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LIFESPAN RESPITE CARE

ISSUE STATEMENT:

Respite Care is care which is provided to a person with special needs in order to give temporary relief to the family or primary caregiver of that person or care provided when the primary caregiver is unable to provide care on a temporary basis. A special need means the physical, behavioral, cognitive, emotional or personal need of a person with a condition which requires care, supervision or both in order to meet the basic needs of the person. Respite is a primary support service consistently requested by parents and other primary caregivers of individuals with special needs. Demand for respite in Wisconsin far exceeds available funding, programs, and qualified providers. Service access and funding are inconsistent throughout the state. In many counties respite programs have waiting lists or are non-existent, or. Some families have access to funding but cannot find skilled providers, while others have providers but no funding. In addition, Wisconsin lacks an efficient means to coordinate respite care statewide, resulting in fragmentation of resources, duplication of efforts, and inconsistencies. There is no set of statewide standards and guidelines, or means to promote quality assurance .

SPONSORING ORGANIZATIONS

ARCH - Association for the Rights of Citizens with Handicaps, Inc, Waukesha
Catalyst Home Health, Madison
Child Care Connection R&R Agency, Wausau
Children's Trust Fund, Madison
Have a Heart Farm , River Falls
Independence First, Milwaukee
Interfaith Partners in Caring, Sinsinawa
Juneau County Committee on Aging , Mauston
La Causa, Inc, Milwaukee
La Crosse Aging Unit, Lacrosse
Lifespan Respite Care Committee, Wausau
Marathon County Commission on Aging
Omatayo, Milwaukee
Piccadilly Place Respite / Child Care, Beloit
Parents Education Project (PEP) - West Allis
Rehabilitation for Wisconsin, Inc, Madison
St. Agnes Hospital, Respite Care, Fond Du Lac
South Central Respite, Inc, Pardeeville
St. Ann's Adult Day Care, Milwaukee
St. Ann Center for Intergenerational Care, Milwaukee
Special Needs Adoption Network, Milwaukee
The Arc of Wisconsin, Madison
The Respite Care Association of WI, Inc, Green Bay
United Cerebral Palsy NCW., Wausau
United Cerebral Palsy SEW., Milwaukee
United Cerebral Palsy of SCW., Janesville
United Cerebral Palsy of Wisconsin, Madison
Wisconsin Family Ties, Madison
Wisconsin Coalition for Advocacy, Madison

Background :

Parents and primary caregivers who are responsibly trying to raise their children with a special need or care for a family member at home search for the appropriate services and supports to help meet their respite care needs. Sometimes this search forces parents or primary caregivers who have exhausted all their own financial , emotional and physical resources to place that individual with a special need in an foster home, nursing home, or institution. This practice is the consequence of inadequate funding of respite care services. Lack of incentives and statewide coordination to develop flexible community based respite to help keep individuals of all ages with special needs at home, in their schools, jobs, and communities also contributes to the problem

These practices:

- Increase the risk of out of home placement by 50%
- Lead to a 4 times higher risk of abuse and neglect
- * Lead to an 80% divorce rate
- * Put the health of the primary caregiver and siblings at high risk . 65% of primary caregivers will develop chronic or life threatening illness i.e. depression, lupus, cancer, muscular dystrophy, multiple sclerosis. 45% of siblings develop serious emotional disorders
- * Force parents or primary caregivers to make an otherwise unthinkable choice between retaining responsibility for and the relationship with the individual and giving decision making authority and control to a state agency by severing legal ties to the individual with special needs in order to obtain the help they so desperately need - In many counties CHIP(children in protective custody) petition has to be filed before families are eligible for respite
- * Waste public funds by placing an individual with special needs in an out of home placement when their basic needs could be provided by their families who love them
- * Force individuals into out of home placements rather than supporting families and promoting the development of community based respite service

Position:

The Lifespan Respite Care committee, and numerous organizations statewide are seeking to increase the availability of respite to Wisconsin citizens as part of a comprehensive service system to all individuals with special needs . Adequate respite care is critical in our efforts to ensure a full continuum of support services for families and primary caregivers. The Lifespan Respite Care committee, along with numerous organizations statewide, and direct service organizations supports a policy of consumer-driven respite care services in which all Wisconsin families and primary caregivers have access to flexible, affordable, and quality respite - regardless of disability, income, or age. Consumers have a right to adequate resources for respite care; a right to choose whether to have respite in their home or elsewhere; and to choose who provides it. Respite should be provided in a variety of settings with a variety of support models, and be flexibly designed to fit the unique circumstances of each person. Consumers should have the option of time-limited respite as an alternative to a more restrictive and long term living arrangement, including out of home placements.

Action Required:

1) The Lifespan Respite Care committee supports the following legislative initiatives: to provide GPR funding of $525,000 for the 1999-2000 biennium to increase availability of respite services and to develop a consumer-driven, well-coordinated, and ready-to-respond respite care delivery system in Wisconsin.

2) Contact your Senator and Assembly Representative to indicate your support for Lifespan Respite

3) Urge your Senator and Assembly Representative to co sponsor / support The Lifespan Respite Care Bill

Fact Sheet #1

Families or primary caregivers caring for someone with significant needs in their home, live with high levels of physical, emotional, and financial stress.
*Studies conducted at both the National, and state level show that without support services such as respite families, primary caregivers and individuals with disabilities are placed at risk. These risks include

- The divorce rate among this population is 80%.
- There is a 50% increased risk of out-of-home placements.
- In those families that lack support services such as respite, 45% of siblings of the special needs person develop emotional problems.
- 65% of primary caregivers develop chronic and life threatening illnesses (i.e., lupus, depression, TMJ, chronic fatigue syndrome, cancer, mulcular dystrophy, multiple scelorsis, heart attacks).

Caregivers report the following negative impacts of caregiving:

Exhaustion	Irritability
Tension	Little time with spouse or other family members

The emotional impact of being a caregiver:

- Feeling of intense sadness
- Upheaval of family dynamics
- Isolation
- depression
- Frustration
- *Isolation
- *Hopelessness
- Lack of leisure time or personal time
- Loss of hopes , dreams

*** National studies and research done at the University of Vermont, reveal that <u>hopelessness and isolation</u> pose a higher health hazard then cigarette smoking. Further research documents The high demands of <u>constant</u> caregiving increase the risk of Cancer, Multiple sclerosis, and Muscular dystrophy.**

Respite Care, on a regular basis, can help to:

- Reduce stress in families
- Reduce risk of abuse and neglect
- Enhance family coping ability
- Increase caregivers' physical and mental well-being
- Reduce out-of-home placements
- Increase family social activities and interactions
- Prevent burnout
- Promote healthy families

*Data collected from ARCH - National Respite Resource Center for Respite and Crisis Care Services, The National Caregivers Association, and The Respite Care Association of Wisconsin, Inc. The university of Kansas. Developed by Nancy Olson RN Project Coordinator Lifespan Respite Care

*Wisconsin's Families

The Murphy's..... Ben and Donna sat quietly in their living room. They were physically and mentally exhausted from the constant demands of caring for their disabled daughter, Annie. Respite had been available to them on a very limited basis. The Murphys were overwhelmed and stated "we have been neglecting our other child, our responsibilities, and each other. We keep getting further and further behind". There was no funding available to the Murphys. CIP, Cop, and family support all have waiting lists and none of them offer respite programs or providers. With no other option available to them Annie was placed in foster care for 2 1/2 years (the amount of time they were on a waiting list). Annie came home with CIP funding , but again only minimal respite was provided. The family went into crisis again and the Murphy's decided to look into institutionalization, only to find out that there was a waiting list as well. Their marriage suffered under the strain and they separated, leaving Donna a single mom with two children. Donna's health continued to suffer and her medical bills grew. Annie's disability progressed and she became eligible for an increase in respite hours. The Murphy's reconciled and are now receiving adequate and appropriate support for their family. Today they state "that respite is the only thing that will keep Annie at home and our family together".

The Anderson's ..... Sheila is a woman in her late twenties, she is married with 5 children. Sheila and her husband, Ed, share their home with and care for her 58 year old mother, Mary, who has had a stroke and needs help with ADL's .To complicate matters Sheila's husband Ed has an inoperable brain tumor. Mary gets frustrated with all the kids and uses her cane to nudge the kids and yells at her daughter to keep them quiet. Sheila and her family need respite and so does her mother. The family does not have money for respite, Mary is under 60 which puts her on a waiting list that could take one to two years for COP funding. She may end up being placed in a nursing home if both do not get respite. If money was available, Mother could attend the Adult Day Services Center paying from a sliding fee scale and both Mother, daughter and daughter's family would have the respite they need. Cost savings of attending the ADS Center vs. a nursing home is about $75 a day. Improvement of family relations can not be measured.

The Yang's... Kevin and Tina are excited about the arrival of their 5th child, but unsure about who will provide care for the other four children while Tina is in the hospital and Kevin is at work. They are particularly concerned about their youngest son who is only 7 months old and medically fragile. Although their English is poor, the Yang's have an interpreter to help them as they search for support for their family. The Yang's would like to fly Kevin's mother here to provide care for all the children while Tina was in the hospital having the baby and stay to help out for a while after she and the baby return home. They contacted a local Service organization who agreed to train grandma to take care of the disabled infant., but they still needed the funding to pay for the flight. The yang's were on waiting lists for CIP and other support programs. The county would not help to pay the $250.00 needed for grandma to fly here. Tina went into the hospital to have her baby , who was born with severe anomalies and will require an extended hospitailization, and the county placed her children in foster care. The county is paying for foster care for five children, one of which is severely disabled and medically fragile.

The Millers.... Ann and Gerry were hesitant to ask for respite care, but they finally called there social worker, got approved for services and were given a stipend of $ 500.00 per year . To date they have never used the money because their attempts to find a respite provider have been totally unsuccessful. Ann tells the following story "The first people we called initially arranged to meet with us, but then called us back and said "we're to busy, my husband doesn't want us to do this, sorry but no". The second number I called did not answer, so I left a message, I was never called back". I was so frustrated the last time, I realized that I honestly could not face picking up the phone again, only to get a negative response or worse still no response. I nearly called the social worker in frustrated anger and told her to keep the $ 500.00, its to cruel to have it sitting in our "credit bank" with no way to spend it. Give it to someone who is more resourceful than I, maybe they can use it. I realized when I felt more rational that I would be biting of my nose to spite my face. And so we remain in limbo, money available, no way to spend it, overtired, overtaxed, and depressed at times. Do we need respite yes! Can we figure out how to get it .. no.

***Data collected at Statewide Respite Forums, and Conferences i.e 1997- 98 Respite and Crisis Care Conferences, 1998 Circles of Life Conference, and 1998 Long term Care Regional Confeerence**

The Many Faces of Respite

Lifespan Respite Bill

04/14/99

ROCK COUNTY HUMAN SERVICES DEPARTMENT

Community Aids

The Basic County Allocation (BCA) of the Community Aids formula is the major funding source from the State for mandated human services delivered at the county level. These dollars, along with a state required minimum county match of approximately 10%, are the source of revenue that counties use to provide a broad array of human services. Some of these programs are foster care, child abuse and neglect investigations, service to the developmentally disabled, services to the mentally ill, and services to the elderly.

The Human Service Department anticipates receiving nearly $6.9 million of BCA in 1999. That figure has declined approximately $250,000 since 1996 despite increases in the county's costs for state required, county administered programs for BCA target groups. The Rock County Human Services Department continues to experience shortfalls between expenditures for BCA services and BCA dollars provided by the State. In budget year 1999, the Rock County Human Services Department overmatch is in excess of $5.2 million. Statewide in 1997, Wisconsin counties provided $253 million of overmatch for these state required programs.

