pilots be viewed and operated as true pilots rather than simply operating as the first phase of state wide Family Care implementation.

2) That the Pilots be allowed to operate over the course of two biannual budget periods so that decisions regarding statewide implementation can be based on more than six to ten months worth of data and experience.

3) That the Pilots be exempted from governance/Family Care Districting changes as proposed in this budget for the duration of the Pilot period, and that the issue of required governance changes continue to be studied.

4) That the Pilots be exempted from requirements for open competition until statewide implementation of Family Care begins, and that all efforts be made by DHFS to extend the time period where competitive bid requirements will be invoked.

5) That the CMO cost model continue to be studied/reviewed to ensure that counties are not put at a fiscal disadvantage as they begin to operate Family Care.

6) That managed care and non-managed care models both continue to be considered by DHFS as the state long term care system undergoes change.

7) That the Department of Health and Family Services work toward including all original targeted populations in the Family Care model, including developmental disabilities.

We are pleased with the level of technical support provided to us as a Pilot from DHFS, and intend to continue to work toward making Family Care successful for residents of Portage County. Thank you for the opportunity to express our opinions about this tremendous change in how services are delivered to seniors and people with disabilities in Wisconsin.

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TESTIMONY
BEFORE THE JOINT COMMITTEE ON FINANCE
BY THE WISCONSIN CHAPTER OF NASW
APRIL 1999

While social workers across the state work in a number of areas affected by budget changes, I would like to highlight three areas of concern for our Chapter: long term care redesign, or Family Care, child abuse and neglect prevention, and W-2. Along with this testimony, I have attached the NASW-WI position statements prepared by the Legislative and Social Policy Committee for our recent Lobby Day.

Family Care

While NASW-WI supports the development of Family Care through pilot projects, we oppose the proposed management of Family Care. NASW-WI supports the public administration of Family Care through the counties. Also, counties should have more than two years to establish their long term care programs before bids from private agencies are requested to operate the Family Care program. Finally, NASW-WI supports an increase in funds for the Community Options Program (COP) for the counties that are not in the pilot program.

Child Abuse and Neglect Prevention

Despite the recommendations of the 1997 Joint Legislative Council Committee on Prevention, the Governor has not included funds in his budget to extend the Prevention of Child Abuse and Neglect (POCAN) Program for this biennium. In addition to the expansion of POCAN, NASW-WI supports the fulfillment of the 1% for Children initiative as intended in the *Truth in Sentencing* legislation. This funding should be made available to make home visiting and family resource services available to all parents of newborn children. We believe that this funding should be **new money**, be dedicated to **primary prevention**, and provide enough **flexibility** for comprehensive, community-wide involvement in the development and delivery of services.

Wisconsin Works

NASW-WI supports the incorporation of the following improvements in W-2 into the budget bill:

1. NASW-WI supports the recommendations of the SSI Parents Coalition that call for increased support for families headed by a parent or parents on SSI. The added cost to the Caretaker Supplement program is small compared to the security it offers families that are already burdened by the stress of a disabled parent. We also recommend that this increase start July 1, 1999 rather than the October 1, 1999 start date in the current budget proposal.
2. Members of NASW-WI have several concerns regarding the contract process for W-2 agencies. NASW recommends the following: W-2 agencies should be required by contract to inform clients of **all options and services available to them**, and the agencies should be required to follow up on clients once they leave W-2 to ensure that they are truly gaining independence and self-sufficiency, as opposed to simply leaving the "welfare rolls". Explicit guidelines and standards for follow-up should be provided in the contract. In addition, broad-based community participation, including input from participants, advocates, service agencies, and community advisory groups should be a required part of all W-2 contract development. All W-2 agencies should be required by contract to participate on an ongoing basis with such groups. Explicit guidelines and standards for collaboration with community groups and individuals as well as for the utilization of their input should be provided in the contract.
3. NASW-WI supports the Governor's budget initiatives to lower the child care co-payments; however, we recommend that the child care co-payments be waived for W-2 participants living below the poverty line and for minor parents, kinship care relatives, and foster parents.

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Wisconsin Chapter, National Association of Social Workers
1999 Lobby Day

MAKING W-2 WORK

NASW-WI believes that W-2 (Wisconsin Works) must be modified if it is to succeed as a program to move people out of poverty and into economic independence. Although W-2 was "designed to reinforce behavior that leads to independence and self-sufficiency," its success has been defined in terms of caseload reduction instead of client independence and self-sufficiency.

Problems with W-2

Simply reducing the welfare rolls is not the stated goal of W-2. We must look beyond this to the genuine welfare, the health and well-being, of all who live in Wisconsin. We must ask ourselves and our elected representatives, what do we have to offer in terms of career jobs, living wages, education, and support to families to make independence and self-sufficiency a reality and not just a catch phrase? For those for whom independence and self-sufficiency are not entirely attainable goals, how can we as a democratic society demonstrate our humanity, our compassion, and our commitment to basic human and economic rights?

Has W-2 provided the means for those leaving welfare to become independent and self-sufficient? The recently released Department of Workforce Development (DWD) survey of those who have left showed that 38% of the former participants were unemployed. This indicates a critical shortfall in a program designed around the slogan of "Only work pays." Such hurdles as underemployment and lack of living-wage jobs, the scarcity of quality, affordable daycare, and insufficient training and education continue to prevent many families from reaching independence and self-sufficiency. Many have turned to private and faith-based charities, community agencies, and extended families simply to survive, placing greater strains on an already overburdened network of support *without achieving the goals of W-2.* Others have simply vanished from the rolls, their fate unknown. DWD has the responsibility for the implementation of W-2 and must be held accountable to its stated goals.

Recommendations

To help accomplish the stated goals of W-2 of helping families to become independent and self-sufficient, NASW-WI recommends the following:

- Evaluate the success of W-2 by a comprehensive measurement of clients' independence and self-sufficiency.
- Require extensive training for W-2 caseworkers so they are prepared to conduct comprehensive, individualized assessments of applicants for barriers to self-sufficiency, including such areas as education, housing, child care, domestic violence, substance abuse, and mental and physical disabilities.
- Allow W-2 participants up to 30 hours per week for education and training (such as high school, GED, post-secondary, life skills, parenting, AODA, and ESL) along with 10 hours per week of work activities. Also, parents still eligible to attend high school must be able do so without an added work requirement.
- Waive the child care co-payment requirements for W-2 participants living below the poverty line, minor parents, kinship care relatives, and foster parents. Follow the DWD recommendations to reduce co-payments in the first month of work; pro-rate co-payments for children in part-time child care; and cap the maximum payments for child care at 10% of income.
- Restore the fair hearing process and allow participants to continue to receive benefits pending a decision.

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PREVENTION OF CHILD ABUSE AND NEGLECT

Today, one can rarely read the newspaper or watch television news without being jolted by stories of beaten, sexually abused, or severely neglected children. In Wisconsin, more than 46,000 cases of child abuse and neglect are reported each year. The people of Wisconsin clearly recognize the need to protect children, and are willing to support prevention programs. In fact, a 1993 survey of Wisconsin voters showed that 88% saw a need for prevention programs, and 80% believed prevention would save taxpayers money in the long run.

It is important to understand that most maltreated children grow up to lead normal adult lives, and they don't grow up to abuse their own children or others. However, studies show abused and neglected children are all at *greater risk* for mental health problems, suicide attempts, alcohol abuse, drug abuse, and poor school performance. Perhaps most disturbing is that physically abused and neglected children are *significantly more likely* than children with no histories of maltreatment to commit violent crimes as juveniles and adults. Pronounced differences between abused and neglected children are their non-abused counterparts can begin to emerge as early as age 8 or 9.

Neglect is by far the most common type of maltreatment reported to child protection authorities, accounting for over half of all national child maltreatment reports and 43% of reports in Wisconsin (1996). While other types of abuse are episodic in nature, neglect generally involves a pervasive and ongoing pattern of behavior. Although there is not a single type of parent who neglects his/her child, researchers have observed some common characteristics: depression, isolation, history of being neglected as a child, drug and/or alcohol use, and stress. National statistics show that neglect disproportionately affects infants and preschoolers, who are at their most vulnerable developmental stage. Recent research on infant brain development suggests that the impact of the environment on a newborn is dramatic: without affection, attention and proper social interactions, the child's brain will not develop properly.

Recommendations

- **Expand Home Visiting Programs**

High-quality home visiting programs which start working with families as soon as the child is born have proven to be effective in preventing child abuse and neglect. The programs are successful because they help parents manage the stresses of raising children before unhealthy patterns develop. NASW-WI recommends the expansion of state supported home visiting programs so that they are available in every county of Wisconsin.

- **Collaboration Between Home Visitors and W-2 Financial Employment Planners**

NASW-WI believes that by working together, home visitors and W-2 Financial Employment Planners can double their impact by providing information and assistance at the local Job Centers or W-2 agencies while reinforcing and extending the message of self-sufficiency in the home environment. By educating parents on parenting skills, family budgeting, interpersonal skills, time management, problem-solving strategies and finding quality child care, the W-2 program and home visitation programs can help individuals maintain employment while encouraging healthy family relationships and child development.

- **Fulfill the Commitment of 1% for Prevention**

Last June, when the Governor signed in to law Act 283, the *Truth in Sentencing* legislation, including the bipartisan-supported "1% for Children" amendment, Wisconsin became the first state in the nation to link crime reduction and child abuse prevention. The amendment calls for the allocation of the equivalent of 1% or greater of the Department of Corrections budget toward the prevention of child abuse and neglect. NASW-WI proposes that the funding for this amendment be **new money** (or money not already allocated to prevention); that it be dedicated to the **primary prevention** of child abuse; and that it provide local jurisdictions with the **flexibility** to design their own programs.

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HEALTH AND LONG TERM CARE

Health Insurance

Almost half a million people in Wisconsin do not have health insurance, and the number of uninsured is increasing. Over 1.5 million people in the state were either denied health insurance, had certain conditions excluded, or paid higher premiums because they had pre-existing conditions. There have been attempts at both the state and national level to secure universal health care coverage for all residents.

Managed Care

Most people in Wisconsin (84%) have their health care through a managed care plan. Although many are satisfied with their managed care plan, the following problems have occurred: limitations on benefits; prior authorization required to receive specialized treatment; restrictions in receiving care from specified providers; inability to receive emergency care without authorization; emergency care limited to specific facilities; not all prescription drugs are available; special provisions and limitations on mental health services; no coverage out of plan area; and restrictions in the availability of grievance and appeal procedures. The 1997-98 State Legislature adopted some changes in managed care, but left out many important protections.

Long Term Care

About 260,000 residents of Wisconsin over age 15 have a permanent or long term disability, and one-fourth of them live in poverty. About a third of these people need to help with three or more basic activities of daily living, such as bathing, dressing, moving around, toileting, eating, or transferring from bed to chair. Another third need help with one or two of these activities of daily living, while the remaining third need help with activities such as managing medications, meal preparation, household chores and using the telephone.

Most of the long term care is provided by family or friends. In Wisconsin, the formal system includes 400 facilities, such as nursing homes. There are 1,300 community-based residential facilities and over 100 county and thousands of voluntary and proprietary agencies providing these services. Since many living in nursing homes have exhausted their resources paying for their care, about 60% of those in nursing homes are covered by Medicaid. The Community Options Program, which provides services to people who remain in their own home, has a waiting list of about 9,000. More than $2 billion in government funds are required to pay for these services. There has been an effort to reorganize long term care in Wisconsin. This has been complicated by capping the funding, including health care and contracting for the administration of long term care.

Recommendations

- Support a Universal Health Care program for Wisconsin resident.
- Support Badger Care, which would provide more people with health insurance coverage and institute sliding scale fees for health care.
- Support consumer protections in managed care, including an independent appeals procedure.
- Permit enrollment in managed care plans, regardless of current coverage or pre-existing conditions.

Support a comprehensive, coordinated long term care system in Wisconsin under public auspices.

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PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE

The Wisconsin Chapter of NASW believes in the need for a Wisconsin Mental Health and Substance Abuse Parity Law. The Federal Mental Health Parity Act of 1996 (P.L. 104-204) was a first step toward equal insurance coverage for persons with mental illness, but the loopholes in that Law mean that, in Wisconsin, there is no substantive change in health insurance coverage for people with mental illness or substance abuse issues.

Over the past 20 years, research has demonstrated the relationship between mental illness and abnormalities in the brains of affected individuals. No one blames a person suffering from a brain disease. At the same time, treatment for brain diseases has improved tremendously. A NIMH study shows the current success rate for the treatment of clinical depression is 80-90%, whereas the overall success rate for cardiovascular disease is only 45-50%.

More than 70% of people who currently use illicit drugs which put them at risk for developing an addiction, as well as 75% individuals who are alcoholics are employed. Most employer-provided insurance policies today discriminate against people with AODA issues requiring greater patient burden for cost sharing, co-payment, and deductibles, while offering less coverage for number of visits or days of coverage and annual and lifetime dollar expenditure limits for treatment. According to the Bureau of Labor Statistics, in 1995 about 80% of employees working for medium and large employers have health plans that cover a minimum level of medical treatment. However, fewer than 7% of these employer provided health plans covered AODA treatment to the same extent as other medical conditions. If alcohol and drug addiction is not treated when an individual has employer provided insurance, the costs of addiction do not go away. They simply become a negative externality, causing costly problems in other areas of public and private systems, such as the Medicaid, Medicare and Corrections systems. Costs may eventually shift back to the private health system which must deal with alcohol and drug addiction-related accidents and diseases when treatment could be made available before such problems surface.

Parity Will Not Increase Insurance Expenses

The following studies show that insurance costs will not rise with the inclusion of mental health and substance abuse coverage.
A recent study by the Federal substance Abuse and Mental Heath Services Administration (March 1998) concludes:

- State parity laws have a small effect on premiums. cost increases have been lowest in systems with tightly managed care and generous baseline benefits.
- Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.
- Costs have not shifted from the public to the private sector. Most people who receive publicly funded services are not privately insured.

A report from the National Advisory Mental Health Council (May 1998) concludes:

- In systems already using managed care, implementing parity raises health care costs by less than 1& over one year.
- Introducing managed parity in systems not using managed care leads to a 30-50% reduction in total mental health costs over one year.
- Maryland reported a 0.2% decrease in the proportion of total medical premium attributable to the mental health benefit after the implementation of full parity.

A 1997 Rand Corporation Study concluded that removing limits on inpatient days and outpatient visits will increase costs by less that $7 per enrollee per year.

Finally, since all employees pay the same premium for their health insurance coverage, it is discriminatory to restrict the treatment for mental health and drug and alcohol addiction when treatments for other chronic illnesses are not restricted. People with brain diseases should have the same health insurance coverage as people with other physical health illnesses.

Recommendation

NASW -WI believes that the Wisconsin Legislature should pass a new law and regulations that require mental health and substance abuse insurance coverage.

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CIVIL RIGHTS FOR LBGT CITIZENS

It is the position of the National Association of Social Workers that same-gender sexual orientation should be afforded the same respect and rights as other-gendered orientation. Discrimination and prejudice directed against any group are damaging to the social, emotional, and economic well being of the affected group and the society as a whole. Denial of legal rights reinforces and legitimizes homophobic and other acting-out behavior of those predisposed toward prejudice, discrimination, and violence. (Social Work Speaks, 1997: NASW Press, 201-202).

NASW WI believes it is essential that the basic rights and responsibilities afforded to heterosexual citizens are conferred upon lesbian, gay, bisexual and transgendered (LGBT) persons in order to obtain true equality. The following is a description of some of the issues facing LGBT persons in Wisconsin.

Domestic Partnership

While LGBT persons pay the same taxes as their heterosexual counterparts, they are denied the same civil rights and responsibilities that marriage confers. It costs gay and lesbian couples thousands of dollars to replicate just some of civil protections that heterosexual couples receive for the cost of a marriage license. Some basic benefits and responsibilities denied to gay and lesbian couples include:

- Health insurance under their partner's policy
- Health insurance for their child if they are the non-biological or adoptive parent
- The ability to adopt their partner's children
- Responsibility for child support or alimony in cases of a dissolved relationship
- Taxation and inheritance rights

Children of Gay and Lesbian Parents

At a time when Wisconsin is receiving national attention for enacting policies aimed at bettering the lives of children, it is important that one group does not go unnoticed: the children of LGBT parents. The familial make-up of our society is undoubtedly changing, and many children are being raised in households where the primary caregivers are not married to each other. This leaves the children in legally precarious situations, threatened with losing all caregivers or support if something should happen to their legal parent or the adult's relationship. Some essential familial securities that should be included in Wisconsin law are the following:

- Adoption of a child into a loving home by two unmarried adults.
- Adoption of a child by a parent-like figure who is not married to the legal parent.
- Visitation or guardianship of a child by a parental figure in the event of death of the child's legal parents.
- Responsibility for child payments and visitation by parental figures in instances of separation.

Recommendations

- In the interest of fairness, justice and economics, it is important that Wisconsin lawmakers support domestic partnership legislation.

To ensure that all children have equal protections under the law, Wisconsin lawmakers should support and pass legislation that is designed to give the protections listed above to children who have few rights under current law.

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The Wisconsin Society for Clinical Social Work

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LICENSURE FOR CLINICAL SOCIAL WORKERS

In 1992, Wisconsin Act 160 was passed by the Wisconsin Legislature and signed by Governor Thompson. Wisconsin Act 160 provided certification and title protection for social workers, marriage and family therapists and professional counselors. Under this act, an individual is prohibited from using the title social worker, marriage and family therapist or professional counselor unless they are certified.

Limitations on Certification

1. While certification provides protection against individuals using the title social worker or clinical social worker, it does not prohibit individuals from practicing social work or clinical social work under a different title.

2. Some managed care companies require subscribers to see a licensed professional for mental health services which would eliminate clinical social workers in Wisconsin who are not currently licensed. The lack of licensure therefore can prevent consumers from being able to choose a clinical social worker for their mental health needs. In addition, due to the lack of psychologists and psychiatrists in certain regions of the state, the lack of licensure can lead to very limited or no access to mental health services for some consumers.

3. Licensure is needed to fully protect the confidentiality of the consumer. In its June 1996 Jaffee v. Redmond decision, the United States Supreme Court ruled that a licensed clinical social worker's notes were confidential. It is not at all clear that the notes of a certified clinical social worker's notes could be considered confidential.

4. Certification and title protection have questionable legal standing. In Abramson v. Gonzales, 949 F.2d 1567 (11th Cir. 1992), the Florida 11th District Court of Appeals ruled that certification (title protection) was unconstitutional based on the First Amendment's guarantee of freedom of speech.

Recommendation

The Wisconsin Society for Clinical Social Work recommends the passage of a bill that would institute licensure and a practice act for Wisconsin's clinical social workers.

April 5,1999

To Whom It May Concern:

Pacific International, Ltd. of Nekoosa, Wisconsin is a company that engages in the correction of nocturnal enuresis (bedwetting).