In November, 1998, counties were notified by the State that their Community Aids would be further reduced in 1999. The reduction was due to a federal reduction in the Social Services Block Grant which was passed directly to counties. The 2.9% reduction amounted to approximately $218,000 in the Human Services Budget. The local impact will be longer waiting lists for services and increased county costs.

The combination of supplanting GPR with Federal dollars, along with reduced base funding for Community Aids, has lead to a steady erosion of this funding source. The Governor's proposed budget calls for a 2.5% and 1.8% future reduction in BCA in each year of the budget biennium, earmarking funds for performance standards, and giving DHFS authority to transfer Community Aid funding into Family Care. These actions seriously impact local flexibility to provide services and the ability to use BCA to provide property tax relief.

Therefore, the following actions are requested:

- We respectfully recommend that you restore the Federal Block Grant cut(s) and increase the Community Aids appropriation by at least 3% in each year of the biennium. This measure in itself would allow current service levels to be maintained.

- Further, it is understood DHFS will have the authority to transfer/reduce Community Aids. We are requesting that this authority be withheld from DHFS until the entire Long Term Care Redesign process is much more stable and refined in its' application and potential impact.

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04/14/99

ROCK COUNTY HUMAN SERVICES DEPARTMENT

Youth Aids

On January 12, 1999, the Legislative Audit Bureau issued Report 99-1 in regard to the Youth Aids Program. Youth Aids was implemented in 1979. Previous to that date, the State paid for all juvenile correction institutional costs and the counties funded after-care and other services to delinquents through the Basic County Allocation (BCA) dollars that they received from the State. The Legislative Audit Bureau Report reveals that in 1982, State Youth Aids funds covered 92% of the costs of mandated services. In 1998, State Youth Aids funds covered only 45% of the cost and the counties were picking up the balance or 55%. The Legislative Audit Bureau report also revealed that the daily rates for the state juvenile correction institutions (JCI) increased from $108.75 in 1992 to $154.94 in 1998. This 42.5% increase was caused by higher JCI operating costs.

In 1993, the total out-of-home placement cost for Juvenile Justice clients in Rock County was $3.35 million while the Youth Aids revenue totaled $3.1 million. The revenue shortfall meant that a quarter million dollars of tax levy was needed to pay for out-of-home placements in 1993. In 1999, the county anticipates spending nearly $6.2 for out-of-home placements. Total State Youth Aids revenue equals only $3.4 million leaving a property tax levy of $2.8 million. Thus, the tax levy used solely for out-of-home placements has gone up by $2.55 million between 1993 and 1999.

The Human Services Department anticipates spending nearly $9.2 million in 1999 on all programs and services that are eligible for Youth Aids funds. To meet this expenditure level, there will be a property tax levy burden of approximately $4.8 million. This tax gap burden has grown significantly since 1995 because Youth Aids funds to Rock County have actually declined while program costs have dramatically increased.

Therefore, the following action is recommended:

- Restore language that increased the Youth Aids allocation to cover the increases in Juvenile Correctional Institution (JCIs) rates.

- Increase the Youth aids appropriation to make up shortfalls in previous biennial budgets

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04/14/99

ROCK COUNTY HUMAN SERVICES DEPARTMENT

Allowable Use of Wisconsin Works (W-2) Funds

There has been significant discussion and news reporting about excess Wisconsin Works (W-2) funding. However, there has been little understanding of the allowable use of W-2 funding. There have been suggestions that the funding is excessive, and these funds could readily be used for community aids and youths aids funding shortages.

The contract for W-2 in Wisconsin is for the period of September 1, 1997 through December 31, 1999. The contract between the State and Rock County sets forth how those excess funds can be used. Under that contract, funds are classified as either unrestricted funds or restricted funds. In fact, the County has applied $919,000 of the unrestricted W-2 "profit" to maintain Human Service Department activities in 1999. The application of these funds directly reduced the property tax levy support for department operations. This application was made in order to make up for the shortfall of Youth Aids and Community Aids funding from the State.

The County has the opportunity to apply for a portion of the remaining funds under the W-2 contract. Ten percent of the remaining "profit" is unrestricted, and ninety percent of the remaining profit is restricted. The restricted dollars are also called "community reinvestment" funds. According to the contract, the State will retain half the available reinvestment funds for its use, and Rock County can apply for the other half of the community reinvestment funds.

The guidelines for the community reinvestment dollars are very restrictive. Families served must be eligible for Temporary Assistance to Needy Families (TANF), the services provided be allowable under TANF, and individuals must be tracked through Client Assistance for Reemployment and Economic Support (CARES) system, except for some group services. Rock County anticipates submitting a plan in late 1999 to access some or all of the nearly $5 million of community reinvestment funds. However, the county does not expect to use any of these restricted dollars for property tax relief. Furthermore, these community reinvestment dollars are really "one time funding dollars" and cannot be relied upon as a continued funding source.

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Rock County, Wisconsin
County Board of Supervisors
51 South Main Street
Janesville, Wisconsin 53545
608/757-5510

April 14, 1999

To the Honorable Members of the Senate Human Services and Aging Committee:

I want to welcome the Senate Human Services and Aging Committee to Rock County, and to thank your for holding this hearing here. The specific purpose of this letter is to **ask you to remove from the Governor's proposed budget those statutory changes relating to the full implementation of Family Care**. Here are my reasons for that request:

- **The statutory language is not necessary at this time**. The State of Wisconsin has traditionally piloted innovative changes to human service programs. Those pilot programs have been implemented, tested, and proven before they are finally adopted statewide. This is not the case this time. The statutory language included in the budget fits pilots that have not shown how they work, or if they work. Only language necessary to implement the pilots needs to be included in the budget.

- **Family Care does not have widespread support**. Many aspects of the program being piloted have not received the support of associations representing the potential consumers of the program, their advocates or the counties which will administer the programs. The fact that the concerns exist at their current levels suggests that the final language in the budget is likely flawed.

- **The inclusion of the language creates mistrust**. Once the language in the budget relating to long term care is passed, the whole idea of "pilots" can be scrapped and the new program implemented in all counties at once - with no trial period.

I do not want any of my objections to including the unnecessary language to give you the idea that I oppose the redesign of Long Term Care. I support the concept of pilot projects, and believe that a new system that is tested and proven will allow for better care. Thank you for your consideration.

Sincerely,

Lowell Trewartha
Chair, Rock County Human Services Board

Cc.
Luanne Kane

ROCK COUNTY, WISCONSIN

Developmental Disabilities Board
P.O. Box 1867
Janesville, Wisconsin 53547-1867
608/757-5050

14-April-1999

Senator Judith B. Robson
State Senator, 15th Senate District
15 South, State Capital
Post Office Box 7882
Madison, WI. 53707-7882

Dear Senator Robson:

Attached please find information which will be presented on behalf of the Rock County Developmental Disabilities Board at your public hearing on state budget issues on April 14, 1999.

Allow us to extend our "Thanks" for the opportunity to share this very important information with members of the Senate Human Services and Aging Committee.

We look forward to continued positive and productive activities on behalf of disabled citizens in Rock County.

Sincerely,

Dale R. Thompson (mjg)

Dale R. Thompson, Director

Public Hearing Information
Rock County Developmental Disabilities Board
Wednesday, April 14, 1999

The Rock County Developmental Disabilities Board currently provides support services to approximately 1200 eligible citizens, with a 1999 budget of $15,170,000. The essential services provided include designated supervised living arrangements, case management, guardianship services, Family Support, diagnosis and evaluation, social development, vocational training/supported employment services, quality assurance, professional consultation, and investigation/follow-up of abuse and neglect circumstances.

INTRODUCTION:

In recent days, the DD Board has begun preliminary projections for the year 2000 budget. This is an important exercise if we are to establish a clearer picture of our funding status. Please consider the following information: In 1999, Rock County was required by the State of Wisconsin, to contribute $200,000 in Community Aids match dollars. For this year's budget, Rock County contributed $1.4 million dollars, which is substantially more than the state's minimum match, and a reflection of the County's continued support of services to the developmentally disabled in order to meet the state's mandated service levels to Developmentally Disabled citizens.

If the State's current proposed budget remains unchanged, there will be a need to increase the county levy in the year 2000 by better than 50% or more than $600,000. The large percent increase occurs because our property tax levy dollars are highly leveraged. Approximately 90% of our revenues come from state and federal sources. When those funds are frozen or reduced, even a "cost to continue" budget will have a significant impact on the property tax levy. Double digit percent increases in property taxes occur because 10% of the program revenue source absorbs 100% of program cost increases.

If the DD Board grants a modest 2.5% inflationary increase to our contract agencies for essential services in 2000, this increase will require more than $375,000 in county dollars. Each and every year, our consumer's needs change, the Board is forced to manage several unanticipated emergencies each year. These unanticipated emergencies have traditionally been due to the deterioration of the health of a caregiver parent. Historically, these unanticipated emergencies have had a price tag of $225,000.

At this point the question continues, where will the revenues come from if not from county tax dollars?

We wish to briefly outline certain areas where your consideration and support is viewed as important if we are to arrive at an answer to this question.

COMMUNITY AIDS:

The Basic County Allocation (BCA) of the Community Aids provide counties with funding to partially pay for mandated services to adults and children with developmental disabilities.

- There has been no inflationary increase in Community Aids for several years.
- In 1998, Federal Block Grant cuts to the State of Wisconsin were passed on to counties, reducing Community Aids by 2.9%. This cut reflects a decrease in available service/support dollars for developmentally disabled consumers in the amount of approximately $50,000 in 1999.
- The impact of this measure on services is significant. Consumers continue to wait for services. Waiting lists for a place to live, a place to work, and Case Management support continue to increase. At this point, Consumers may wait for two-three years for a supervised living arrangement, waiting for the support services of a Case Manager for at least twelve months is not uncommon. Responding to the needs of the consumers we serve remains the Developmental Disabilities Board's highest priority.
- The Board is forced to "do more with less", keeping in mind that service needs change, the population eligible for service/support continues to grow, and there are several consumers and their families in Rock County who are facing potential emergency situations: elderly parents caring for their disabled child.
- In fact, based on the real needs of the consumers the Board serves, there is not enough money to go around.

RECOMMEND/REQUEST:

We respectfully recommend that you restore the Federal Block Grant cut(s) and increase the Community Aids appropriation by at least 3% in each year of the biennium. This measure in itself would allow current service levels to be "maintained" at best.

Further, it is understood DHFS has the authority (at this time), to transfer/reduce Community Aids if a consumer's service needs are covered by a managed care organization. We are requesting that this authority be withheld from DHFS until the entire Long Term Care Re-design process is much more stable and refined in its' application and potential impact.

COMMUNITY INTEGRATION PROGRAM-C.I.P. 1-B (see attachment-#1)

The Community Integration Program (CIP 1-B) is a federal waiver program that provides funding for service/support to approximately 350 disabled consumers in Rock Co.

- According to data from the Department of Health and Family Services, the actual cost to provide services to consumers participating in CIP 1-B is $68.63/day. (This is a 1997 figure). The State reimbursed the Board/County at a rate of $48.33/day. There has been no inflationary increase in funding for this program in several years. The County is financially pressed to continue to cover the difference.