Our family has used these services and we believe they are not only successful in correcting the bedwetting problem, but also very beneficial to our child's quality of life as a result of the elimination of the problem.

It was a year ago when our son turned eight years old that we finally decided we had to try and help him kick this problem which was causing him a lot of embarrassment. He was being asked to overnight birthday parties and campouts with friends but chose to stay home for fear of being "found out". We had approached our son's pediatrician two years earlier with the problem and he tried to reassure us that he would eventually mature out of this. However, he did give us a prescription for a bedwetting device that might help if our son was mature enough to use it. We decided to wait. I contacted Pacific International through an add I found in the newspaper. Within days our family was contacted by a representative and asked if we would like to make an appointment in our home to hear how the program worked. My husband and I decided that we had nothing to lose to listen and our son had everything to gain. Our conference with the representative from Pacific International was very professional. It was not a "hard sell". The research on its success spoke for itself. The representative also talked with our son in a very respectful way about the bedwetting problem. Although the program seemed expensive we felt that our son's happiness and self-esteem was definitely worth the financial investment. Five and a half months later, in July of '98, our son was declared dry and has been ever since. I need to underscore one very important point before I close this letter. Had it not been for the letters and phone calls from the counselor assigned to us by the company we would have given up. The bedwetting device alone would not have been enough to ensure his success. Each of us needed the emotional as well as the physical support this program provided.

Our family was so fortunate to be able to afford this program but we can understand the dilemma faced by many families. Children today have so many challenges to meet on a daily basis. Bedwetting and the resulting unhappiness and low-self esteem it causes should not be added to the list. State Senator Kevin Shibilski is in favor of the cost of Pacific's correction being handled by the State of Wisconsin for those who cannot afford it. We urge you to support this coverage so there is a comprehensive and successful correction of this problem that is also cost effective. Our son just turned nine. He is happy and confident. Not too long ago he attended an overnight birthday party for a friend at a local hotel. His comment to me was that the party was "awesome". A year ago he would have stayed home. If you have questions, please let us know.

Sincerely,

Mr. and Mrs. Dennis Brotz

Mr. and Mrs. Dennis Brotz

Portage County Right From the Start Coalition

P.O. Box 457
Stevens Point, WI 54481

Phone 715 344-5759

April 12, 1999

Wisconsin Joint Committee on Finance
316-S Capitol
P.O. Box 7882
Madison, WI 53708-7882

Dear Joint Finance Committee,

This letter is in lieu of personal testimony at the Stevens Point Finance Public Hearing. The Portage County Right From the Start Coalition would like to go on record supporting the 1% for Child Abuse and Neglect Prevention amendment included in the "Truth in Sentencing Act" passed last year.

If Wisconsin ever expects to decrease its cost for Child Abuse and Neglect, Foster Care, Juvenile Detention and County and State Prisons it needs to go back to the beginning and beef up its primary prevention programs. Wisconsin cannot expect these expenses to go away or even decrease without a statewide plan for primary prevention.

With the passage of the "Truth in Sentencing Act" last year, Wisconsin became the first state to directly tie the relationship between Child Abuse and Neglect and crime. This was a powerful statement and celebrated all around the state. The amendment in the "Truth in Sentencing Act" stated that an equivalent of 1% of the Department of Correction's budget will be allocated to the Department of Health and Family Services for the purpose of Child Abuse and Neglect prevention.

Nowhere in the budget proposal did I see anything that came close to fulfilling this promise. For the state of Wisconsin to begin to see a decrease in its expenditures related to crime it must look at creating a greater commitment to primary prevention - getting to the problems before they start. This means early support for all families.

For every dollar Wisconsin spends on corrections, lets find one penny that can be spent on primary prevention.

Sincerely,

Amy Bakken RN
Member of Portage County Right From the Start Coalition

4/12/99

To: Joint Finance Committee

I would like to go on record as opposing several of the governor's proposals for the planned budget. Specifically, the Vocational Rehabilitation base allocation, the Community Integration Program and the Community Options Program are all inadequately funded. I will be brief, but let me explain why.

I am a public school, special education teacher. I work with cognitively disabled young adults, transitioning them from school services to adult services. To be succinct, the last few years have been extremely difficult for our students. Services that were formerly available to them are slowly disappearing. Practically, what this means is that a large portion of our students are struggling to make it in the world outside of school. Reducing or freezing funds that have already been compromised is unconscionable. I can safely say that if funds are neglected in these areas, many handicapped individuals who are capable of successful community integration will be put at risk. At some point finances will be needed to deal with the negative results of a lack of funding. Perhaps money would be better spent on the front end, rather than waiting until problems develop.

Thank you for your help.

Dennis J. Nordstrum

Dennis J. Nordstrum
Teacher, Lincoln High School
Wisconsin Rapids, WI

4/12/99

To: Joint Finance Committee

I am the mother of a young boy with Downs Snydrom. He is a very special person, he is happy, loving and very determined, however; he is the kind of person in need of funding for supported adult living arrangments and supported employement. My husband and I love our son very much but; their will come a time when we will not be able to care for him. We do not want our other children to be forced to take on the responsibilities that would come along with **our** son. Housing options and job supports are very limited and in time many of us as parents will need care for our children, if they are not being productive and constructive they will find something else to do with their time. The something else could be nonconstructive and is not an option. We need this committees support and understanding to keep funding programs for our children.

I would like to express my extreme concern with the tragedy of cuts and decreases in the Community Integration Program, the Vocational Rehabilitation based allocation and the Community Options Programs. These programs need to be reconsidered and funded more now than ever before. At one time our children were instatutionallized, we have made great gains in society with helping our children stay in their homes and showing them what love, responsibility and employment are all about. We do not want to take steps backword and be forced to have instatutions again. Our children can be productive members of society with support. We all need to help this happen with more money being allocated to the programs metioned above which support employment and housing.

Thank you for your support.

Mary Gillette

Mary Gillette
4606 Huser Rd.
Vesper, Wi 54489

April 12, 1999

The Joint Budget Committee:

Dear Sir or Madam:

Mark and I are the proud parents of a kind and loving young man named James Robert Grundman.

Jim is fourteen years old, has Down Syndrome and is currently in Jr. High School in Wisconsin Rapids. Jim is completely dependent on my husband and I for all of his needs. He cannot be at home alone, at any time because his current mental state is that of a four to five year old. I am employed by the Wisconsin Rapids School district, so that I will be home when Jim gets home from school. I have to be here for Jim because there is no day care for a fourteen-year-old. I am not complaining but, what will happen when Jim graduates from High School, and there is no funding for housing, jobs, or career training, because our Governor has decided to decrease monies going into programs for handicapped people such as CIP and COP.

Do I have to quite my job and become a full time, stay at home mom again?

And what about Jim?

He has an older brother and sister who have grown and have gone off to school. He knows the natural progression of things and wants to work and live on his own someday just like his brother and sister. Jim wants to live his life as independently as possible, but that will not happen unless we get support from our government.

In closing, I think it is a real shame that we house, feed, clothe, educate and entertain people that are currently in our jail system, yet our children who have never hurt anyone, do not even get a place to live and a chance at a normal life. If this child is not supported, he will live with us, but what happens when we die? If he has no career skills or living skills the government will have to support him then anyway. So, please help give our son a chance to be all that he can be. He is a warm and wonderful human being who deserves a chance in life too.

Sincerely,

Bonnie and Mark Grundman
3531 Coach Lantern Drive
Wisconsin Rapids, WI. 54494

P.s. Remember you could be in his shoes, you never know what tomorrow brings.

Testimony before the Joint Committee on Finance

Intoxicated Driver Intervention Programs

April 13, 1999

Diane Y. Oonk, Executive Director

Triniteam, Inc.

202 Graham Ave., Eau Claire, WI 54701

(715) 836-8106

My name is Diane Y.Oonk. I am the Executive Direrter of Triniteam, Inc. a nonprofit social service agency in Eau Claire. I am here today to urge you to include additional state dollars into the Department of Transportations' intoxicated driver pre-trail intervention programs. Last session's

state budget bill included $150,000 for this program. Since that time 4 additional counties have started programs based on the success of the Milwaukee program. The Department has combined these state dollars with federal funds under the Alcohol Incentive Grant funding to expand this program and save lives.

The Eau Claire Intoxicated Driver Intervention Program began in August, 1998. We have worked with 63 people as of March 31,1999. 19 people have successfully completed the program and 18 are currently enrolled. In looking at the 63 people we have worked with, only 2 of those who were unsuccessful have reoffended. We have saved 710 jail days which would have cost our county $31,950. We have support for the program from the judges, D.A. and public defenders.

Our concern is that we have two thirds of our funding from the federal funds. These funds are meant only to be a match for pilot programs and gradually need to be replaced by all state funding. The Department is also concerned that changes in the criteria as required of the Transportation Equity Act for the 21st Century may not allow Wisconsin to qualify for these funds.

Intoxicated Driver Intervention Programs work! We need your help to make certain they are sustained. I have attached the Department's estimates of what will be needed to keep these programs operating.

		Estimates	state funding '99	state funding '00	state finding '01	state funding '02
Kenosha, year one	$ 79,141.00		$ 26,380.00	$ 39,570.00	$ 52,761.00	$ 79,141.00
Eau Claire, year one	$ 57,812.00		$ 19,271.00	$ 28,906.00	$ 38,541.00	$ 57,812.00
Marathon, year one	$ 62,608.00		$ 20,870.00	$ 31,304.00	$ 41,738.00	$ 62,608.00
Waukesha, year one	$ 99,933.00		$ 33,311.00	$ 49,966.00	$ 66,622.00	$ 99,933.00
Milwaukee, state funding	$ 110,000.00		$ 110,000.00	$ 110,000.00	$ 110,000.00	$ 110,000.00
Oneida, Forest, Vilas* $5,000	$ 71,646.00		$ 23,882.00	$ 33,232.00	$ 44,430.00	$ 66,646.00
		Total	$ 233,714.00	$ 292,978.00	$ 354,092.00	$ 476,140.00

Interest from followng counties:

Brown
Chippewa
Sheboygan

1st year efforts, 2/3 fed, 1/3 state
2nd year efforts, 1/2 fed, 1/2 state
3rd year efforts, 1/3 fed, 2/3 state
4th year efforts, all state funding

*estimated start up costs

State Funding Projections without 410 monies

		Estimates	state funding '99	state funding '00
Kenosha, year one	$ 79,141.00		$ 26,380.00	$ 79,141.00
Eau Claire, year one	$ 57,812.00		$ 19,271.00	$ 57,812.00
Marathon, year one	$ 62,608.00		$ 20,870.00	$ 62,608.00
Waukesha, year one	$ 99,933.00		$ 33,311.00	$ 99,933.00
Milwaukee, state funding	$ 110,000.00		$ 110,000.00	$ 110,000.00
Oneida, Forest, Vilas* $5,000	$ 71,646.00		$ 23,882.00	$ 66,646.00
		Total	$ 233,714.00	$ 476,140.00

Interest from followng counties:

Brown
Chippewa
Sheboygan

*estimated start up costs

TESTIMONY TO THE JOINT FINANCE COMMITTEE

John A. Gruenloh
Director of Pupil Services
Wisconsin Rapids Public Schools

Tuesday, April 13, 1999
10:30 a.m.

University of Wisconsin – Stevens Point
University Center; Alumni Room

Good morning. My name is John Gruenloh. I am the Director of Pupil Services for the Wisconsin Rapids School District. I not only represent our school district with this testimony, but also the Wisconsin Council of Administrators of Special Services (WCASS) and the School Administrators Alliance. The Wisconsin Council of Administrators of Special Services is a professional organization comprised of administrators in the area of pupil services and special education. The School Administrators Alliance is an alliance of school administrators comprised of four professional organizations; Wisconsin Association of School District Administrators (WASDA), Association of Wisconsin School Administrators (AWAS), Wisconsin Association of School Business Officials (WASBO) and Wisconsin Council of Administrators of Special Services (WCASS). I want to express my thanks for the opportunity to testify before the Joint Finance Committee and for the support and interest of Senator Shibilski on educational issues. My testimony will primarily address two issues; special education funding and the Student Achievement Guarantee in Education (SAGE program).

Special Education Funding – Categorical Aids

Wisconsin statutes currently require the state to reimburse local school districts for 63% of the allowable costs incurred in providing special education. Actual reimbursements to school districts, however, have been frozen at $275.5 million since the 1994-95 school year, and actual reimbursement rates to school districts are approximately 34% as opposed to the 63% figure. The Governor's 1999-2001 biennium budget contains a freeze in the reimbursement at $275.5

million and it also eliminates the statutory reimbursement rate of 63%. With the dollar amount frozen at $275.5 million, along with the state and federal mandates to serve students with special education needs, the actual reimbursement rate is predicted to fall even further below the actual 34% that districts are receiving at the present time.

The erosion in levels of state funding is forcing school districts into a position of having to cut regular education, maintenance, materials, and equipment to pay for the state and federal mandated programs for special education. While we recognize that categorical aids are inherently de-equalizing in an era of revenue caps, they provide districts with the greatest discretion and hold the state accountable for funding special education. With special education costs expected to continue to increase, school districts can no longer be expected to absorb what is essentially a budget short-fall of at least $195 million. It is estimated that the $195 million is what is required to achieve the 63% statutory reimbursement of special education services.

With the categorical aid reimbursement rate continuing to decline, local school districts are forced to pay for more of the state and federally mandated programs for which they do not have the money to do under revenue caps. In addition, districts are having to cut what they can out of regular education, maintenance, and curriculum materials to pay for the mandates and increased number of children being placed in special education programs.

I would make the following recommendation regarding categorical aids. Ideally, I would recommend that categorical aids be sufficient to fund special education at the 63% reimbursement rate; however, if that is not possible, an increase set at a 50% sum sufficient level would be extremely helpful and beneficial to school districts. A 50% sum sufficient rate of reimbursement would require an increase in categorical aids of over $100 million.

Student Achievement Guarantee in Education (SAGE program)

The biennium budget proposes increasing funding for SAGE by $3.5 million in fiscal year 2000 and $13.5 million in fiscal year 2001. With this increase, it is estimated that 32 SAGE schools would be added to the program. Of the 32 schools, 20 of the schools will be in the Milwaukee Public School system. The preference to school districts in 1999-2001 will be given to the Milwaukee Public School District in schools with above the 80% poverty level and to other schools that are above the poverty level by 62%.

With this amount of estimated future funding for SAGE, it is predicted that current schools over the 50% low income level may need to wait six years or more to receive funding. The research, as conducted by the SAGE evaluation team through the School of Education, University of Wisconsin – Milwaukee, concluded that the SAGE program has had a significant positive effect on the achievement of first graders. It is an exemplary program that should receive both state and federal funding so that class sizes at that level can be reduced to a ratio of 15 students to 1 teacher. Lowering class sizes does have a significant impact on the window of opportunity for students to learn to read in the first grade. Our current school district funds do not allow us to impact class size to the same degree that SAGE and federal dollars would allow us to do. We also realize that with our poverty level at 50% in some schools, it may be as much as six years before the Wisconsin Rapids School District would be able to access funds in order to lower class sizes to a point that would have a significant positive effect on students' ability to read. Statewide, we know that reading achievement could be significantly impacted if all schools over the 50% low income level were brought into the SAGE program in a more condensed timeline.

We realize that it would take a significant amount of funds to pay for a program of such magnitude. However, we do know that lowering class sizes, particularly at the first grade level, does have a positive effect on student learning and any funds that could be brought to bear on

this program would be funds well spent on the education of our children. We know that this program works and that more schools need to be funded so that class sizes can be lowered.

Other items contained in the biennium budget that we can support include the revenue exemption limit for school districts experiencing declining enrollments, the state's commitment to continue two-thirds funding, and the continued funding at the proposed level to support the TEACH Board.

Again, I appreciate the support of Senator Shibilski on educational issues and I appreciate the opportunity to address the Joint Finance Committee on issues of education and on issues that impact the children in the State of Wisconsin.

Joint Finance Committee Hearing
Testimony from the Wisconsin Health and Hospital Association
Tuesday, April 13, 1999

My name is Bob Taylor and I am the President/CEO of the Wisconsin Health and Hospital Association.

WHA is a trade association representing over 130 hospitals and health systems in this state.

There is no question that health care in general and medical assistance in particular did not fare well in this budget. Specifically, the budget proposes to essentially freeze medical assistance rates for care provided in Wisconsin hospitals for the biennium. It also begins the first two years of an ongoing process to cut back on the state's financial support for training the physicians Wisconsin will need in future years.

These proposals come at a time when a number of other important dynamics are occurring in the state.

First, the Legislature has recognize that Wisconsin has not traditionally fared well in its fair return of federal dollars. A legislative committee has actually been looking at ways to improve Wisconsin's track record in this area.

Medical assistance, because it is a matching program with the federal government, has the potential to return 60 cents of federal dollars for every 40 cents committed by the state. The state's freeze in MA base rates and cuts in medical education funding mean that Wisconsin will forfeit almost $14 million of federal money as exhibited in Chart A attached.

Second, the MA proposals are playing out at the same time Wisconsin hospitals and health systems are bracing for huge cuts in Medicare payments under the Balanced Budget Act of 1997. These cuts began in FY 1999 and will play out through FY 2002. Over that timeframe, this will result in cuts of around $770 million. Over the state's biennium alone, Medicare is projected to take about $347 million out of Wisconsin's health care system. **[[RT—could add Chart B and make reference if desired.]]**

The combined impact of these simultaneous freezes and cuts by Medicare and Medicaid is staggering. Wisconsin's health care system will have a significant challenge determining how to absorb the cuts imposed by Medicare; additional shortfalls coming out of Medicaid make an already difficult situation more so.

Cuts of this magnitude will have troubling implications for care in our communities. They cannot simply be absorbed through "becoming more

Wisconsin Health &
Hospital Association, Inc.

5721 Odana Road
Madison, WI
53719-1289

608/274-1820

FAX: 608/274-8554

http/www.wha.org

efficient." Based on federal Medicare data, Wisconsin health care providers are already some of the most efficient in the country.)

These cuts can only be dealt with in one of two ways:

The first is eliminating or reducing needed services to the community. While our members are currently analyzing the impact of these cuts on their projected bottom lines, they are of such a magnitude that many may have no choice but to limit service areas or eliminate financially marginal services.

The second is to shift costs to individual patients or employers who provide and pay for health insurance coverage for their employees.

Currently, almost $80 million in MA payment shortfalls alone are shifted to the private sector annually. This budget proposal will increase that number to about $88 million in the first year of the biennium and about $93 million in the second.

Finally, these cuts come at a time when health care, like other industries in Wisconsin, is finding it difficult to recruit and retain qualified personnel to serve our patients.

A freeze in MA rates makes it difficult, if not impossible, to give our staffs even a cost of living increase, much less make it an attractive place to work for new employees.