RECOMMEND/REQUEST:

We are requesting the legislature promote and support an increase in the per diem reimbursement amount for participants/services in the Community Integration Program. An increase in the CIP 1-B per diem rate to $68.63/day would provide an additional $350,000 in available service dollars to Rock County.

COMMUNITY INTEGRATION PROGRAM (C.I.P. 1-A) (see attachment #2)

The Community Integration Program (CIP 1-A) is a federal waiver program providing funding for service/support to eligible individuals discharged from an institutional setting and returning to their home community. Currently, there are thirty five (35) consumers participating in this program in Rock county.

- Data from the Department of Health and Family Services indicates in 1997 the actual cost to provide services to consumers participating in CIP 1-A is $146.70/Day. The State reimburses the Board/County at an average rate of $125/day. Once again, the County is forced to supplement the difference due to inadequate state funding.

RECOMMEND/REQUEST:

- We are requesting the legislature promote and initiate an increase in the per diem reimbursement amount from $125/day to $146.70 day for participant services in the CIP 1-A Program. Doing so would provide an additional $200,000 in funding. This funding would serve to minimize yet another instance where there has been no inflationary increase in the per diem amount in several years. Any relief afforded county tax payers in this regard is essential if we are to continue services at their current level.

MEDICAL ASSISTANCE REVENUES:

In an effort to capture additional federal funding which is utilized to offset ongoing state funding shortfalls; the DD Board has sought Medical Assistance reimbursed dollars for both Personal Care services and Case Management. Please consider:

- In 1998, the DD Board received over one million dollars in M.A. Personal Care Service reimbursement.
- In 1998, the DD Board was reimbursed for M.A. Personal Care services at a rate of $11.50/hour for approximately 70 consumers. The real expense for these services was $15.22/hour. Yet there continues to be no inflationary increase for this program
- 1998, the DD Board was reimbursed for approximately 6000 hours of M.A. Case Management services at a rate of $21.00/hour, the real expense for this service is closer to $33.00 hour.
- In both of these circumstances, the true cost of providing services appears to be routinely and consistently overlooked.

RECOMMEND/REQUEST:

Once again, we are requesting that the legislature support and implement at least an inflationary increase of 3% for Medical Assistance Personal Care and Case Management Services.

SUMMARY:

We continue to hear about the necessity of a "partnership" between, federal, state, and county government in order to provide essential services. Yet we face: no increase(reduction) in state aids, -no increase in Community Integration Program Dollars, and an ever increasing burden on the local taxpayer.

It would seem that prisons, schools, highways, and the University System are the priorities. We have deserving Consumers who cannot wait for help, we have a growing elderly population who have spent their lifetime(s) caring for their disabled son or daughter. Who will provide that care when they are no longer able to? Where is our continued commitment to people who are developmentally disabled? We need to increase all of our efforts at "renewing the partnership" to ensure essential services are provided to this population.

Thank You.

ATTACHMENT #1

Community Integration Program 1B

Goal: Provide cost-efficient services

Average Daily Costs			
CIP 1B Expenditures	1995	1996	1997
Total CIP 1B Expenditures	$73,878,276	109,520,614	139,692,967
CIP 1B Daily Expenditures	$66.13	$69.45	$68.63
MA Card Costs	$16.03	$16.00	$19.25
SSI-E Benefits	$20.97	$21.36	$21.82
Total Average Daily Costs	$103.13	$106.81	$109.70
ICF-MR Rate	1995	1996	1997
ICF (non-DD) Daily Rate	$105.02	$109.26	$114.56
MA Card Costs	$6.65	$7.25	7.25*
Total Average Daily ICF-MR Costs	$111.67	$116.51	$121.81
CIP Costs as a Percentage of ICF-MR Costs	92.4%	91.7%	90.1%

*1997 MA Card Costs is an estimate based on 1996 rates.

Goal: Provide quality community living to clients

Client/Guardian Satisfaction 1996 vs.1997**								
	Residential		Vocational		Case Mgt.		Health	
Year	1996	1997	1996	1997	1996	1997	1996	1997
Excellent	57.2%	76.8%	46.5%	71.4%	53.1%	74.4%	49.9%	74.9%
Satisfactory	40.2%	19.0%	49.6%	22.4%	44.9%	21.1%	47.6%	21.2%
Unsatisfactory	2.0%	3.1%	3.3%	4.6%	1.6%	3.4%	2.0%	3.1%
Unacceptable	0.6%	1.0%	0.6%	1.6%	0.4%	1.1%	0.5%	0.9%

** Satisfaction survey instrument changed significantly in 1996.
As a result, caution should be used when comparing results over time.

Goal: Provide timely and responsive services

Guardian Opinion			
	1995	1996	1997
Proportion of guardians indicating counties address concerns promptly	80%	82%	90.9%

CIP 1B Relocations/Diversions vs. ICF-MR (non-DD Center)/ Nursing Home Population				
	1994	1995	1996	1997
Relocations	783	987	1,002	1,099
Diversions	1548	2906	3804	4,999
Total Relocations & Diversions	2,331	3,893	4,806	6,098
NF Clients	2,299	2,490	2,371	2,189

Number and Status of CIP 1B Participants Leaving the Program		
Reason	1996	1997
Deceased	36	40
Institutionalized	30	39
Temporary closure	14	10
Services no longer needed	12	20
Moved Out of State	9	10
Loss of Eligibility	5	5
Other	27	46
Total	133	170

ATTACHMENT #2

Community Integration Program 1A

Goal: Provide cost-effective services

Average Daily Costs			
CIP 1A Expenditures	1995	1996	1997
Total CIP 1A Expenditures	$34,595,698	$42,308,962	$46,960,788
CIP 1A Daily Expenditures	$129.52	$141.45	$146.70
MA Card Costs	$16.03	$16.00	$19.25
SSI-E Benefits	$20.97	$21.36	$21.82
Total Average Daily Costs	$166.52	$178.81	$187.77
DD Center Expenditures	1995	1996	1997
DD Center MA Rate	$254.22	$272.81	$290.23
DD Center MA Card Costs	$6.65	$7.42	$7.42
Total Average Daily Center Costs	$260.87	$280.23	$297.65

Goal: Provide timely and responsive services

Guardian Opinion			
	1995	1996	1997
Proportion of guardians indicating counties address concerns promptly	76%	81.9%	92.1%

Number of Residents/Clients in Center and CIP 1A				
	1994	1995	1996	1997
Center	1,334	1,236	1,148	1,053
CIP1A	706	817	846	938

Number and Status of CIP 1A Participants Leaving the Program During Calendar Year		
Reason	1996	1997
Deceased	5	12
Institutionalized	10	8
Temporary closure	7	1
Services no longer needed	2	2
Loss of eligibility	5	1
Other	11	11
Total	40	35

Goal: Provide quality community living to clients

Client/Guardian Satisfaction 1997				
	Residential	Vocational	Case Mgt.	Health
Excellent	82.9%	72.0%	76.6%	79.0%
Satisfactory	14.3%	24.3%	19.5%	18.7%
Unsatisfactory	2.1%	2.9%	2.5%	1.8%
Unacceptable	0.7%	0.8%	1.4%	0.5%

Guardian Satisfaction with Overall Services*				
	1994	1995	1996	1997
Excellent	48.2%	48.6%	50.9%	77.9%
Satisfactory	49.3%	48.8%	46.6%	19.9%
Unsatisfactory	2.2%	2.2%	2.2%	2.1%
Unacceptable	0.4%	0.4%	0.3%	0.2%
response rates	59.7%	66.8%	68.4%	55.9%

*Satisfaction survey instrument changed significantly in 1996. As a result, caution should be used when comparing results over time.

TO: STATE SENATE HUMAN SERVICES AND AGING COMMITTEE
STATE SENATORS AND ASSEMBLY REPRESENTATIVES

FROM: CATHY HINDS, PRESIDENT AFSCME LOCAL 1258 RCHCC

RE: 7% WAGE PASS-THROUGH PROPOSAL

DATE: APRIL 14, 1999

I'm Cathy Hinds, I have been employed at Rock County Health Care Center for 20 years. Over those years I have served as a union officer for 15 years. I have seen a lot of turnover of staff, but we have never been this short of staff that want to help take care of our elderly or disabled residents. The saying years ago to the CNA's was, "Your a dime a dozen." The field that these people choose is not made for just anyone. You have to have patience, ability to listen and be caring. We are not a factory applying parts to create an object. We take care of people less fortunate than ourselves that can't for reasons beyond our control can no longer do it for themselves, but they are people too. God put them on this earth as he did you and me. They deserve respect, proper care and a right to have as much as they can from life.

A lot of people that choose this field are single parents and need a proper income. Cost of living is the same for them as it is for the person that makes double what the staff are paid in nursing home facilities. Child care alone is very hard to get and afford. To help keep costs down, many of our staff work one shift and baby-sit for their co-workers on another shift. Then, if they get mandated they run the risk of losing their job or child abuse by having no one to watch their children. Our facility does not get to shut down because it's Christmas or Thanksgiving or because it's the weekend. We need proper staffing so our patients/residents can have someone to help them enjoy the holiday. I am in total support of 7% wage pass-through proposal and a 3.3% increase in the Medicaid reimbursement rate in each year of the biennium.

Staff understands that residents come first, but it becomes real hard to stop living a life with family, friends and reality. When staff punch the clock for their shift they never know how many hours it will be before they can join their family and friends. We understand that mandation and overtime is a fact of life in these positions, but when it's due to staff shortages it is a lot harder to take.

TESTIMONY: NEEDED: The ASSURANC[redacted] GOOD QUALITY CARE in Nursing Homes-------for CLIENTS & STAFF April 14, 1999

Those of us signed below wish to testify that we feel that the problem of forcing staff to work overtime is detrimental to the quality of care of the clients. MANDATION detracts from the level of this care. The wages & benefits in nursing homes vary. Some pay better than others. None, evidently, pay an acceptable enough wage to attract & retain a sufficient number of employees. We support any means it takes to attract & retain good employees dedicated to the care & welfare of clients in nursing homes. We, FULLY, understand that the clients cannot be left unattended. We, also, understand & want the decision makers to realize that good quality care can ONLY be attained by recognizing that the staff also has needs. We ALL have a life to live. We KNOW the clients NEED us but we don't want to be FORCED to put in more time than we can healthfully manage. Our lives and families are as important to us as is the case with our clients.

We, truly, DO CARE!!!! We want the best for the clients of nursing facilities & for all the staff members, also. We feel that FULL STAFFING is the most important point in finding a solution to the MANDATION problem.

****

Michelle Martin
Anna Thompson
[illegible] CNA
Jolyn Welch
Chris Shaw
Dawn A. Richter, CNA
Stacey J. [illegible], CNA
[illegible] CMA
Mary Christianson
Marilyn Rein CNA
Deborah Johns LPN
Russell Bue
Nancy Lee Neuss RN
Ann Pliner CNA
Bridget Stueda CNA
Tonya D Ray CNA
Heather Condon CNA
Kathy Crawford RN
[illegible]
Christine [illegible] CNA
Miranda Reese CNA
Carlyn DeHaan CNA
[illegible] Hayden
[illegible] CNA
Nadine M Briley CNA
L Bright[illegible]
Julie [illegible]
[illegible]
[illegible] Bruce
Terri Stafford CNA
[illegible] CNA

TESTIMONY: NEEDED: The ASSURANC[redacted] GOOD QUALITY CARE in Nursing Homes-------for CLIENTS & STAFF [redacted] April 14, 1999

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Mary Christianson
Marilyn Rein CNA
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Mary Lee Kerns RN
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[illegible] Hayden
[illegible] CNA
Nadine [illegible] CNA
L. Bright[illegible]
[illegible]
[illegible]
[illegible] Bruce

Terri Stafford CNA
[illegible] CNA
[illegible] CNA
Rosie Hewlett CNA
Mary Vandell CNA
[illegible] CNA
Julie [illegible] CNA
[illegible] CNA
[illegible] Fisher
[illegible] CNA
Sandra [illegible] CNA
Linda DeLeon
[illegible]

TESTIMONY: NEEDED: The ASSURANCE of GOOD QUALITY CARE in Nursing Homes-------for CLIENTS & STAFF April 14, 1999

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****

Reinicke family FOOT clinic, s.c.

4450 Milton Avenue, Suite 201
Janesville, WI 53546-9673
(608) 752-1080
Fax (608) 752-1394

B

April 14, 1999

Human Services and Aging Committee
Judith Robson, Chair
Public Hearing April 14, 1999
Janesville, WI 53545

I am present today in support of maintaining the Point of Service Coverage option in the proposed Budget Bill (Section 3036 609.23). This is in the best interest of the health care consumers of our state, and the public benefit for exceeds the concern over minor increases in premium it may cause.

Second, regarding an issue which will arise in the future. I support the concept of independent external review of claims denied by managed care organizations. This would be most effective when done by experts in the specialty field of the denial.

Alan J. Reinicke DPM

Alan J. Reinicke, D.P.M.

BELOIT ANCILLARY SERVICES
HOME IS WHERE THE HEART IS

Home Companion Registry
Supportive Care / Personal Care
CITY HALL • 100 STATE STREET • BELOIT, WI 53511
608-364-6631

TO: Senator Judy Robson

FROM: Trudi Ludois, RN
Nursing Supervisor
Beloit Ancillary Services

DATE: April 9, 1999

SUBJECT: Proposal to increase Medicaid Personal Care

As a member of the Wisconsin Personal Services Alternatives, Inc. (WPSA), I support the proposal to increase Medicaid Personal Care. The proposal encourages the increase of Medicaid Personal Care to exceed the budgeted increase amount of $.11/hr, and proposes raising the increase by $4.00/hr. A sample letter to legislators, written by the WPSA Legislative Committee, is enclosed.

Beloit Ancillary Services provides personal, supportive and home companion services to the elderly and disabled residents of the community. As employers of personal care workers, we are experiencing the issues related to staff shortages and share the concern of fulfilling the needs of our clients.

Sincerely,

Trudi Ludois, RN
Nursing Supervisor
Beloit Ancillary Services

Sample Letter to Legislators

Date

Legislator name
PO Box 7882, Capitol
Madison, WI 53707

Dear :

The need for more workers to care for a growing elderly population is causing turmoil in Wisconsin and across the country. Staff shortages in community-based long-term care are so severe that financially strapped home-care providers are going out of business, cutting services and turning away clients **because they can't pay enough to attract workers to care for the growing numbers of those who need help.** Without at least a $4 increase in Medicaid Personal Care (MA PC) that providers can use to attract more workers, we will face even higher nursing home and hospital bills. The $.11 per hour increase in the governor's budget for MA Personal Care is alarmingly insufficient. Consider the facts:

FACT: It already costs providers up to $15 or more to provide an hour of MA PC, well above the $11.27 reimbursement. With these losses, they can't offer benefits or offer competitive wages.

FACT: It would cost the State $986 for the 68 hours the average MA PC client receives monthly, if the $4 increase is approved. The average Medicaid cost for a month of nursing home care was about $3000, a difference of **more than $2000 PER MONTH, PER CLIENT**. Not all MA PC providers will shut down without an increase. Not all clients will need nursing homes. But many will. If even a conservatively estimated 10% do, Medicaid will find itself paying **$15.7 million MORE for nursing homes** than it would have paid for the higher MA PC rate for in-home care. And there will be added MA costs for more frequent hospital stays that former MA PC recipients will undoubtedly experience due to deteriorating health brought about by the loss of the assistance with feeding, medications, and ambulation that MA PC workers provided to keep them stable.

FACT: Four dollars sounds high. ***But if the MA PC rate hadn't been frozen for so long, we wouldn't need this large an increase now.*** And $4 is needed to help employers purchase health insurance – the one benefit likely to attract the most workers. Don't all State employees receive this benefit? Shouldn't PC workers who deliver state-funded services?

FACT: The tobacco settlement will greatly enrich Wisconsin's general revenues for 25 years, making the $4 increase affordable now. Tobacco related illness disproportionately affects today's elderly, who had the highest rates of smoking of any U.S. generation. MA PC provides care to hundreds of older Wisconsinites with smoking related respiratory illness, cancer and heart disease. Governors Whitman (R-NJ) and Bush (R-FL) have already allocated some tobacco funds for community care of the elderly. So has Paul Celluci of Massachusettes. So should we.

We know you would rather give tax breaks than pay more for MA PC. But tax breaks no longer resonate with the public. ("Doesn't anybody here want a juicy tax cut?" U.S. News and World Report, March 1, p. 24) ***Don't*** lower taxes at the expense of vulnerable elderly and poorly paid workers who keep them out of nursing homes. ***Do*** acknowledge the vital importance of home-care workers who keep down the State's expenses for institutional long-term care. Increase MA PC. Face facts.

Sincerely,

Your Name, Title

a

STATEMENT April 14, 1999 to Senate Human Services and Aging Committee
Rock County Courthouse

I am Carolyn Brandeen, 2020 S. Crosby Avenue, Janesville. I stand to speak as a member of this community, representing only myself. I've been a faithful nursing home volunteer most of my adult life, a loving caregiver and advocate for a disabled older sister who died last summer, and an opinionated activist who serves on the county Council on Aging advisory board and represent Church Women United in Wisconsin's state board as a member of CWAG, the Coalition of Wisconsin Aging Groups. I demonstrate by my time and effort that the caring community, both family and church, has a keen interest in the Community Options Program and Elderly and Disabled Transportation Assistance.

The Governor's proposed state budget continues COP placements that were created in the last budget bill. But, there is nothing in the budget, as proposed, to serve additional people over the next two years. I know first hand what it is like to be on a waiting list. My sister sat in her wheelchair in her small apartment after she retired from the Wisconsin School for the Deaf waiting for COP help. She was on a waiting list from over three years. She spent every penny she had and a lot of mine too, trying to stay in her own apartment. She sold as many of her personal possessions as she could (like her copper pots and pans), she put expenses like over the counter drugs and dental care, on her credit cards. She declared bankruptcy. She was one of the lucky one: she finally outlived the waiting list and got help from COP.

She stayed in her own home with that help for another three years before moving into a nursing home at $150 a day. Older people on waiting lists just cannot wait. There should not be a waiting list for home and community care.

And that leads to my other point about Elderly and Disabled Transportation Assistance. Older people and people with disabilities have as much right to home and community care as they do to institutional care. The proposed budget includes only a 3% increase each year for Elderly and Disabled Transportation programs. This is inadequate. We need improved mobility for a growing population. My favorite volunteer driver for the Council on Aging is my husband, a retired GM worker. He gets a great deal of satisfaction in helping get county seniors to medical appointments at the UW Hospital Clinics or to the VA. These clients tell the most woeful stories about their lives in isolation and are so appreciative of a service that they can use to get them to the VA or to a clinic to get their artificial leg fitted better or to see an eye specialist about approaching blindness.

In closing: the aging in our community deserve a long-term care system that provides choices and eliminates waiting lists. I ask you to address these issues and make changes in the proposed budget to accomplish this while we wait for the next steps in Long Term Care Redesign.

The Honorable Judy Robson
Wisconsin Senate
State Capitol
P.O. Box 7882
Madison, WI 53707

12 April 1999

Dear Senator Robson,

I appreciate your invitation to testify on the budget before the Senate Human Service and Aging Committee at the Rock County Courthouse this Wednesday, April 14. Unfortunately, I will be unable to attend, so as per your instructions I am sending my written testimony to your office. Before I get started, I just wanted to mention that I read over the review of your bill for use of the tobacco funds presented in the Janesville Gazette and I feel it is a much better approach than what the Governor currently has proposed.

I am testifying against the proposed reduction to Medicaid pharmacy reimbursement. It suggests to cut pharmacy reimbursement from AWP-10% to AWP-18%. While this would only save the state $7.5 million per biennium, it would cost pharmacists $18.2 million due to federal matching funds. This proposition was based on a federal study that showed that pharmacies could purchase drugs at AWP-18%. The problem is, this study is methodologically flawed, and so are the results. The truth is that most pharmacies purchase drugs in the AWP-14% to 15% range. Also, a comparison of all states Medicaid pharmacy reimbursement shows that 22 other states have higher reimbursement than does Wisconsin (see attached table). Also, not a single state has a reimbursement formula lower than AWP-13.5%, and only three have a rate lower than AWP-12%. Is it just me, or is AWP-18% off base just a little??!!

The underlying problem of course is the skyrocketing costs to the Medicaid program for prescription drugs. No one will refute this, however the culprit is not pharmacies or the pharmacist. From 1983 to 1998, the actual cost of a prescription has risen from $9.34 to $37.48, while the amount paid to the pharmacist has increased only from $3.40 to $4.36, not even keeping up with inflation (see attached figure). The main reason for growth in Medicaid drug expenditures are: (1) an increase in the cost of newly developed and marketed drugs, (2) an increase in utilization of prescription drugs by patients, and (3) manufacturer price increases for existing drug products. A couple examples may be helpful. First, a new drug was just approved for the topical treatment of Kaposi's Sarcoma in AIDS patients - the cost of it will be over $2,000 for a 60 gram tube of cream!!! Second, the generic industry is currently being investigated by the FTC for increases of 100's and 1000's of percent in existing generic drugs over the past year. Regardless of all of these facts, drugs still remain the most cost-effective means of healthcare.

In closing, I ask that you strongly support the complete elimination of this proposed budget item. As the numbers show, if anything, pharmacists deserve an increase, not a decrease, in payment. The addition of this item to the budget would have horrendous ramifications! The average reduction in reimbursement for a Medicaid prescription would be $4.80, and would only increase in the future as drug costs continue to skyrocket. Just think of the results - many pharmacies may actually have to go out of business, others may simple decline participation in Medicaid, and as a result, needy Medicaid (and Badgercare) recipients may have to travel 20, 30, 50 + miles to obtain pharmaceuticals. The flip side is that those pharmacies staying open and providing for Medicaid patients would have to do so much more business just to break even, that the level of professional

service would decrease greatly. What does this mean? Currently we spend a dollar on treating the adverse consequences of medications for every dollar we spend on medications. The most experienced and available practitioner to prevent these costs is the pharmacist, and this ability would be severely inhibited if he/she would have to practice in an environment not conducive to professional practice.

I hope this letter helps to clarify some of the issues surrounding the proposed reduction in Medicaid reimbursement to pharmacies. If I can be of further assistance, please feel free to contact me.

Professionally,

Chris Klink R.Ph.

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(608)758-8662
cklink1@hotmail.com

Work:
ShopKo Pharmacy
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ATTACHMENT #2

Profile of Medicaid Reimbursement in 1998

Which state received the highest Medicaid reimbursement in 1998 and which received the lowest? The following table, provided by the National Pharmaceutical Council, gives a state-by-state breakdown.