We are asking your help to achieve the following on medical assistance:

a) an inflationary increase of 2.4% in the first year and 2.6% in the second for medical assistance hospital inpatient and outpatient rates ($7.1 million GPR);

b) restoration of the medical assistance funding for medical education ($2.5 million GPR);

c) maintenance of the $2.4 million in the proposed budget to fund a medical assistance supplement, which is designed to assist those providers experiencing increases in charity care due to welfare reform; and

There are two other elements in the budget on which we need your help. We need to institute a reasonable system of doing criminal background checks and, once and for all, developing a fair and consistent funding source for the health data initiative with the Board of Health Information.

Thank you for the opportunity to share some of our thoughts with you today. These are important issues to consider in maintaining a quality health care system in Wisconsin.

Chart A

	State Share	Resultant Federal Loss	Total Shortfall
Base Rate Freeze			
FY 2000	(2,300,000)	(3,400,000)	(5,700,000)
FY 2001	(4,800,000)	(6,800,000)	(11,700,000)
Subtotal	(7,100,000)	(10,200,000)	(17,400,000)
Medical Education Cuts			
FY 2000	(900,000)	(1,300,000)	(2,300,000)
FY 2001	(1,600,000)	(2,300,000)	(3,800,000)
Subtotal	(2,500,000)	(3,600,000)	(6,100,000)
TOTAL	(9,600,000)	(13,800,000)	(23,500,000)

EDGEWATER HAVEN FACT SHEETS

WRITTEN TESTIMONY - JOINT COMMITTEE ON FINANCE PUBLIC HEARING, APRIL 13, 1999, BETWEEN 10:30 am and 5:00 pm IN STEVENS POINT, WISCONSIN

1. Edgewater Haven received approximately 75% of it's cost in Medicaid revenues to care for it's frail elderly guests. Our private pay skilled rate of $125.00 per day is 31.4% greater than the $95.13 Medicaid daily rate, compelling the private resident to subsidize our Medicaid deficit.

2. The anticipated Medicaid rate increases of 1.77% and 1% during the first and second years of the 1999-2001 state budget, respectively, are woefully inadequate to offset targeted cost increases of between (3) and (8) percent for supplies and equipment during the same period. How will we be able to hire additional staff needed and increase wages for present staff if we cannot adequately meet the financial demands imposed by inflation?

3. Presently, the turnover rates for our staff (by position) are as follows:

Part-time Registered Nurse	33%
Part-time Licensed Practical Nurse	150%
Full-time Certified Nursing Assistant	17%
Part-time Certified Nursing Assistant	130%

In addition, we routinely utilize between 150 and 200 hours of expensive staff overtime to meet resident care needs.

4. Our pay scale is relatively restrictive as determined, to a large measure, on the reimbursement we receive from Wisconsin for our services provided to Medicaid (70% of Total Occupancy) beneficiaries. By position, historical hourly rates by position are:

A. Housekeeping, Laundry and Kitchen

	Hourly Rate		
	07/01/96	07/01/97	07/01/98
Probation	6.59	6.79	6.99
60 days - 2 years	7.01	7.22	7.44
2 years - 5 years	7.25	7.47	7.69
5 years - 8 years	7.48	7.70	7.93
8 years - 12 years	7.56	7.79	8.02
12 years - 15 years	7.93	8.17	8.42
15+ years	8.10	8.34	8.59

B. Certified Nursing Assistants, Therapy Aides

Probation	7.68	7.91	8.15
60 days - 2 years	7.87	8.11	8.35
2 years - 5 years	8.08	8.32	8.57
5 years - 8 years	8.28	8.53	8.79
8 years - 12 years	8.37	8.62	8.88
12 years - 15 years	8.76	9.02	9.29
15+ years	8.91	9.18	9.46

C. Cook

Probation	6.64	6.84	7.05
60 days - 2 years	7.26	7.48	7.70
2 years - 5 years	7.50	7.73	7.96
5 years - 8 years	7.73	7.96	8.20
8 years - 12 years	7.82	8.05	8.29
12 years - 15 years	8.19	8.44	8.69
15+ years	8.35	8.60	8.86

D. Cook's Helper

Probation	6.59	6.79	6.99
60 days - 2 years	7.14	7.35	7.57
2 years - 5 years	7.37	7.59	7.82
5 years - 8 years	7.58	7.81	8.04
8 years - 12 years	7.67	7.90	8.14
12 years - 15 years	8.05	8.29	8.54
15+ years	8.21	8.46	8.71

E. Maintenance Man	07/01/96	07/01/97	07/01/98
Probation	7.67	7.90	8.14
60 days - 2 years	8.47	8.72	8.98
2 years - 5 years	9.15	9.42	9.70
5 years - 8 years	9.38	9.66	9.95
8 years - 12 years	9.49	9.77	10.06
12 years - 15 years	9.87	10.17	10.48
15+ years	10.02	10.32	10.63

F. Maintenance Man Assistant			
Probation	6.99	7.20	7.42
60 days - 2 years	7.69	7.92	8.16
2 years - 5 years	7.97	8.21	8.46
5 years - 8 years	8.19	8.44	8.69
8 years - 12 years	8.30	8.55	8.81
12 years - 15 years	8.67	8.93	9.20
15+ years	8.84	9.11	9.38

G. RN - LPN	Starting Wage	Average Wage	Highest Wage
RN	16.46	17.50	19.69
LPN	12.18	12.98	13.21

Staff Shortages

In each of the following staff categories, <u>on average</u>, these positions were budgeted but the facility was unable to fill in 1998,

Position	Ave. Starting Hourly Wage 1997	1998	Budgeted FTE Positions	Ave. # of Vacant FTE Positions	Average Length of Time to Fill a Vacant Position
a. CNA	7.68	7.91	49.0	1-2	6 weeks
b. LPN	11.83	12.18	5.6	.5	1 year
c. RN	15.98	16.46	14	1	3 months
d. Dietary Aide	6.59	6.79	8.9	0	30 days

Recruitment Techniques Used

Which of the following recruitment methods are you currently utilizing? For those methods used by your facility, please rate their level of success ranging from; 1-unsuccessful; 2-moderately successful; and 3-very successful. Please circle each method you use:

		Unsuccessful	Moderately Successful	Very Successful
a.	Advertising in local publications	(1) LAUNDRY HSKPG. MAINTENANCE	(2) NURSING	(3) DIETARY
b.	Other publications	1	2	(3) DIETARY
c.	Sign on bonus for new employees	1	2	3
d.	Recruitment bonus for current employees	1	2	3
e.	On-site training for Nursing Assistants	1	2	3
f.	Shift differential	1	2	3
g.	"Weekend-only" differential	1	2	3
h.	Higher wages in lieu of benefits	1	2	3
i.	Flexible scheduling	1	2	3
j.	Outreach to students	1	2	3
k.	Linking with community through colleges	1	2	3
l.	Tuition reimbursement/assistance	1	2	(3) CNA'S
m.	Professional image of Nursing Assistants	1	2	3 (TURNOVER CONCERNS)
n.	Use of regional pools	1	2	3
o.	Transportation to and from work site	1	2	3
p.	Child day care	1	2	3
q.	Other (please describe)	1	2	3

Lincoln Center
1519 Water Street
Stevens Point, Wisconsin 54481-3548
(715) 346-1401

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Fax: (715) 346-1418
Information & Assistance: (715) 346-1405
Email: dept.aging@co.portage.wi.us

April 13, 1999

To: Members of the State of Wisconsin Joint Finance Committee

From: Carol Moore, Portage County Department on Aging Nutrition Program Director

RE: INCREASED FUNDING FOR THE ELDERLY NUTRITION PROGRAM

Attached is a summary issue statement developed and endorsed by the Wisconsin Association of Nutrition Directors (WAND), of which I am a member, addressing increased state funding for the Elderly Nutrition Program. Please endorse this request on behalf of older residents of the state of Wisconsin.

Thank you.

April 13, 1999

ISSUE STATEMENT: The state funding for the Elderly Nutrition Program has not changed since 1994. This service is critical for older persons to remain independent, in their own homes. Wisconsins' Aging Network effectively delivers meals to the elderly with federal, local, charitable and volunteer resources. The need for services grows daily. The Wisconsin Association of Nutrition Directors (WAND) is asking to have an additional $3.6 million put into the nutrition program to assist the 72 counties and 8 tribes live up to the standards that everyone expects from the State of Wisconsin.

- $1.2 million — These funds would be used to keep up with the current increase in the Home Delivered Program. This Program delivered over 2.5 million meals last year which amounted to a nearly 200% increase in the last 11 years. These dollars would help with increased costs in food, condiments, disposable, transportation (to deliver more meals to more outlying areas of the counties), and reduce or eliminate waiting lists.

- $950,000 — These funds would be used to expand Congregate Services. This would allow counties to provide county-wide service. Our Congregate Meal Sites provide the basis of the 20,000 volunteers used by the Home Delivered Program. Our Congregate Meal Sites also provide the most cost effective settings for the Aging Network to address issues facing the elderly. Just as a small example; some of the topics discussed at Congregate Meal Sites include nutrition education, scams and frauds that are targeting the elderly, elder abuse issues, education, and numerous social activities.

- $800,000 — These funds would be used to provide specialized diets throughout the State of Wisconsin. Currently, only 25% of the Nutrition Programs offer any types of specialized diets. This would allow counties to expand existing specialized diets and offer an opportunity for counties not offering specialized diets a way to serve their clients more fully.

- $650,000 — These funds would be used to expand dietician services offered by the Elderly Nutrition Program. This would increase our emphasis in preventive services to help reduce our clients medical costs. These services would primarily be available to our homebound clients of which 57% are already at high nutritional risk. This could provide nutrition education, intervention, and provide a much higher quality of live than they have had in the past allowing them to stay independent and in there homes longer.

PUBLIC HEARING OF THE JOINT FINANCE COMMITTEE
APRIL 13, 1999

Written testimony prepared by Judy Omernik of
Marathon County Health Department

ISSUE: Tobacco Settlement dollars and the Governor's Budget

The Governors Budget proposes spending just 4 million dollars over the biennium on efforts related to tobacco. That's less than 1.5% of the 338 million settlement payment Wisconsin will receive over the next two years.

The basis for the law suit was to recover the costs from tobacco related illness the State has had to pay. It would be hypocrisy to not invest the money in programs to reduce the costs associated with tobacco use. The tobacco industry leaders would be very happy if we did nothing to reduce the use of their deadly products.

Preventing people from ever beginning the habit is a profitable investment in our future. Wisconsin voters say reducing tobacco use should be a priority in spending the funding the state receives. The Campaign for Tobacco-Free Kids conducted a poll of 813 registered voters and 89% favor using the money on efforts to reduce tobacco use among kids.

There are many other states which have planned, funded, and implemented comprehensive tobacco control programs. We should look to them for models of success. We need to include prevention and education of young persons, counter the glitzy and slick advertising of the most unregulated industry in our country, and provide support and service to those who want to quit using tobacco.

There are proposals made which would increase the amount of settlement money we spend on prevention and intervention and evaluation. We can do more! Just two years ago we saw the price of a liquor license increase from $500 to $10,000 to help limit the number of new license holders in the state. *If we can increase a license fee by 20 times the original amount, we should be able to increase by 20 times the amount of money we invest in saving lives ultimately lost to tobacco related illness.*

Gamma-Butyrolactone — Continued

labeled as dietary supplements, GBL-containing products are illegally marketed, unapproved new drugs that have been involved in at least 55 reports of adverse events, including one death (*10*). On January 21, 1999, FDA asked manufacturers to recall their GBL-containing products and warned consumers through press releases to avoid taking these products (*10*). Public education efforts should inform consumers that FDA review procedures for drugs are different than those used for dietary supplements. Consumers should be alert to the potential dangers of these products and understand that terms such as "natural" do not necessarily imply safety. Physicians should counsel patients about these products and be prepared to recognize and treat the toxic reactions that some might produce. Chronic GBL users should be monitored for withdrawal symptoms when discontinuing use of the product. Depending on the severity of the withdrawal symptoms, medical intervention may be required. Physicians are encouraged to report serious adverse events associated with these products to FDA's MedWatch program, telephone (800) 332-1088.

References

1. Li J, Stokes SA, Woeckener A. A tale of novel intoxication: a review of the effects of gamma-hydroxybutyric acid with recommendations for management. Ann Emerg Med 1998;31:729–36.
2. Lettieri J, Fung HL. Improved pharmacological activity via pro-drug modification: comparative pharmacokinetics of sodium gamma-hydroxybutyrate and gamma-butyrolactone. Res Commun Chem Pathol Pharmacol 1978;22:107–18.
3. Mamelak M. Gammahydroxybutyrate: an endogenous regulator of energy metabolism. Neurosci Biobehav Rev 1989;13:187–98.
4. CDC. Multistate outbreak of poisonings associated with illicit use of gamma hydroxy butyrate. MMWR 1990;39:861–3.
5. CDC. Gamma hydroxy butyrate use—New York and Texas 1995–1996. MMWR 1997;46:281–3.
6. Rambourg-Schepens MO, Buffet M, Durak C, Mathieu-Nolf M. Gamma butyrolactone poisoning and its similarities to gamma hydroxybutyric acid: two case reports. Vet Hum Toxicol 1997;39:234–5.
7. LoVecchio F, Curry SC, Bagnasco T. Butyrolactone-induced central nervous system depression after ingestion of RenewTrient, a "dietary supplement" [Letter]. N Engl J Med 1998;339:847–8.
8. Galloway GP, Frederick SL, Staggers FE, Gonzales M, Stalcup SA, Smith DE. Gamma-hydroxybutyrate: an emerging drug of abuse that causes physical dependence. Addiction 1997;92:89–96.
9. Higgins TF, Borron SW. Coma and respiratory arrest after exposure to butyrolactone. J Emerg Med 1996;14:435–7.
10. Food and Drug Administration. FDA warns about products containing gamma butyrolactone or GBL and asks companies to issue a recall. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Food and Drug Administration, 1999. (Talk paper T99-5). Available at: <http://www.fda.gov/bbs/topics/ANSWERS/ANS00937.html>. Accessed February 24, 1999.

Decline in Cigarette Consumption Following Implementation of a Comprehensive Tobacco Prevention and Education Program — Oregon, 1996–1998

In November 1996, residents of Oregon approved a ballot measure increasing the cigarette tax by 30¢ (to 68¢ per pack). The measure stipulated that 10% of the additional tax revenue be allocated to the Oregon Health Division (OHD) to develop and implement a tobacco-use prevention program. In 1997, OHD created Oregon's

Cigarette Consumption — Continued

Tobacco Prevention and Education Program (TPEP), a comprehensive, community-based program modeled on the successful tobacco-use prevention programs in California and Massachusetts (*1,2*). To assess the effects of the tax increase and TPEP in Oregon, OHD evaluated data on the number of packs of cigarettes taxed before (1993–1996) and after (1997–1998) the ballot initiative and implementation of the program. Oregon's results also were compared with national data. This report summarizes the results of the analysis, which indicate that consumption of cigarettes in Oregon declined substantially after implementation of the excise tax and TPEP and exceeded the national rate of decline.

OHD obtained data on the sale of Oregon cigarette tax stamps from the Oregon Department of Revenue for 1993–1998. OHD also obtained data on the proportion of revenue received at the old and new rates after the tax change (February 1997) to calculate the number of packs sold each month. Per capita consumption was calculated by dividing the number of packs sold by the total population of Oregon each year (*3*).

National comparison estimates were generated using data from the Tobacco Institute on state tax receipts for wholesale cigarette deliveries. Reliable figures were available through December 1997 (*4*). Data from Oregon and the other three states (Arizona, California, and Massachusetts) with tobacco-use prevention programs funded through state initiatives were excluded from the comparison estimates. National per capita consumption was calculated by dividing the total number of packs sold by the total population in the remaining 46 states and the District of Columbia (*5*). Calculations for Oregon for 1996–1998 represent the 1 year before and the 2 years after the tax increase.

From 1993 to 1996, taxable per capita consumption of cigarettes increased 2.2% in Oregon and decreased 0.6% in the 46 remaining states and the District of Columbia. In Oregon, from 1996 to 1998, taxable per capita cigarette consumption declined 11.3% (from 92 packs to 82 packs) (Figure 1). Despite a 2.7% increase in the state's population, 25 million fewer cigarette packs were sold in Oregon in 1998 than in 1996. In the United States during 1996–1997, per capita consumption declined 1.0% (from 93 packs to 92 packs).

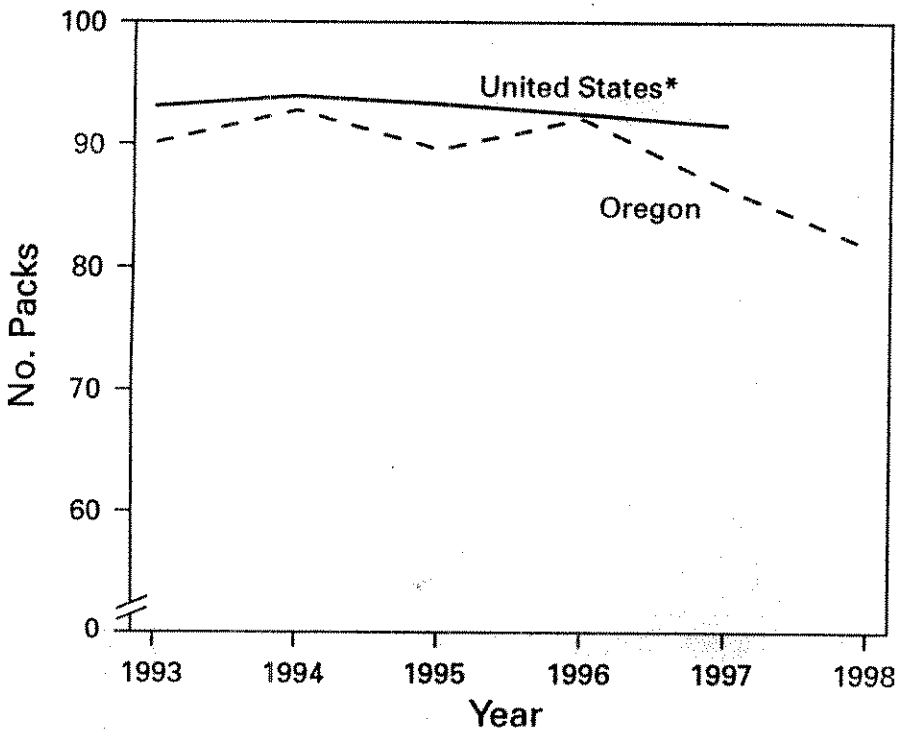
Reported by: B Pizacani, MPH, C Mosbaek, K Hedberg, MD, L Bley, PhD, M Stark, PhD, J Moore, PhD, D Fleming, MD, Oregon Health Div. Epidemiology Br, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Two years after the implementation of a ballot measure to increase the excise tax on tobacco and initiate TPEP, per capita consumption has declined 11.3% in Oregon, or the equivalent of 200 cigarettes (10 packs) per capita. Elements of the program include community-based tobacco-use prevention coalitions in every county; a statewide public awareness and education campaign; comprehensive school-based programs; tribal tobacco-use prevention programs; multicultural outreach and education; a quitters' help line providing smoking cessation support; and projects evaluating new approaches to prevent or reduce tobacco use. TPEP has an annual budget of $8.5 million, 93% of which is awarded in grants or contracts to external partners (e.g., county health departments, community-based agencies, tribal governments, and private-sector partners implementing the public awareness campaign).