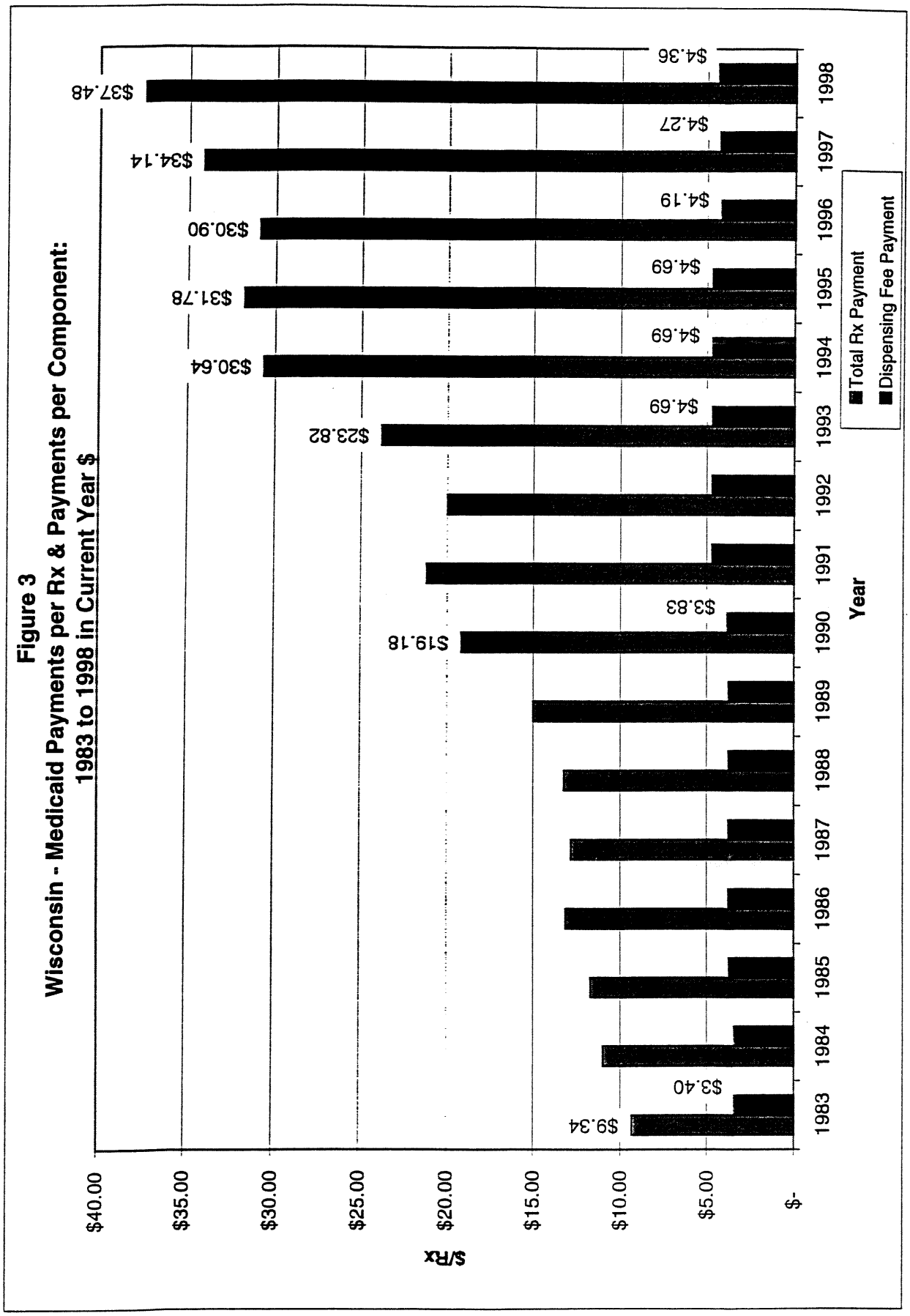
State	Dispensing fees	Co-pay	Ingredient reimbursements basis
Alabama	$5.40	50 cents-$3	WAC+9.2%
Alaska	3.45-11.46	$2	AWP-5%
Arizona*	-	-	AWP-10%
Arkansas	4.51 + 0.103 (EAC)	50 cents-$3	AWP-10.5%
California	4.05	G: $1 /B: $2	AWP-5%
Colorado	4.08	G: 50 cents/B: $2	AWP-10%;WAC+18%
Connecticut	4.10	No	AWP-12%
Delaware	3.65	No	AWP- 12.9%
District of Columbia	3.75	$1	AWP-10%
Florida	4.23	No	WAC+7%
Georgia	4.41	50 cents	AWP-10%
Hawaii	4.67	No	AWP-10.5%
Idaho	4.54	No	AWP
Illinois	3.30-14.72	No	AWP- 1 0%; multisource drugs are AWP-12%
Indiana	4.00	50 cents-$3	AWP-10%
Iowa	4.02-6.25	$1	AWP-10%
Kansas	4.82 (average)	$2	AWP-10%
Kentucky	4.75 OP/$5.75 LTC	No	AWP-10%
Louisiana	5.77	50 cents-$3	AWP-10.5%
Maine	3.35	50 cents-$3	AWP-10%
Maryland	4.21	$1	WAC+10%
Massachusetts	3.00	50 cents	WAC+10%
Michigan	3.72	$1	AWP-13.5%orAWP-15.1%
Minnesota	3.65	No	AWP-9%
Mississippi	4.91	$1	AWP-10%
Missouri	4.09	50 cents-$2	AWP-10.43%
Montana	2.00-4.20	G: $1/B: $2	AWP-10%
Nebraska	2.84-5.05	$1	AWP-8.71%
Nevada	4.64	No	AWP-10%
New Hampshire	2.50	G: 50 cents/B: $1	AWP-12%
New Jersey	3.73-4.07	No	AWP-10%
New Mexico	4.00	No	AWP-12.5%
New York	4.50-5.50	G: 50 cents/B: $2	AWP-10%
North Carolina	5.60	$1	AWP-10%
North Dakota	4.60	No	AWP-10%
Ohio	3.70	No	AWP-11%
Oklahoma	4.15	$1/$2	AWP-10.5%
Oregon	3.80-4.16	No	AWP-11%
Pennsylvania	4.00	$1	AWP-10%
Rhode Island	2.85-3.40	No	WAC+5%
South Carolina	4.05	$1.50	AWP-10%
South Dakota	4.75-5.55	$2	AWP-10.5%
Tennessee[1]	-	-	
Texas	5.27 + 2%	No	AWP-10.49%;WAC+12%
Utah	3.90-4.40	$1	AWP-12%
Vermont	4.25	$2	AWP-10%
Virginia	4.25	$1	AWP-9%
Washington	3.90-4.82	No	AWP-11%
West Virginia	3.90	50 cents-$2	AWP-12%
Wisconsin	**4.38 ($4.88 - $.50[2])**	**$1**	**AWP-10%**
22 states across the country have higher pharmacy reimbursement than Wisconsin.			
Wyoming	4.70	$1	AWP-4%

WAC = Wholesalers Acquisition Cost; AWP = Average Wholesale Price; EAC = Estimated Acquisition Cost;
G = Generic; B = Brand name; OP = Outpatient; LTC = Long-term care.

Source: As reported by state drug program administrators in the National Pharmaceutical Council Survey.

[1] Within federal and state guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.
[2] Wisconsin Medicaid cut $.50 per prescription during the 1995-96 biennium. Adapted from *Drug Topics*, February 15, 1999

ATTACHMENT #3



CWAG

Thomas L. Frazier, *Executive Director*

Coalition of Wisconsin Aging Groups

April 14, 1999

Senator Judy Robson
State Capitol – 15 South
P. O. Box 7882
Madison, Wisconsin 53707-7882

Dear ~~Senator Robson~~ Judy:

Thank you for holding a public hearing on human services and aging issues in the state budget. Since I have had the opportunity to testify before Senator Moen's Committee, of which you are a member, I thought it would save both of us time if I just turned in written testimony instead of traveling to Janesville.

I would like to add two things that are not included in my enclosed written testimony. First, of 39,000 older people receiving long-term care services at the end of 1997, 30,000 of them (77%) were in nursing homes. So in spite of the success of COP we are only serving 23% in home and community settings. The system is still failing the elderly. Second, the trend in nursing home utilization is down and is projected to continue to decrease in the proposed 1999/2001 state budget. In fact, if the projections are accurate, this decreased utilization will result in a Medicaid savings of $25.5 million over the biennium based on average nursing home costs.

I believe that these statistics show that we need to develop a better system for the elderly (i.e., implement the Family Care pilots) and that we need to fund additional COP slots to assure the continued downward trend in nursing home utilization. It would indeed be unfortunate if at the same time that we were trying to reform the existing programs to give people choice, we forced more people into costly nursing homes because in 63 of the 72 counties we provided no other choices.

Again, thank you for holding the hearing of your committee and for your great support of programs for older people in Wisconsin.

Sincerely,

Thomas L. Frazier
Executive Director

cc: Human Services and Aging Committee Members
Senator Gwen Moore Senator Kimberly Plache Senator Bob Wirch
Senator Carol Roessler Senator Peggy Rosenzweig Senator Alberta Darling

P.S. I thought you might enjoy the enclosed 1981 editorial in the Milwaukee Journal.

5900 Monona Drive • Suite 400 • Madison, WI 53716-3554 • 608/224-0606 • FAX 608/224-0607

CWAG

Thomas L. Frazier, *Executive Director*

Coalition of Wisconsin Aging Groups

Testimony to the Senate Human Services and Aging Committee

April 14, 1999

by

Thomas L. Frazier

Reform of long-term care in Wisconsin has been the top priority of CWAG for at least the last six years and we have been working long and hard over the past three years with DHFS on Family Care.

The Family Care benefits are outstanding. The Resource Center or one-stop shopping plan is very much needed by older persons and their families to get the information they need to make good decisions. We also are very supportive of the "grandfathering" of existing recipients of long-term care services and the funding of external advocacy through the Board on Aging and Long-Term Care. But the most important benefit is creating the same entitlement for home and community care as we now have for nursing home care. This gives people **CHOICE** which is the most important thing we need to do.

I have talked with thousands of older people over the last few years and they want a public system or as we say public accountability for public dollars. Family Care as proposed has two significant barriers to a county-managed system. First, counties cannot be both Resource Centers and Care Management Organizations (CMOs). Counties that want to provide long-term care services to their citizens will be required to create Family Care Districts, a public authority, to either be the Resource Center or the CMO. Second, counties will only be given two years after they enter into CMO contracts with DHFS to operate Family Care before they will have to compete to provide the services. I fear that

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many counties will not want to accept the risk of building the necessary capacity to run Family Care only to see DHFS award the contract to another organization after two years. We recommend that Family Care be amended to give counties four years instead of two years to operate Family Care without competition, and clarify that the Family Care District requirement should not apply to the pilot counties.

Wisconsin has done a pretty good job over the last 17 years in helping people remain in their own homes. Based on Legislative Fiscal Bureau papers in 1997 Wisconsin served 23,405 (35%) people under COP and Waiver programs and 44,489 (65%) persons in nursing homes. We spent $243 million (20%) for home and community care and $983 million (80%) for nursing home care. Also, according to the LFB, the cost of nursing home care was about $28,000 versus $21,000 a year for home and community care.