Decreased consumption is probably a result of both the increase in the price of cigarettes and the tobacco-use prevention program. Price elasticity of demand,

Cigarette Consumption — Continued

FIGURE 1. Annual per capita sales of cigarettes — Oregon and United States, 1993–1998



*Excluding Arizona, California, Massachusetts, and Oregon.

defined as the percentage change in demand for cigarettes resulting from a 1% change in price, is an estimated –0.4% (*6*). A 15.8% increase in the price of cigarettes (the amount of the price increase in Oregon, calculated in 1996 dollars) should result in a 6.3% decrease in cigarette consumption. The findings in this report are consistent with reports from other states with tobacco-use prevention programs and indicate that excise taxes in conjunction with prevention programs reduce cigarette consumption more than excise taxes alone (*1,7*).

Other factors that could account for the decrease in cigarette consumption in Oregon probably did not contribute to the decline. Smuggling or cross-border sales probably are insignificant because a large proportion of Oregon's population resides in Portland, near Washington, where cigarette prices are higher. Increased sales on Indian reservations in the state probably would not contribute to the decline because cigarettes sold on reservations are taxed, and tribes are reimbursed only for tobacco taxes paid by tribal members. Another possibility is that the observed downward trend for Oregon may reflect national declines. Although reliable national data are not available for 1998, it is unlikely that the decrease in Oregon reflects secular trends.

Cigarette Consumption — Continued

During 1990–1997, the annual rate of decline in consumption for all 50 states averaged only 1.4% (*8*).

Oregon's decrease in cigarette consumption also appears to be resulting in decreases in smoking prevalence. Preliminary data from the Behavioral Risk Factor Surveillance System for 1996–1998 indicate that prevalence of current smoking among adults in Oregon declined 6.4%, representing 35,000 fewer smokers. The decline in cigarette consumption in Oregon, California, and Massachusetts indicates that an adequately funded, comprehensive tobacco-control program can quickly and substantially reduce tobacco use.

References

1. Pierce JP, Gilpin EA, Emery SL, et al. Has the California Tobacco Control Program reduced smoking? JAMA 1998;280:893–9.
2. Connolly G, Robbins H. Designing an effective statewide tobacco control program—Massachusetts. Cancer Supplement 1998;83:2722–7.
3. Center for Population Research and Census. Population estimates for Oregon, July 1, 1998. Portland, Oregon: Portland State University, College of Urban and Public Affairs, 1998.
4. Anonymous. Monthly state cigarette tax reports, Jan. 1997 to Jul. 1998. Washington, DC: The Tobacco Institute, 1998.
5. Population Estimates Program, Bureau of the Census, Economics and Statistics Administration, US Department of Commerce. State population estimates: annual time series, July 1, 1990 to July 1, 1998. <World-Wide Web site http://www.census.gov/population/estimates/state/st-98-3.txt> Accessed February 10, 1999.
6. Chaloupka FJ, Warner KE. The economics of smoking. In: Newhouse J, Culyer A, eds. The handbook of health economics. Amsterdam, The Netherlands: Elsevier Science, 1999 (in press).
7. CDC. Cigarette smoking before and after an excise tax increase and an antismoking campaign—Massachusetts, 1990–1996. MMWR 1996;45:966–70.
8. Anonymous. The tax burden on tobacco: historical compilation. Vol 32. Washington, DC: The Tobacco Institute, 1997.

Neighborhood Safety and the Prevalence of Physical Inactivity — Selected States, 1996

Physical inactivity is an important risk factor for premature morbidity and mortality, especially among high-risk populations. Although health-promotion programs have targeted high-risk groups (i.e., older adults, women, and racial/ethnic minorities) (*1*), barriers exist that may affect their physical activity level (*2*). Identifying and reducing specific barriers (e.g., lack of knowledge of the health benefits of physical activity, limited access to facilities, low self-efficacy, and environmental issues [*2–6*]) are important for efforts designed to increase physical activity. Concerns about neighborhood safety may be a barrier to physical activity (*2,3*). To characterize the association between neighborhood safety and physical inactivity, CDC analyzed data from the 1996 Behavioral Risk Factor Surveillance System (BRFSS) in Maryland, Montana, Ohio, Pennsylvania, and Virginia. This report summarizes the results of this analysis, which indicate that persons who perceived their neighborhood to be unsafe were more likely to be physically inactive.

The BRFSS is a population-based, random-digit–dialed telephone survey of the civilian, noninstitutionalized U.S. population aged ≥18 years. In 1996, data on physical activity were analyzed for 12,767 persons (5320 men and 7447 women) who

TO: Members, Joint Finance Committee
FROM: Peter DeSantis, Chair Blue Ribbon Commission on Mental Health
DATE: April 13, 1999

Governor Tommy Thompson appointed the Blue Ribbon Commission on Mental Health in May of 1996. It consisted of 40 members representing legislators, advocates, consumers, providers, etc. A final report was submitted in February 1997. It's recommendations included:

1. Model System that emphasizes managed care, client outcomes and performance.
2. Ways that federal, state and county governments can cooperate to gain fiscal efficiencies.
3. A system targeting prevention, early intervention, recovery and positive consumer outcomes.
4. Ways to reduce stigma.

All of our efforts were coordinated with D.H.F.S. Family Care projects. In 1994, $400 million of public funds were spent on mental health services -- not including Medicare, D.V.R., those in jails, S.S.I. or S.S.D.I.

The D.H.F.S. requested funding for eight demonstration projects. This was reduced to two in the Governor's budget. To effectively determine how we can bring about changes required, we are requesting four additional projects be added to the budget.

Starting two demos on1/1/2000, two more on 7/1/2000 and two additional demos on 1/1/2001. The budget for each year would be:

Source of Funds	FY 2000	FY2001	Biennial Total
GPR	145,500	480,000	625,000
FED	65,000	160,000	225,000
TOTAL	*210,000	**640,000	850,000

Each demo is eligible for $160,000 for one year.

* This amount includes $50,000 for evaluation plus $160,000 for funding two demos for six months from 1/1/00 to 6/30/00.

** This amount includes funding of $160,000 for six more months for the demos started the first FY; two new demos starting 7/1/00 for one year at $160,000/demo for a cost of $320,0000; and six months funding for two demos starting 1/1/01 at cost of $160,000. T

The total increase to the G.P.R. is $395,000.

In closing, I ask you to look at investing $395,000 GPR to bring about changes needed in a $400 million dollar operation which affects thousands of Wisconsin citizens and to not remove the supporting statutory language which is vital to success.

Joint Committee on finance Public Hearing
Tuesday, April 13, 1999
UW - Stevens Point
University Center -- Alumni Room
1015 Reserve Street
Stevens Point, WI

My Personal Story:

I sit in on Committees that involve County agencies, School Administrative Personal.

I organize and facilitate meetings for parents of special needs children.

I have been made aware of the many families who are struggling with the lack of support - for supporting their children within their homes . The question is often how can we make people understand us without sounding like we are whining complaining or feeling sorry for our selves?

Very often we are required to purchase or adapt specialized equipment to make it physically easier for our children to be safe, mobile and independent. We need computers that promote learning, communication, and independence . We need to adapt or homes to promote safety, accessability and again independence. We as parents are responsible for providing daily therapies to keep our childrens bodies and minds from turning into a spastic nightmares. We as parents are responsible for making sure our children have a healthy diet which can be more then a little difficult if you are dealing with a child on a special diet or one which refuses to eat. Have you priced ensure or glucerna lately? How about diapers? Don't forget the wipes and laundry for those "accidents! We won't get into poop painting or vomiting.

How do we reach you, to make you understand the financial and emotional impact our beautiful children have on our household. We love our children and are willing to do what ever we can to give them happy full productive lives.

Our love for Dani and her love for us is our greatest light!

Personally, I plan on living forever to take care of Danielle

But.....the reality wether we want to face it or not is.....

Who will love and care for our children when we simply can't do it anymore? I know parents who are battling cancer and aging that are at crisis stage because their adult child is bigger then they are and after more then 20 years they simply can not do it anymore! Where will their child live, work and play? Who will watch over our children when we are gone? Who is Responsible??????? In Wood county their are waiting lists for everything.

It is our plan to keep Dani with us to eternity. To always be able to provide for her. But what if we turn into those other families - we get sick, old - die. How will Dani move on to a happy healthy environment in which people love her. Will she continue to learn and grow? Who responsible? What community supports are there?

Why, when we as parents accept and are responsible for the new direction our children have taken our lives, must we be put on waiting lists in some cases for years, instead of supported so we can continue to work, make and encourage a better life for ourselves and our children.

Families need The Family Support to be funded to its full potential. Giving children and their families supportive choices and opportunities to have the best life possible, should be the goal each and every person in this room.

I encourage you to do what ever it takes to get schools helps us teach our children that they are a great value and can be an active positive person in their community.

Continuing education to work funding resources (DVR) is as key to our childs goals as it is to any other young adult.

I know families that have supported and done all the right things to make sure school goals and work training all went off so there would be no gaps, skills wouldn't be lost...there made sure their child had a variety of work skills/experience.....funding ended and after two years of sitting home, that child will need all new training.

Realizing that high paying jobs will never be in their future. The need to expand slots and funding for CIP and Cop so that our children are able to be integrated in their community is vital to promoting self worth, and acceptance. I believe in the "Village" concept.

I want you to think of your own situation as a young couple just starting a family. How overwhelming would this financial responsibility be to you and your spouse! I want you think all the emotions and stress you have experience at the death of a person in your own life who has died way before their time. The happy healthy life we for saw our child having is gone - dead. Someone told me that 80% of our families are broken with divorce. Is it a wonder?

Before & After School Care for Special needs children.

* no Child care for these children 3-21 yrs

Thank you!

State graduation test -

I have a child that totaling Freezes on test!

(94 yrs)

Pam Ironside

parent - mom

6311 North Park Rd

Wisconsin Rapids WI

54494-9152

I would like to thank the Joint Committee
on Finance for holding this ~~he~~ hearing
and giving parents like my self the opporton.
to share & support some of the terrific
things we have happening in Wisconsin

Danielle at 5 months of age

viral encephalitis (at 5 mons)

present Diagonis Lennox Gaustaut
uncontroled
(severe seizure disorder)
I carry a pager / cell phone

$300,000.00 med. bills ~~[illegible]~~ in first 6 mons.

Katie Becket
of remove stress of unknow future med ~~[illegible]~~ cost.

Danielle is 13½ now
COS school program

I am here in support of
Family Support
CIP
COP
Long Term Care design

* Currently work on a program for before & After School Care for special needs Childre
- Looking into ~~[illegible]~~ Adult Day Care & Housing needs

Pam Ironside
6211 North Park Road
Wis. Rapids, WI 54494
715-423-7182

Parent Co-ordinator of
Parents Helping Parents
of Special Need Children

Memorandum

To: Joint Finance Committee Members

From: Donna Warzynski RN, CNA

Director of Chronic Care Services

Saint Michael's Hospital

Date: April 13, 1999

Re: Testimony R/T Budget Bill

As the chairperson of Saint Michael's Hospital's Community Health Delivery Team and our Chronic care Committee, I have had the opportunity to examine the Family Care proposal very closely. We are fortunate in Portage County and very pleased to be a pilot for both the Resource Center and Care Management Organization aspects of the proposal. With this in mind, there are some concerns related to the funding of the Family Care pilots. Funding the pilots for two years is short sighted and inadequate if we are to ensure valid, accurate outcomes data to determine the effectiveness of this program. The pilots will have barely begin to function completely when the funding will be ending. Such a major change to the long term care system in our state deserves to be looked at adequately before a final decision is made regarding which pilots are the most efficient and effective for the consumers of long term care. Funding the pilots for four years would provide adequate time for outcomes data collection and review. Family Care could then be moved out statewide based on complete information, knowledge of the true risk that counties and others involved in the program could anticipate up front.

It is imperative that the Family Care pilots be funded adequately also. We should not be touting a carrot in front of consumers which promises no waiting lists and funding for needed services if , in fact, those moneys will not be available. This program relies very heavily on informal supports to assist persons to remain in the least restrictive environment. A recent study completed by the Alzheimer's Association places a $196 billion / year price tag on the care provided by family and friends for the chronically ill. In Wisconsin the cost is estimated to be $3,791,800. If we take into account the decrease in birth rates, the smaller family size overall, the fact that women are no longer at home to be the "free caregiver", the numbers of informal

caregivers/supports will not be increasing over time but rather decreasing. This information must be taken into account as the program is funded. Realistic dollar amounts will have to be included to ensure the availability of the needed support systems.

Last, but certainly not least, is the whole issue of an adequate, fairly paid workforce. The opportunities for people to make the same amount of money or , in many cases, more money at less physically and mentally stressful jobs is enticing workers away from the role of caregiver to persons in need of long term care. We should pay those who care for human beings at least as much as we are willing to pay those who care for the animals in our zoos. Without an adequate workforce, the Family Care proposal is set up for failure. I urge you to consider the wage pass through that is proposed at a minimum and to evaluate the possibility of more than what is proposed.

Thank you in advance for your consideration related to these issues.

Joint Finance Committee Hearing

April 13, 1999

Nicole DeBettignies / Family Care

On behalf of the Aging and Disability Resource Center of Marathon County I wish to extend a welcome to the members of Joint Finance and express our appreciation to you for bringing this hearing to Central Wisconsin. My name is ~~I am~~ Nicole DeBettignies, and I am ~~an~~ Aging and Disability Specialist with the Resource Center. I am here on behalf of the Resource Center and Deb Menacher our director, who had another commitment.

As I believe you already know Marathon County was selected as one of the pilot counties for implementation of the Aging and Disability Resource Center concept and as an alternate county for the demonstration of the Care Management Organization. The Resource Center has been operational for one year on April 15th. During this time we have served over 1900 persons with chronic care inquiries. There is a lot of rhetoric being bantered about regarding Family Care and that we should as some advocates call it "build on what works" meaning build on the current system. Let's talk about the current system and how it has worked for some of those 1900 persons who contacted the Resource Center.

There is Mrs. "A" who needed some help in the home due to her dementia and was becoming a bit suspicious of people but had developed a repertoire with our office. We had worked with her to understand the Community Options program (COP) and made the referral to COP. However, the time between our referral and the first assessment spanned several months. So long, in fact that when she was approached about the assessment she turned it down because she didn't

remember nor trust the nurse who was contacting her. Mrs. "A" was denied COP based on this refusal. This is one example of how the **current community care system is not dependable**. People can not rely on it to receive help when they need it. Most older persons either die or go to a nursing home while waiting for COP services.

Then there is Mr. "B". Mr. "B" had a stroke. Cognitively he was very intact but his motor skills were somewhat impaired and he required assistance with personal cares and activities of daily living. Mr. "B" had been discharged from the hospital and received rehab services from a nursing home. The long range plan was continued residence at the nursing home. Mr. B's daughter became concerned as her father's outlook deteriorated in the nursing home. He was eating his meals with other patients who were shoveling food into their mouths with their hands. His daughter decided that she could provide a more positive care environment for her father in her home. However, she had not given consideration for how she was going to pay for personal care services when they were no longer covered by Medicare. Her frustration with the system was that "the system would pay $5,000 a month to care for my father in a nursing home but will not pay even $500 a month toward the cost of his care in my home" even though she was willing to meet the majority of her father's caregiving needs. The current system **costs too much.** As I believe you know the current system legally entitles eligible people to nursing home care and other medically oriented services, but not to less expensive, less formal and usually preferred care in the home. Wisconsin uses nursing homes at a rate of 45% over the national average. We currently spend $1.5 billion on long term care (about 8% of the total state budget). 95% of the Medicaid fee for service expenditures for the elderly is spent on nursing home care.

Next Mrs. AB

~~Then~~ there is ~~Ella~~ who all she wanted was one more bath a week. She had an above the elbow amputation in additional to other health problems and had great difficulty bathing her self. She was contemplating going to a nursing home because the home health agency which provided her personal cares did not believe another bath per week was necessary. Our current system **is not responsive to individual needs.**

Finally,

~~Then~~ there is the paper mill executive who instead of driving himself to the office on this given morning (like he had done for thirty years) drove himself to the emergency where he was found to have had a stroke. His son, a professional in the health field, and his daughter-in-law, a social worker, found themselves in a complicated and unfamiliar world as they needed on short notice (less than 24 hours) to make decisions on where grandpa was to rehab. When he was to be discharge from rehab where he was going to live. What is a CBRF, AFH, and RCAC anyway? Residential Care Apartments And what's the difference between them anyway? Fortunately, this gentleman had the economic resources to pay for his care, but even with this his family found our current system **to be too complicated**. Trying to access timely, accurate information was difficult even for the highly educated professional who was new to the chronic care world.

I am here today to ask that you support the Family Care legislation put forth in the Governor's budget. Family Care will **give people better choices.** It decreases the institutional bias that exists in our current system and allows persons to receive service in a setting that appropriate to their care need level. No longer will someone have to make a choice between another bath and moving to a nursing home.

Family Care is **reliable and fair.** It is designed to cover a flexible benefit covering everything from meal preparation to nursing home care and everything in between. COP, residential options, and nursing home options are available to everyone who enrolls. Family Care lets funding follow each person across service settings, county lines and time. No longer would a daughter willing to provide care for her father be asking why the system will pay ten times as much for care in one service setting and nothing in another.

Family Care **is simpler for the consumer.** The establishment of the Aging and Disability Resource Center provides a place where everybody can learn about resources and get unbiased, professional advice about their options. No longer would a family struggle to find information about chronic care options or make decisions about care provision based advice from providers of particular services without knowing the full range of options that might be available to meet their needs. Furthermore Family Care **is more affordable now and into the future.** The Resource Center's primary function is to provide information and assistance to prevent or delay the need for long term care. This can be accomplished through helping individuals and their families to make their own resources last longer by identifying resources that provide the right amount ~~ad~~ and kind of paid services and supports in the right place, at the right time. Family Care reduces our reliance on services that are more medical, professional and/or more restrictive than people want or need.

Most importantly though, Family Care **allows the 1900+ people who contacted the Resource Center in the last year to have true choice in meeting chronic care needs for themselves or a family member. The stories provided here today are** ~~**exemplary**~~ an example **of the persons who call the**

Resource Center each and everyday. Please support Family Care legislation and make the saying "There's no place like home" a reality for physically disabled adults and frail elders.