This is not bad but we can do much better. For example, the state of Oregon serves 72% of LTC cases in home and community care and spends 43% of LTC dollars in home and community care. How did they do it? Oregon received a federal waiver in December 1981 and the first thing they did was eliminate the institutional bias—they gave people a real ***CHOICE*** between home and community care and nursing home care.

Wisconsin can do better. Through COP and federal waivers we have been helping people receive services in their own homes for the last 17 years. The difference between Wisconsin and Oregon is that we never really gave people ***CHOICE***. The Family Care proposal will give people in the nine pilot counties a choice, but what about all the people on waiting lists in the other 63 counties? It is a cruel irony after the progress of the last 17 years to now say the best we can do is pilot Family Care in nine counties while doing nothing in 63 counties where all that people want is ***CHOICE***. Wisconsin can do better.

In conclusion, we support the Family Care pilot projects and believe that they will demonstrate that you can give people the choices that they want, better manage the public investment in long-term care and serve more people by reducing the overall average cost of long-term care in Wisconsin. We cannot, however, do nothing in the other 63 counties while we wait on the results of the pilot projects. I urge the Legislature to also provide

funding for the Community Options Program (COP) in the other counties because older persons on waiting lists cannot wait three or four more years for help, and because we need to build momentum to give consumers greater choices everywhere in Wisconsin.

We already know how to help people stay in their own homes—give them the **CHOICE**.

And let's not wait for the 21st century—with leadership from the Governor, from DHFS and from the Legislature we can give people choices in this budget, in this century.

Remember When...

On, Wisconsin

An Editorial

A way to help aged live at home

With Medicaid threatening to drain $2 billion from Wisconsin's next two-year budget, it's high time society stops sending people unnecessarily into costly nursing homes.

How many people do you know who moved into a nursing home because the government would pay the bill for that, but would not provide the extra help that might have allowed those people to say at home? We know plenty. And we know that it can be not only a waste of taxpayers money but also a tragic waste of long-time taxpayers. Wisconsin's citizens with seniority deserve better.

And they'll have a good chance of getting better alternatives soon if the lobbyists for county governments don't jam up the works in Madison. The Wisconsin County boards Association has been relentlessly picking away at the state's innovative proposal to change Medicaid so that nursing homes become the last, not the first, resort.

Under the proposal, called the Community Options Program, eventually 11% of the state's 30,000 nursing home residents would be offered the alternative of staying home and getting some help, such as a visiting nurse, a homemaker, or meals.

Counties would administer the program—and that makes some county officials nervous. Thus, their opposition. Citizens who want to have more options available when they grow older should demand that their elected county officials support the proposal (and, in fairness, also demand that the State Legislature pay for it).

After all, this proposal is, as the state's top health official says, "our best chance to reverse the bias and trend toward fiscal and human bankruptcy."

Milwaukee Journal, April 28, 1981

Front Page Editorial

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SENATE HUMAN SERVICES AND AGING COMMITTEE
Public Hearing
April 14, 1999

Thank you for giving me an opportunity to speak with you today.

I am a recently retired public health nurse who has had fourteen years of public health nursing experience with families living in Beloit. A major part of my work experience has been conducting home visits.

I am advocating that a portion of the tobacco settlement funds be allocated to funding home visitation programs in Wisconsin, especially those working with first time parents. My vast experience in home visiting has convinced me that home visitors play an important role in the lives of families. This is also substantiated by the plethora of research on home visiting.

Home visiting provides a unique opportunity to educate and support young parents in making lifestyle choices that contribute to improving not only their health, but the health of their children also. One behavior addressed in pregnancy and the early years of parenting is cigarette smoking. Our goal is to educate parents on how smoking negatively impacts on their health, the health of the unborn and their children's health through second hand smoke.

Home visiting occurs at critical times in the family's lives; pregnancy and during those first influential years of parenting where behaviors may be established for their remaining parenting years. Public health universally knows the value of home visiting as an effective prevention and early intervention strategy. The prevention of smoking and smoking cessation are key topics addressed in home visitation programs.

Please fund home visitation programs with funds from the tobacco settlement.

Thank you for your attention.

Respectfully submitted by

Bonnie Cunningham

Bonnie Cunningham, RN MS

Testimony for the Senate Human Services and Aging Committee
Wednesday, April 14, 1999.
Submitted by Mat Haeger, RN
Nursing Director
Rock County Health Department

TOBACCO SETTLEMENT FUNDS

Senator Robson and members of the Senate Human Services and Aging Committee. In February of this year, the State of Wisconsin made nicotine patches (a self help program to stop smoking) available at no cost to the citizens of Wisconsin. Initially these kits were to be directed to low income women in Wisconsin. However, because there were so many kits to be distributed the guidelines were altered to make the kit available to anyone requesting the nicotine patches. Local public health agencies were selected to distribute these kits to citizens in Wisconsin. We had two weeks to figure out how to rearrange work loads in order to provide the nicotine kits.

The Rock County Health Department received a total of 400 kits. A total of 144 kits went to First Choice Women's Health Clinic, Healthnet, Mercy Hospital Addictions Program, and Edgerton Memorial Hospital. The remaining 256 kits were distributed by public health nurses at the Rock County Health Department. The only publicity on the availability of these nicotine patches was the press conference with Sue Ann Thompson that was covered by public T.V. , radio, and local news stations and a flyer in the Rock County employee newsletter.

Within 6 weeks, all 256 kits were distributed by the Rock County Health Department. I also assume distribution went equally as well at the four sites we provided kits, because all four contacted me before the end of March requesting additional kits. We also received requests from Grant Green, Jefferson, and Walworth Counties, but could not spare any of the nicotine kits to meet these requests.

There have only been two times when word of mouth advertising created a greater demand for a product that I am aware of in the last 20 years. In the Fall of 1997, when someone had Green Bay Packer tickets to sell and in 1979, during my college years, when a local tavern provided free beer for one hour.

I am passing out data on the distribution of the 256 nicotine kits from the Rock County Health Department. The age range of people receiving the patches was 18 to 75. Persons under age 18 could not receive the kits, even though we had requests. The greatest demand for the nicotine kits was from persons between the ages of 30 and 50. Sixty-nine (69%) percent of recipients were women and 97% were white.

I believe this data clearly indicates the need and interest in Rock County for no cost/ low cost assistance with smoking cessation programs. The results in Rock County support what a number of reports have indicated, and that is that many people who smoke want to quit. They really don't want to smoke, but they are addicted to the

cigarettes. They need support.

I am here today to support the Tobacco Trust movement for a larger portion of the Tobacco Settlement Fund be used to address on of the leading public health needs in Wisconsin, that being smoking and a reduction of it's serious health effects. These funds should be used to not only support cessation services, but also programs to prevent our youth from starting to smoke.

These dollars were awarded to States because of the increased medical costs the States incurred from people who smoked. We need to use more of the Settlement Funds for the purpose the State received the funds: to address the negative health effects of smoking. Thank you.

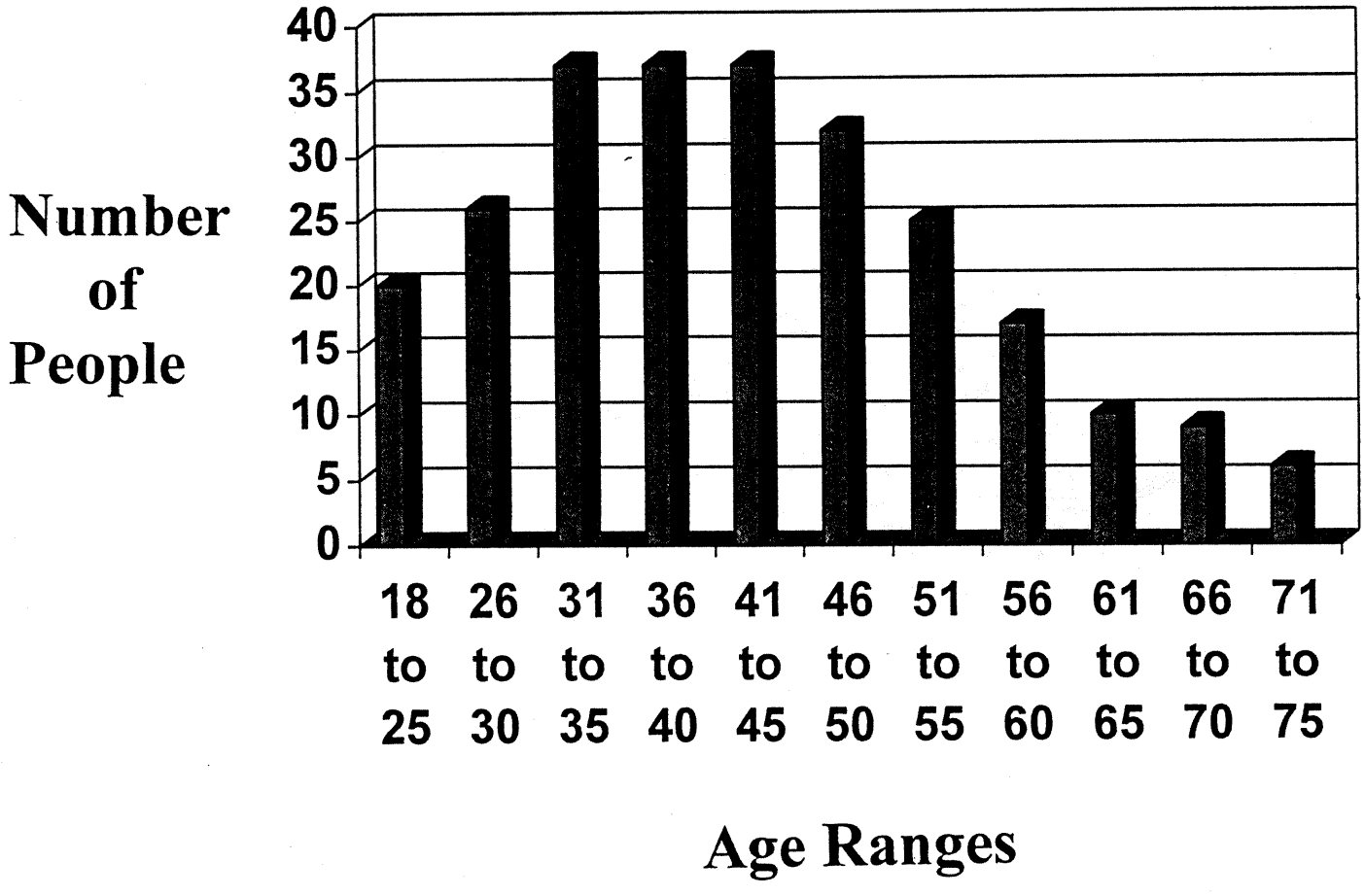
ETHNICITY OF PERSONS RECEIVING NICOTINE PATCHES FROM THE ROCK COUNTY HEALTH DEPARTMENT IN 1999

WHITE	97%	(249)
BLACK	1%	(3)
HISPANIC	1%	(3)
ASIAN		(1)

SEX OF PERSONS RECEIVING NICOTINE PATCHES FROM THE ROCK COUNTY HEALTH DEPARTMENT IN 1999

FEMALE	69%	(177)
MALE	31%	(79)

Chart 1: Age Range of People Receiving Nicotine Patches from the Rock County Health Dept. in 1999



To: Senator Judy Robson, Chairperson of the Senate Human Services and Aging Committee.

Due to some previous union and company meetings that we have scheduled on April 14th both Marshall Bown and myself, Joe Michalski will not be able to attend your hearing at the Rock County Courthouse in Janesville, on the State Budget.

However we both would like to go on record and say that we are appalled at the way our Governor has used the 4.2 billion dollar tobacco windfall to fund other measures in his budget. The legislators in Madison should remember why this money was awarded to our State. It was due to the illnesses that tobacco smoke causes to its users. That plus the second hand smoke dangers are the reasons this money was awarded.

Therefore we feel programs that sponsor Healthcare Aid for the needy, Prescription Drug Plans that are affordable and research that could find cures for tobacco caused illnesses

. Keep up the good fight Judy. You'll always be Local 1533"s favorite Lawmaker.

With best regards
Joe and Marshall

ROCK COUNTY HEALTH DEPARTMENT

P.O. Box 1143
Janesville, Wisconsin 53547

Public Health Nurses 608/757-5440
Environmental Health 608/757-5441
Administration 608/757-5442

April 14, 1999

Senator Robson and Members of the Senate
Human Services and Aging Committee,

Thank you for this opportunity to talk with you today about an important environmental public health concern, protection of our drinking water supplies from leaking underground storage tanks. The laws that we have been living with in the past have allowed underground storage tanks to operate until they have leaked into the soil and ground water before repair or replacement. Large public expenditures through the PECFA Fund are being spent to clean up these contaminated sites. Recent projections place the estimated total cost of the PECFA program to taxpayers at more than one billion dollars. Additional costs, not PECFA covered, are also borne by home owners and businesses.

Our Department studied the impacts (i.e., public health, environmental, economical, social, and political) caused by leaking underground storage tanks and predicted them to be large. We proposed an alternate use of PECFA funds that could have saved money and protected the publics' health and natural resources. Clean up costs were predicted to be near forty million dollars in Rock County(one billion dollars statewide), if all underground storage tanks continued to operate until leaks developed. A proposed alternative option of PECFA Fund use would have been to assist tank owners in removing high risk tank systems and offering financial assistance for replacement with double wall containment tank systems. One half of the PECFA expense could have been avoided because many underground storage tank systems would have been removed before leaks developed. Also, future leaks would be further reduced by installing a double wall containment system that is the most environmentally protective system available.

Of special concern to our department, are the large number of new and replacement single wall underground storage tank systems currently being installed. Are we going to be in this same situation again in twenty-five to thirty years, conducting expensive groundwater and soil remediations? Recent reports from Iowa and California indicate that modern leak detection methods are not always capable of detecting leaks. Corrosion protection may only delay the deterioration of buried steel tank systems. Leak detection and corrosion protection must be properly installed, operated, and maintained to prevent the release of chemicals. Protection of our only drinking water source is too important to be exposed to contamination risks that can be prevented in a cost effective manner.

Our department proposes using PECFA funds for the purpose of protecting ground water used as a drinking water supply. Under our proposal, a storage tank system owner could receive financial assistance to install a double wall underground storage tank system. The amount would equal the cost difference between a single wall and a double wall system. Double wall containment offers the best protection for public health and environment since leaks are detected without chemical release into the environment.

At least two communities in the upper midwest and two states require double wall containment. Florida sunseted their state insurance program on December 31, 1998. Tank owners must insure 100% coverage for remediation and third-party liability. The premiums are ranging from $100 per tank for double wall containment to over $1500 per tank for single wall systems. Some owners are putting in double wall containment and amortizing the extra cost with the same money they are paying for premiums on their single wall tanks.

In closing, we must adopt policy that truly protects our public health and environment. Preventing costly chemical leaks and spills from underground storage tank systems protects citizens, business and government. Providing assistance for protecting our drinking water supply is a wise investment that will benefit all citizens of Wisconsin.

Thank you.

Sincerely,

Timothy C. Banwell

Timothy C. Banwell
Groundwater Program Manager
ROCK COUNTY HEALTH DEPARTMENT
P. O. Box 1143
Janesville, WI 53547-1143

ROCK COUNTY, WISCONSIN

Rock County Health Care Center
P.O. Box 351
Janesville, Wisconsin 53547-0351
Phone 608-757-5000
Fax 608-757-5010

MEMORANDUM

To: Senate Human Services and Aging Committee

From: Terry Scieszinski
Health Care Center Administrator

Date: April 14, 1999

Subject: State Budget - Intergovernmental Transfer Program

The Rock County Health Care Center is a 388-bed skilled nursing facility. The Health Care Center serves the chronically mentally ill, the developmentally disabled, and geriatric residents from approximately 20 Wisconsin counties, including all surrounding counties.

In 1998, 90 percent of the patient days were funded by Medical Assistance, 5 percent by the Medicare, and 5 percent by private pay. Due to insufficient funding from the federal and state programs, the Rock County taxpayer provided $4.9 million in tax levy support for the Health Care Center.

As federal and state funding for nursing homes, in general, and Rock County Health Care Center in particular, has declined, our facility has become more reliant on a relatively new funding source called the Intergovernmental Transfer Program (ITP). This program uses county nursing homes' Medical Assistance losses to capture federal matching dollars. During the early years of the ITP the matching dollars provided sufficient funds for Wisconsin to fully reimburse county homes for their losses and have additional funds to use for other state expenses. Since 1995, however, Wisconsin has returned a decreasing share of those funds to reimburse county nursing home losses and utilized the difference to replace state General Purpose Revenues.

This action by the State has created significant hardship for Rock County and its taxpayers. The following table summarizes ITP revenue for the Health Care Center:

FISCAL YEAR	BASE	SUPPLEMENTAL	TOTAL
93-94	$3,949,199	--	$3,949,199
94-95	$4,550,380	--	$4,550,380
95-96	$4,273,426	--	$4,273,426
96-97	$3,943,346	$1,973,028	$5,916,374
97-98	$3,624,557	$ 995,861	$4,620,418
98-99E	$2,787,257	--	$2,787,257

Also attached is a position paper developed by the Wisconsin Association of County Homes (WACH) and the Wisconsin Counties Association (WCA). As you can see, since 1995, an increasing portion of county homes' losses are not being reimbursed with the State retaining more of the federal matching dollars for its own purposes. These actions must stop. The ITP was developed to fund county nursing home operations rather than replace state support for the Medical Assistance Program.

I ask that you both support an amendment to Wisconsin Statutes which would increase the ITP awards to county nursing homes from $37.1 million to $72 million in each fiscal year of the next biennial budget.

TAS/TF
G:\HCCADMIN\TERRIF\ADMIN\SHSAC.DOC

Attachment

INTERGOVERNMENTAL TRANSFER PROGRAM

The facilities in Wisconsin that care for individuals with the most complex and challenging care needs are at risk of being forced out of business due to state policy. County nursing homes in Wisconsin have historically accepted the individuals who privately run facilities routinely turn away. Accepting these high-need, high-cost individuals obviously has an effect on a facility's bottom line.

In recognition of this unique nature of county homes, the Intergovernmental Transfer Program (ITP) was established in 1992. This program allowed the state of Wisconsin to use county homes' Title XIX allowable expenses to garner federal matching dollars.

This federal "matching" program provides enough dollars for Wisconsin to fully reimburse county homes for their losses and have additional funds left to use for other state expenses. From 1992-1995 that is how the program worked. Since 1995, however, despite continuous increases in the amount of federal funds coming to Wisconsin, the state has returned a decreasing share of those funds to reimburse county losses and utilized the difference to supplant General Purpose Revenues (GPR) (see chart).

(In Millions)

Fiscal Year	County Nursing Home Certified Losses	Fed. Funds Received to Cover Those Losses	Funds Returned to Counties	Taxes Paid by County Property Taxpayers for Funds Received by State
1992-93	46.3	70.6	15.0	31.3
1993-94	43.1	65.9	52.1	-9.0
1994-95	48.1	72.1	55.7	-7.6
1995-96	52.2	77.3	37.1	15.1
1996-97	59.2	85.7	37.1	22.1
1997-98	63.6	91.0	41.7	21.9
1998-99	68.0	96.4	37.1	30.9
TOTAL	380.5	559	275.8	104.7

As you can see, since 1995 an increasing portion of county homes' expenses are not being reimbursed. This is despite the fact that the amount of federal dollars these losses are generating is increasing every year.

The policy of utilizing more and more of these federal dollars that are "matching" the county home losses for non-county home purposes will ultimately force county nursing homes out of business. That would be a tremendous mistake for everyone involved. First, there would be a void for people with intense needs that have historically ended up in the county nursing home. Second, the tens of millions of federal dollars that Wisconsin is receiving every year via the county nursing homes would disappear.

Counties are simply asking that the state reimburse the county homes' losses that were utilized to generate the federal funds. The state can do this and still have a significant amount of money left over to use for its purposes. This would seem to be a win-win situation. If the state's greed, however, continues to drive decision-making, the "well" will dry up for everyone concerned - most importantly, for those currently receiving care that isn't offered anywhere else.

PROPOSAL: Amend Wis. Statues s. 49.45 (6u) to read:

Notwithstanding sub. (6m), from the appropriation under s. 20.435(5)(o), for reduction of operating deficits, as defined under criteria developed by the department, incurred by a facility, as defined under sub. (6m)(a)(3), that is established under s.49.70(1) or that is owned and operated by a city, village or town, the department shall distribute to these facilities at least $72 million in each fiscal year...

Charting the Mainstream

ew of Trends in the Dominant Medical System

by John Weeks, Publisher/Editor
THE INTEGRATOR *for the Business of Alternative Medicine: Shaping an Industry / Creating Health*
Principal, Integration Strategies for Natural Healthcare
- 59th Avenue SW, Seattle, Washington 98136 USA
206-933-7983; fax 206-933-7984; pihcp@aol.com

l CAM, Depressed Use CAM, es, Managed Care and Presidential Politics

ournal marily , issue ournal lished id that paper AMA t "over ability y" for id the olata, berg's AMA were some ctices erage oston some with ative wn – bited ingly art of AMA opics verse have ation ssue ices, here dual data the fact, old's t by uch

Lundberg sometimes showed Barry Goldwater-like disarming honesty. Back in 1991, at a conference of the old National Wellness Coalition, Lundberg lambasted academic medicine for failing to move nutrition into its curriculum. More recently, he gave the integration movement a pointed, explanatory metaphor for our current challenges. In a November 28, 1997, interview in *USA Today*, Lundberg implicitly affirmed the pivotal role of prejudice and polarization in keeping CAM in the closet. Said Lundberg: "A bamboo curtain (between conventional medicine and CAM) is beginning to splinter." Lundberg's metaphor is from the cold war. That is: there's a human (and economic) dimension to the historic externalization of CAM that has nothing to do with science.

One cannot help but wonder how much of the AMA's loss of "confidence and trust" in Lundberg relates to his willingness to break down the barriers and fold CAM inside *JAMA*'s pages by affirming its place side-by-side with "real" medicine. The AMA Politburo might have found Lundberg's glasnost too much too soon. The AMA's course of action is not, by any account, smart long-term medicine. The action is rather, not surprisingly, merely the suppression of symptoms of a deeper shift in the population. Here's hoping Lundberg does sue, as he has suggested he might, and airs all this out before his former employer and to the general public.

Too bad the AMA leaders didn't wait until February 2 for the editorial assassination. If Lundberg's bringing CAM into the light was partly at issue, the AMA's response was classic Groundhog Day: Wake up, see your shadow, decide it's too early for darkness to end, and go back down into your hole.

Source: "Medical journal's editor ousted over sex article" by Gina Kolata. The *New York. Times*, as carried in the *Seattle Post-Intelligencer*, June 16, 1999, pages 1, 3. Also an article by Howard Wolinsky and Mary Houlihan in the *Chicago Sun-Times*, January 16, 1999. And a *Boston Globe* article by Larry Tye, January 19, 1999.

Depressed Individuals Reach for Herbs – Even More than the Rest of Us

Consumer Health Sciences, recently reported data from its Mental Health & Wellness Project, a national, longitudinal study of individuals with mental health problems. Of the 1,570 surveyed individuals with depression, 19% reported using St. John's Wort, making it the agent used by the highest percent of respondents. Rankings were as follows (herbs in bold):

St. John's Wort	**19%**	Zoloft	14%
Ginseng	**18%**	**Valerian**	**8%**
Prozac	17%	Effexor	8%
Ginkgo	**17%**	Wellbutrin	7%
Paxil	16%	**Kava**	**4%**

Reach 23

Among those depressed, 92% report using CAM. Forty-two (42) percent use botanicals. Other CAM modalities analyzed were acupuncture, homeopathics, spiritual healing, massage and diet changes. Jane Donahue, president of CHS notes that given the high level of use of St. John's Wort, especially by those who may also be on prescription drugs, "the potential for dangerous drug interactions is a major concern."

COMMENT: Evidence of the soaring use of botanicals among consumers in the United States, subsequent to the unmuzzling of therapeutic claims since passage of the 1994 Dietary Supplement Health and Education Act continues to roll in, like water from behind a washed out dam; or, to borrow former *JAMA* editor George Lundberg's metaphor from immediately above, pent-up demand behind a "splintering bamboo curtain." While the much publicized Eisenberg update (*JAMA*, November 11, 1998) found general use at 12.1% in 1997, the Landmark study from late the same year put it at 17%. In published national data from 1998, the Stanford/American Specialty Health Plans (ASHP) study found use at 31%. Now Consumer Health Services puts the use of herbs among those depressed at a significant 42% and use of all CAM among this population at 92%. The question begged by this data, with this population, is whether it's time to turn our conceptions of "alternative" and "mainstream" upside down. To extend the metaphor, this gushing forward of CAM interest since the cultural and regulatory opening of opportunity to explore CAM is actually carving a new "mainstream" in our collective river bottom.

The following irony is emerging. Data on increased use of CAM is motored by use of both botanicals and vitamin supplements. The latter category, listed as "vitamin therapy" in the Stanford/ASHP study, was a whopping 36%, while just 5.5% in Eisenberg, who uses the distancing term of "megavitamin therapy." (Would one who uses zinc and vitamin C when a cold is coming on call it "megavitamin therapy"? Probably not. But "vitamin therapy"? Yes.) Given the increased investment by conventional pharmaceutical and personal care corporations into these sectors, and the concomitant expansion of direct-to-consumer advertising of supplements, one may say that one significant force behind the growing CAM movement is the pharmaceutical industry. And of course, one may need to add, while ticking off the "principles" behind this movement, not only *the healing power of nature* but also *the financial clout of the drug industry.*

Source: Mental Health & Wellness Project, Consumer Health Sciences, Princeton, NJ. From AOL News, December 22, 1998.

Paternalistic Push toward Health Creation: Health Care University at Pitney Bowes

The cover article in this publication, which targets human resources personnel, captures the transition of benefits planning at mailing machine manufacturer Pitney Bowes. The goal: "getting people into the health care system earlier to keep them at work or get them back to work, producing more quickly. It's a different model of paternalism." The firm developed onsite clinics where employees receive free care, no-cost prescriptions, physical therapy and routine secondary prevention screenings. Another strategy is development of an elaborate "for credit" series of wellness programs they call Health Care University (HCU). Employees who complete these classes earn credits which can be applied to purchase of additional employee benefits. In a trial period 40% completed programs, and an additional significant percentage of the Pitney Bowes workforce took classes, although not for credit.

...ers are presenting themselves as candidates who would be more sympathetic to Thompson's outlook, then I'm certainly not more inclined to vote for them.

Michael Rawdon

CELEBRATING JOEL

I'm glad you reprinted the *Utne Reader* story about Joel Rogers ("Whiz Kid," 1/3/97). Joel deserves a lot of credit for his work, and local folks especially should be aware of his efforts. I found the "whiz kid" label and sidebar to be distractions, however. The sidebar's charges seemed unsubstantiated, and it had that Madison smell of a snide unwillingness to simply celebrate an alternative activist without throwing a slap upside the head. I've seen Joel in action, and amidst the mediocrity and even maliciousness of our current political, corporate and public leadership, he is an asset well worth praising. Go second guess the other guys.

Geno Becker

HISTORY LESSON

I was excited to see the Village co-housing success story make it to your pages ("It Takes a Village," 12/20/96). However, I must take exception to author Jessica Fugate's lack of research into the subject of cooperative living in Madison. She states that the Village Co-housing Community is about "to implement Madison's first cooperative housing project." This is hardly the case.

Cooperative housing has been going strong in Madison for a good 80 years! The first examples were sponsored in the 1910s by the university to offer family style housing for new female students. The Depression inspired the formation of yet more affordable, cooperative housing by the university and by churches. In the 1940s, a number of families formed a "cooperative neighborhood" in the now-swallowed suburb of Crestwood. Then, in the 1960s and 1970s, university students were catalyzed to create tenant-owned and managed housing to answer the terrific lack of affordable housing in the campus area.

Since that time, cooperative housing has diversified. The only "student co-op" left in Madison is the university-run Zoe Bayliss House. The rest of the 25 or so residences, providing housing for approximately 300 Madisonians on the east side, west side and downtown, would be more aptly named "community co-ops."

Amanda Werhane
Madison Community Cooperative

The history of co-op housing in Madison goes back to September 1919 when Tabard Inn was organized as a women's cooperative house in conjunction with the UW Self Government Association and the UW-YWCA. In 1928, Terrace Homes Co. was founded and advertised as "apartment living where every tenant is his own landlord." These buildings still stand at 114-118 Breese Terrace, across from Camp Randall Stadium. In 1931, Babcock House was founded for men in the UW School of Agriculture. In 1943, Groves Women's Co-op was founded at 102 E. Gorham St. For some time, Groves was the only integrated housing in Madison, and counted as one of its members *A Raisin in the Sun* playwright Lorraine Hansberry. Groves later became a retirement home, and years later this same building became Mulberry and, finally, Hypatia Co-op.

THE ENEMY WITHIN

I know that I'm not a world-renowned medical expert, or even a researcher at UW-Madison, but I am certain that I can clarify most of the confusion over the etiology/pathology of osteoporosis (Letters, 1/3/97 and "Is Milk Good for You?" 10/4/96). Like any other major disease that develops over a long period of time, osteoporosis has a wide gamut of causative factors.

The trouble starts with what we eat. Americans consume a diet that consists largely of refined/processed (enzyme-dead) starches/sugars and hydrogenated oils. This diet will not support life, and plays right into the hands of pathogenic microbes like bacteria, fungi, viruses and parasites. As we age (the diet accelerates this process), levels of hydrochloric acid diminish as does the production of pancreatic enzymes.

Food allergens of all types also play into this degenerative action. Proteins that cannot be assimilated or are perceived as toxic by the body have the effect of enhancing this whole process. A component in the food that stresses the immune system in the digestive tract will lower resistance to pathogenic microbes. This destructive mechanism encourages the formation of mucous (the body uses it to contain and smother the microbes), which gradually sludges up the digestive tract. As the intestines are damaged by this toxic crud (which collects in nooks and crannies in the "tubing"), this structure's ability to function properly is compromised.

The lower part of the small intestine and the large intestine are largely responsible for the digestion-assimilation-absorption of minerals in many forms. When the colon sludges up, nothing works right because pathogen mycotoxins produced there leak through the intestinal wall into the bloodstream, thus making their way (often with the bad microbes) to any organ or gland in the body. Similar toxic sludge can coat the small intestine and stomach walls.

This havoc is further enhanced by a lack of good fiber in the diet and insufficient exercise, as well as toxic food additives, a dearth of pure water intake daily, and the position in which we defecate—we should be squatting.

Unfortunately, there is more. Fluoride compounds in the water supply interfere with the absorption of calcium. The body mistakes radioactive cesium as calcium (atomic testing and accidents have nuked everyone). This, like "radiation therapy," has a degenerative effect on bone tissue.

The final part of this disease puzzle is the disruption of the endocrine system. The adrenals, parathyroid, thyroid and even the lymph glands (just to name a few) work together to regulate the availability and use of minerals, most notably calcium, magnesium and several other primary (non-trace) minerals. Low DHEA levels (the adrenal steroid precursor dehydroepiandrosterone) has reached epidemic proportions across the adult population.

If you don't have a clear gut level feeling for what really is going on because you are confused, just go back and read this all again once or twice; then sleep on it. And if you can't do that you surely need some calcium and magnesium.

Edward Reich
Janesville

608-757-0343

LETTERS WE DON'T RUN

ISTHMUS MAGAZINE 2-14-97

ALSO FACTORS DRINKING POP COFFEE (FOODS MINERALS) ANTI-BIOTICS STEROIDS (IN FOOD SUPPLY)

MY 4TH LETTER IN ISTHMUS IN 3 1/2 MONTHS

Madiso

By LINDA FALKENSTEIN

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WISCONSIN ASSOCIATION OF LOCAL HEALTH DEPARTMENTS AND BOARDS

Pat Grove RN MS
Health Officer

Partnering To Improve Public Health

Senate Human Services and Aging Committee

April 14, 1999

Rock County Courthouse

Health Alert: Lack of Funds in the Governors Budget for Childrens Immunizations

Good afternoon honorable members of the Human Services and Aging Committee and the citizens of Wisconsin gathered here today. My name is Pat Grove, I am a Public Health Nurse and Health Officer of Walworth County. We have a statewide organization called the Wisconsin Association of Local Health Departments and Board Members (WALHDAB) and in our Southeast Region there are 60 members. Today my comments are representative of the Health Officers and Health and Human Service Board Members of WALHDAB.

Immunization of children is a required service of all the health departments in the state. This program is a top priority service in all health departments. Immunization protects children from illness and death. We need a comprehensive and coordinated immunization program throughout the state as young families are mobile and there are many under-insured and under-immunized children.

The Wisconsin Immunization Registry (WIR) will provide such a system to link physicians offices and public health agencies together to have an automated system to provide a omplete and accurate immunization record for each child. We need GPR funds to accomplish this task. At the local health department levelwe will need new administrative dollars to implement and then maintain the WIR system. We are asking for funding for training for our staff and the local providers. Local health departments are more accessible than Madison.

Our present grant funds for the immunization programs at public health departments are generated from four sources. The funds are now 90% federal and 10% state. There is much overlap in the grants and much record keeping and accounting. Last year when the local health departments asked for infrastructure dollars to upgrade equipment, purchase supplies for clinics and increase the staff hours needed to maintain such a program, we received an "MA Outreach" grant to enroll children in Medical Assistance. The immunization grants now require the local public health departments to audit physicians office records. It is the role of public health nurses to vaccinate children at clinics and educate families. We need more resources to continue to provide assurance and a leadership role in immunizing our children.

Thank you for your time and consideration of this request.

Pat Grove RN MS/ Health Oficer/Chairperson Legislation Comittee/WALHDAB

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WISCONSIN ASSOCIATION OF LOCAL HEALTH DEPARTMENTS AND BOARDS

Senate Human Services and Aging Committee

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